Royal Commission into Aged Care Quality and Safety

Final Report: Care, Dignity and Respect

Volume 4C

Hearing overviews and case studies:

Adelaide Workshop 1 to Counsel Assisting's final submissions

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Introduction to Volume 4

Introduction

This volume of the Final Report details some of what the Royal Commissioners heard in public hearings. It also contains the conclusions that Commissioners have reached about the case studies that have been examined at some of those hearings.

Volume 4A contains the hearing overviews and case studies that were first published in the Interim Report. The accounts in that part of this volume represent the views of Commissioners Tracey and Briggs. The text in Volume 4A, apart from the Introduction and the redaction of a name, is an exact reproduction of the Interim Report text, including page numbers.

Volumes 4B and 4C contain the hearing overviews and case studies from the Mildura Hearing, in July 2019, to our final hearing, in October 2020. The accounts of the hearings held in Brisbane and Mildura were finalised after Commissioner Tracey's death and represent Commissioner Briggs's account of, and findings in, those hearings. Commissioner Briggs presided alone at Melbourne Hearing 1 and the account of that hearing represents her views. The accounts of the hearings from Melbourne Hearing 2 onwards are those of Commissioners Pagone and Briggs.

This volume is not intended to be a comprehensive record of all evidence received at hearings. Some of the evidence has been drawn upon in Volumes 1 to 3 of this report. Whether or not summarised here, or in other volumes of this report, we have considered and been informed by all the evidence which has been received.

Hearings: overview

As set out in Volume 1, there are many ways in which we have conducted our inquiries, including through public hearings. This volume contains an outline of some of the evidence received at our hearings.

Public hearings and hearings in the form of workshops were held between 11 February 2019 and 23 October 2020.[1] There were 99 hearing days in total. Witnesses included people receiving aged care, family members and friends of people receiving care, experts, advocates, volunteers, researchers, service providers, and representatives from government departments and agencies.

Counsel and Solicitors Assisting the Royal Commission selected witnesses to give evidence based on their connection to the matters being examined in a case study or based on their expertise or experience in connection with the themes being focused on at the particular hearing. In addition, many people gave accounts of their experiences with aged care. In most cases, providers are not identified in these direct accounts. The purpose of direct accounts was to allow Commissioners and the public to bear witness to individual experiences. These valuable accounts assisted us in understanding the range of issues relevant to our Terms of Reference.

Our Terms of Reference required us to consider appropriate arrangements for evidence and information to be shared by people about their experiences, recognising that some people need special support to share their experiences.[2] In most cases, witnesses gave evidence in person. However, in some cases it was necessary to take evidence remotely or by pre-recorded video.

In Volume 1, we explained that early in the Royal Commission's operation, the Commissioners decided that each hearing would focus on a particular theme or themes associated with the Terms of Reference.

Public hearings

Public hearings were conducted in courtrooms or in courtroom-like settings. They were conducted formally with witnesses being summonsed to appear before the Royal Commissioners. Witnesses were generally required to provide written statements in advance of giving oral evidence directed to the theme of the public hearing.

Counsel and Solicitors Assisting determined that, where appropriate, case studies would be used to illustrate the themes to be examined at public hearings.

Case studies

Case studies that had the potential to expose the themes being explored at a particular hearing were selected for investigation. Solicitors and Counsel Assisting investigated many more case studies than ultimately proceeded to examination at public hearings. These investigations involved:

- detailed review of submissions from the public
- interviewing potential witnesses
- issuing notices to relevant entities and comprehensively reviewing the material returned.

Following this process, Counsel and Solicitors Assisting decided which case studies would proceed to examination at a hearing. Following the conclusion of our hearing in Hobart in November 2019, we decided it was unnecessary to hear further case studies. This was because our focus shifted to the recommendations we might make in our Final Report.

Case studies at Royal Commission hearings focused on the experiences of individuals with particular approved providers of aged care. They involved some consideration of approved providers' responsibilities and obligations, as well as the regulatory environment within which they operated.

Leave to appear and post-hearing submissions

In the weeks before public hearings, details of the hearings were announced on the Royal Commission's website. These announcements included details of the scope of matters that would be examined. People or organisations with a direct and substantial interest in matters being examined were invited to apply for leave to appear at the hearing. These applications were considered, with leave usually granted to those being called as witnesses or those with an interest in the factual matters being examined in a case study, especially when their interests may have been adversely affected.

After most hearings, Counsel Assisting provided written submissions. These written submissions generally concerned the case studies. Where Counsel Assisting considered it appropriate, they invited us to make findings about facts and issues arising in case studies. Counsel Assisting's submissions were provided to parties with leave to appear whose interests were affected by those submissions. Those parties had the opportunity to respond in writing, making submissions in reply. We have considered all the submissions. Where appropriate, we have reached conclusions based on the evidence and submissions before us.

Standard of proof

Our hearings were conducted differently to trials conducted in courts; they were inquisitorial rather than adversarial in nature. Royal Commissions are not bound by the rules of evidence but we have been guided by them and we have applied a civil standard of proof. Findings are made and conclusions reached only where we have 'reasonable satisfaction' of the fact or issue in question. We have been guided by the principles discussed by Dixon J in *Briginshaw v Briginshaw*:

> it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing

> from a particular findings are consideration which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal…the nature of the issue necessarily affects the process by which reasonable satisfaction is attained.[3]

While not binding or enforceable, the conclusions or findings we made can have significant impact upon those who are the subject of them. We have not reached conclusions or made findings lightly.

Hearings in the form of workshops

Hearings in the form of workshops were conducted in early 2020 to allow us to gather evidence in a less formal setting than public hearings. They were not conducted in courtrooms or in a courtroom-like environment. Hearings in the form of workshops were used to test propositions and ideas with panels of witnesses and were focused on specific issues or topics.

Virtual hearings

On 20 March 2020, we suspended all hearings and workshops as a consequence of the evolving coronavirus (COVID-19) pandemic. We resumed our hearing program in August 2020. To ensure public health advice related to the ongoing pandemic was followed, we elected to conduct our remaining public hearings using a virtual model. This model allowed witnesses and parties with leave to appear to participate in the hearings using a real-time video link.

Submissions

At various points during our schedule of hearings, Counsel Assisting made submissions about recommendations that they considered we could make. In addition, Counsel Assisting made various calls for submissions directed at particular matters. The process of submissions in response culminated in a hearing held over two days on 22 and 23 October 2020, when Counsel Assisting made their final submissions to us. We have considered Counsel Assisting's submissions and responses to them in making the recommendations contained in Volume 3 of this report.

Endnotes

1 A full list of public hearings and hearings in the form of a workshop is set out in Volume 1 of this report.
2 Commonwealth of Australia, *Letters Patent*, 6 December 2018, paragraph (r).
3 (1938) 60 CLR 336 at 362–3.

15. Adelaide Workshop 1: Redesign of the Aged Care System

15.1 Workshop overview

15.1.1 Introduction

Our first hearing in the form of a public workshop, Adelaide Workshop 1, was held on 10 and 11 February 2020 at the Adelaide Convention Centre. The workshop was designed to gather evidence as part of a multi-step process to inform our inquiry into improving the design of government programs through which aged care services are funded and delivered.

Prior to the workshop, on 6 December 2019, we published *Consultation Paper 1: Aged Care Program Redesign: Services for the Future*. In Consultation Paper 1, we set out our preliminary thinking for a redesigned aged care system based on 12 key principles, and for an aged care program containing three separate funding streams: entry-level support (basic) stream, investment stream and care stream.[1]

Consultation Paper 1 promoted 12 key principles for a new aged care system:

- respect and support for the rights, choices and dignity of older people
- quality and safety
- equity of access
- transparency and ease of navigation
- care according to individual need
- independence, functioning and quality of life
- support for a good death
- informal care relationships and connections to community
- the recruitment and retention of a skilled, professional and caring workforce
- support effective interfaces with related systems, particularly health and disability
- affordability and sustainability
- practicable implementation, monitoring and evaluation.[2]

It included the following key design features:

- measures to improve information and access including face-to-face services from a new workforce of 'care finders'
- the establishment of three service streams (an 'entry-level support stream', an 'investment stream' and a 'care stream')
- streamlined access to the entry-level support stream
- comprehensive assessment of eligibility for the more intensive service streams (the care and investment streams)
- in the investment stream, funding for interventions to help restore functioning, provide respite and delay or prevent progression to more intensive forms of care
- in the care stream, funding for services delivered either in the home or in more flexible and less institutional forms of residential care, a move to individualised funding for care matched to need, irrespective of setting, and the potential that care services could be separately funded
- improvements in the availability of nursing and allied health services across the system
- the potential for removal of rationing or controls on the numbers of subsidies provided (sometimes described as 'uncapping supply'), and a move to the assignment of 'an entitlement to the efficient cost of care that is both reasonable and necessary, and of high quality and safety'.[3]

We invited submissions from the public in response to Consultation Paper 1 and received approximately 170. Each submission was reviewed by staff of the Royal Commission, who also conducted a series of consultations on the paper to assist in the preparation of this workshop.

We adopted a panel format to enable discussion between witnesses and with panels structured to reflect the various concepts outlined in Consultation Paper 1. Over two days, we heard evidence from 33 witnesses across the following six panels:

Panel one: Big picture

- Mr David Tune AO PSM, Independent Chair, Aged Care Sector Committee
- Mr Ian Yates AM, Chief Executive, COTA Australia
- Professor Mike Woods, Professor of Health Economics at the Centre of Health Economics Research and Evaluation at the University of Technology Sydney and member of the Aged Care Financing Authority
- Ms Patricia Sparrow, Chief Executive Officer, Aged and Community Services Australia
- Dr Kirsty Nowlan, Co-chair, Every Age Counts
- Mr Michael Lye, Deputy Secretary, Ageing and Aged Care, Australian Department of Health

- Mr Robert Bonner, Director, Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch)
- Mr Glenn Rees AM, Chairman, Alzheimer's Disease International.

Panel two: Information, navigation and assessment

- Mr Ian Yates AM, Chief Executive, COTA Australia
- Mr Paul Versteege, Policy Manager, Combined Pensioners and Superannuants Association
- Professor Michael Fine, Department of Sociology, Macquarie University
- Dr Ricki Smith, Chief Executive Officer, Access Care Network Australia
- Dr Nicholas Hartland PSM, First Assistant Secretary, In Home Aged Care, Australian Department of Health
- Ms Samantha Edmonds, Managing Director, Ageing with Pride and Chair of the Aged Care Sector Committee Diversity Sub-Group
- Professor John McCallum, Chief Executive Officer, National Seniors Australia
- Mr Sean Rooney, Chief Executive Officer, Leading Aged Services Australia
- Professor Mark Morgan, Chair, Royal Australian College of General Practitioners Expert Committee – Quality Care
- Mr Bryan Lipmann AM, Chief Executive Officer, Wintringham.

Panel three: Entry-level (or basic services) stream

- Mr Graham Aitken, a Yankunytjatjara descendent and Chief Executive Officer, Aboriginal Community Services
- Dr David Panter, Chief Executive Officer, ECH Incorporated
- Professor Michael Fine, Department of Sociology, Macquarie University
- Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care
- Ms Jane Mussared, Chief Executive Officer, COTA SA
- Professor John McCallum, Chief Executive Officer, National Seniors Australia
- Dr Nicholas Hartland PSM, First Assistant Secretary, In Home Aged Care, Australian Department of Health.

Panel four: Investment stream

- Professor Julie Ratcliffe, Caring Futures Institute, Flinders University
- Dr Gill Lewin, School of Nursing, Midwifery and Paramedicine, Curtin University
- Mr Jaye Smith, First Assistant Secretary, Residential Care, Australian Department of Health

- Dr Henry Cutler, Director, Centre for Health Economy, Macquarie University
- Ms Sue Elderton, Chief Executive Officer, Carers Australia
- Dr David Panter, Chief Executive Officer, ECH Incorporated
- Ms Patricia Sparrow, Chief Executive Officer, Aged and Community Services Australia.

Panel five: Care stream

- Ms Annie Butler, Federal Secretary, Australian Nursing and Midwifery Federation
- Ms Maree McCabe, Chief Executive Officer, Dementia Australia
- Mr Nick Mersiades, Director, Aged Care, Catholic Health Australia
- Mr Matthew Richter, Chief Executive Officer, The Aged Care Guild
- Professor Deborah Parker, Chair, Ageing Policy Chapter, Australian College of Nursing and Professor of Aged Care (Dementia), University of Technology Sydney
- Professor Mark Morgan, Chair, Royal Australian College of General Practitioners Expert Committee – Quality Care
- Ms Melissa Coad, Executive Projects Coordinator and National Office Development and Industry Coordinator, United Workers Union
- Dr Nicholas Hartland PSM, First Assistant Secretary, In Home Aged Care, Australian Department of Health.

Panel six: Transition and implementation

- Mr Sean Rooney, Chief Executive Officer, Leading Aged Services Australia
- Mr Robert Bonner, Director, Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch)
- Ms Sandra Hills OAM, Chief Executive Officer, Anglican Aged Care Services Group T/A Benetas
- Dr Henry Cutler, Director, Centre for Health Economy, Macquarie University
- Dr Nicholas Hartland PSM, First Assistant Secretary, In Home Aged Care, Australian Department of Health.

In some instances, evidence from a witness on one panel related closely to the topics addressed by another panel. A thematic overview of the evidence given during the workshop follows.

15.1.2 Big picture

The first panel session focused on the overarching structure of the aged care system redesign proposed in Consultation Paper 1. Witnesses expressed their opinions about structural aspects of a redesigned system including the governing principles of an aged care system, areas requiring fundamental reform, the proposed funding streams and uncapping supply.

The governing principles of the aged care system

The witnesses on this panel were invited to comment on the 12 key principles proposed in Consultation Paper 1 and outlined above.[4] The importance of embedding consumer choice and control within the principles was highlighted in this discussion.[5]

Mr David Tune AO PSM, Independent Chair of the Aged Care Sector Committee, told us that 'The empowering of [the] consumer is absolutely central. And turning that into reality is a really important part of this process'.[6]

Ms Patricia Sparrow, Chief Executive Officer of Aged and Community Services Australia, recommended the adoption of a 'life-force lens' to examine 'how aged care sits in the context of supporting an older person overall'. Ms Sparrow explained that while the principles draw out the individual human rights quite well, there is a need to balance this with the concepts of community investment and building community to ensure that there is sufficient 'infrastructure in the community to support older people with which aged care services interact'. She also raised the importance of respect, transparency and comparability of services, as well as development of the aged care workforce to ensure 'a right fit workforce to support older Australians'.[7]

Dr Kirsty Nowlan, Co-Chair of Every Age Counts, told us that there is a need to 'recognise the normative context in which a system exists' and to adjust 'ageist mindsets'. While Dr Nowlan commended the inclusion of principles focusing on quality of life, she cautioned that:

> if the objective is to support the wellbeing of older Australians, we need to come at this from a perspective that doesn't reduce that wellbeing to a biomedical model. So that [it] takes into account the social and psychosocial needs of that community.[8]

Dr Nowlan explained that 'there is a critical need for the governance of the system to engage a significant dimension of co-design'.[9]

Mr Glenn Rees AM, Chairman of Alzheimer's Disease International, said that he did not find the principles in Consultation Paper 1 helpful. He explained that they do not 'extend to core values such as efficiency, effectiveness, equity and autonomy' and that 'they suggest consensus where there isn't consensus'.[10] Mr Rees stated:

> For me as a consumer, the central point is how do you reconcile person-centred care with lack of empowerment? And if we can get that right in terms of the conflicting interests of government, consumer and service providers, I think we might have the makings of some good design principles…[11]

Mr Rees suggested that the aged care system would greatly benefit from a clearly articulated overall objective. He said that upon reading Consultation Paper 1, he understood the objective of the redesigned aged care system may be 'to enable every older person to remain as independent as possible'.[12]

Professor Mike Woods, Professor of Health Economics at the Centre of Health Economics Research and Evaluation at the University of Technology Sydney and member of the Aged Care Financing Authority, agreed that there was merit in articulating an overall objective of the redesigned system to 'allow those higher level concepts of ageing, wellbeing, quality of life to be brought in and provide that context for the aged care arrangements'.[13]

Areas requiring fundamental reform

Access to and eligibility for aged care services

Consultation Paper 1 proposed that fundamental change is needed to ensure the aged care system supports 'older people and their families to understand the system' and to 'get the services and care they need, including by getting much better information and face-to-face support'.[14] The witnesses of this panel considered the connection between healthy ageing and entry into Australia's aged care system.

Ms Sparrow commended the emphasis on face-to-face support proposed in Consultation Paper 1. Both Ms Sparrow and Professor Woods spoke of the need for a balance to be struck between quick and easy referral for aged care services, and a comprehensive independent assessment process designed to capture a holistic view of a person's needs.[15]

Ms Sparrow emphasised the importance of balancing early access to basic services, including transport and meals, with an efficient independent assessment to establish what further services may be required. She said that there may be benefit for some of the services within the investment stream being provided 'right up front'.[16]

Professor Woods explained this balance sometimes requires:

> dealing with an immediate issue and not making it such a barrier that people don't want to… be registered with the government and, therefore, don't even receive those basic services.[17]

Professor Woods expanded on the idea of a two-tier system of basic screening and of comprehensive assessment, which would offer a 'soft entry' into the system for those people requiring basic services, shortly followed up by a comprehensive assessment 'to make sure that you understand why they need those [basic] services, because that may be an indicator of broader need'.[18]

Dr Nowlan emphasised the importance of ensuring that the system 'isn't alien at the point that one needs to start to engage with it'. She explained:

> One of the reasons that people come to aged care at the point of crisis is because of internalised ageist beliefs and a desire not to engage with the system and a sense that engaging with the aged care system may result in the loss of autonomy.[19]

While Dr Nowlan described the concept of a 'no wrong door' entry into the system as 'in some senses unimpeachable', she cautioned that 'ageist mindsets' within health care at a systemic level may act as a barrier. She also highlighted that it is often those people with the highest need for services who do not access the system out of concern that engaging 'may result in the loss of autonomy'. She encouraged further thinking in relation to these problems.[20]

Mr Tune expressed general support for the expansion of referral points for entry into aged care to include health services and other similar services, but he did not support them being the point of assessment. He stated that there was a need for 'an independent assessment process for eligibility in the system'.[21]

Mr Robert Bonner, Director, Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch), expressed the view that 'if we don't improve referral and eligibility for care from hospitals and GPs [general practitioners] and the like, then we're going to continue to trap people in inappropriate points of care' which may not best meet their needs and may be more expensive for the community.[22] He outlined that while health professionals may be able to identify 'need for access and ongoing support and care', they are not in a position to assess eligibility for an aged care subsidy which is a different test. He emphasised that 'we need to be clear about what we are assessing for'.[23]

Care management and the potential role of a 'care finder'

Counsel Assisting canvassed the question of whether the role of the 'care finder', proposed in Consultation Paper 1, should be extended to encompass care coordination and management. Dr Nowlan considered that it should do so:

> if we accept that ageing is not a…linear experience and…under a system that values restoration of reablement, then, yes, we need ongoing support to enable connections to varying and different services as different needs and priorities present.[24]

Mr Tune suggested that the 'care finder' role outlined in Consultation Paper 1 may have a broader scope in assisting the consumer to navigate the system from the assessment process onwards.[25] Mr Rees agreed, explaining that often people do not recognise that they need help and so 'the care navigator has an important role of persuasion, as well as directing people to services'.[26]

Ms Sparrow stated that care management could be performed by someone from the service provider, once a link is made, however this should be a choice for the individual.[27] She said:

> there's a point at which you need both, keeping some independence, but also making sure that those people who are dealing on a day-to-day basis and can provide valuable insights are part of the process.[28]

According to Professor Woods, 'The importance of relationship for the older person needs to remain central because there's a danger if we try and design it too tightly, we are going to get fragmentation'. He explained that assistance with navigation should be broadly defined so that it is conducted by somebody who the person trusts. The provider should

have the responsibility of notifying the navigator when there is a change in circumstances, however in his view they should remain as separate functions.[29]

Mr Bonner agreed that the management or navigation role should remain separate from the service provider. He highlighted the risk that a service provider may focus only on the information relating to that particular environment, and may not take into consideration the wider view of that person's needs or aspirations.[30]

Issues surrounding information, access, care finding and assessment were addressed in further detail by the second panel, as outlined below.

The proposal for three streams of aged care services

In Consultation Paper 1 we proposed three streams of funding for different types of services, namely:

- an entry-level support (basic) stream to provide support with everyday living activities including assistance with meals, transport, social support and centre-based activities
- an investment stream to fund interventions to help restore functioning, provide respite and delay or prevent progression to more intensive forms of care
- a care stream for services delivered either in the home or in more flexible and less institutional forms of residential care.[31]

The first panel was asked whether such an approach to system design was appropriate and 'fit for purpose'. They considered the model as an overall concept as well as considering each stream individually.

Mr Tune outlined the need for a continuum of care approach. He stated that the proposal in Consultation Paper 1 may 'perpetuate some of the problems we have got in the [current] system if we don't think more broadly'. He said:

> whilst I appreciate that people could receive assistance under all…three streams, I think it's just creating boundary issues that are not necessary, in effect. If we think about it as one big system with various components and various intensities…I think we might be getting somewhere.[32]

Mr Ian Yates AM, COTA Australia Chief Executive, broadly agreed with Mr Tune, explaining that when a person enters the system they may 'need some very basic community engagement connections…[and also] quite significant medical intervention'. Mr Yates suggested that a person-centred approach should frame services around a person's 'set of needs'. He considered the term 'entry' level as distinct from 'care' as creating unnecessary confusion.[33]

All witnesses on the first panel strongly supported the concepts of restoration and reablement being more prevalent in a redesigned aged care system. Dr Nowlan raised concerns about the periodic nature of the investment stream interventions versus ongoing support, noting that managing a person's expectations is an important consideration in providing care. She also raised concerns of the risk of 'siloing' between the separate streams.[34]

Mr Rees was strongly critical of the investment stream stating that it 'offends every principle that I have in terms of system design'.[35] He said he believed that reablement should be integrated across the whole aged care system:

> I think system design should be based on two main principles and that's a continuum of care for older Australians, that supports access to a range of services, including allied health and nursing care as assessed needs change. The second principle is that reablement, if it's going to be transformative, needs to be across the totality of aged care... [36]

Mr Bonner was supportive of Mr Rees's view, saying that isolating restoration and reablement to a particular stream is 'problematic in terms of best possible life for people in all aspects of care'. Mr Bonner agreed that Consultation Paper 1 endeavoured to instil principles of reablement throughout all of the streams, but stated that the structure created some sense of false dichotomies between the streams.[37]

Most witnesses expressed concern at the concept of individualised funding under the care stream outlined in Consultation Paper 1. Ms Sparrow said that while individualised funding can be beneficial in a home care setting, it may not work in a residential setting. She referred to the recent Australian National Aged Care Classification study:

> If we look at the residential care model of funding that's being trialled at the moment, it actually has a combination of acknowledging that there are some costs that are related to the place of service delivery that should be funded so the door is open, and also that there are individual funding streams that then follow the individual. And I think that's important.[38]

Ms Sparrow also said that individualised funding may create difficulties in ensuring that there is sufficient capacity and services available in all locations where services are required.[39] Mr Bonner explained that there 'are huge workforce issues associated with individualised funding, both in the community and in residential care', including greater casualisation of the aged care workforce and disaggregation of work into the future.[40]

Some witnesses on other panels also expressed views on the wisdom of the three-stream model during the course of their evidence. Notably, during the fifth panel discussion, Professor Deborah Parker of the Australian College of Nursing expressed doubts about the model. Professor Parker referred to the opposition of the Australian College of Nursing to any potential for the separation of personal care from nursing care. While accepting that there might be economic efficiencies in basic supports being assessed and funded differently from care, she urged caution in adopting any such approach, noting that care needs are not stable, that rigorous oversight of the people receiving services in the high volume stream would be needed, and that it was unclear how this would be achieved.[41]

The uncapping of supply of aged care services

Australia's aged care system is 'capped' by the number of allocated places: residential care through the Aged Care Approvals Rounds, home care by the Home Care Packages Program, and collectively by the set ratio of places per 1000 people aged over 70 years. The panel considered the merits and implications of uncapping supply in aged care, and most supported it.[42]

Mr Michael Lye, Deputy Secretary, Ageing and Aged Care, Australian Department of Health, stated that moving to a system of uncapped supply would require emphasis being placed on the assessment process to ensure that there is a good understanding of eligibility. He also noted the need for better understanding of current demand in the aged care system. He explained that careful consideration would be required so that people with equivalent levels of need receive similar levels of assistance to ensure consistency.[43]

Professor Woods supported Mr Lye's comments on the need for a rigorous assessment process.[44] Mr Yates supported uncapping supply, and said that there is a need for more flexibility within the regulatory system to allow for more creative approaches to residential care.[45]

Mr Bonner highlighted that the alternative to uncapping aged care services would be a continuation of the current system in which people are 'trapped either without services or in completely inappropriate settings' which is economically inefficient and also increases demand for Australia's acute care services.[46]

Connections with housing issues

Two witnesses in the second panel expressed views about the connection between any redesign of the aged care system and issues relating to housing. Mr Paul Versteege, of the Combined Pensioners and Superannuants Association, said that for many older people, remaining in the family home becomes a 'symbol of independence' however unsuitable that home may be. Mr Versteege explained that 'if we can overcome that and encourage people to think rationally about…what does the home do for you and what doesn't it do for you, that would be a big gain'.[47]

In its submission in response to Consultation Paper 1, the Combined Pensioners and Superannuants Association stated that when first seeking to access aged care:

> people need to be actively encouraged to look at what type of housing they need as their physical functionality continues to decline. This is an opportunity to orient people away from staying in a home that (1) may not have the accessibility required as mobility declines, that (2) may be too big, that (3) may not be located near services and that (4) may be in a more or less isolated location. The aged care system should not gear itself to keeping people in the home they have always lived in, it should gear itself to housing people where they can be better and more cost-effectively looked after.[48]

Wintringham is an aged care provider that specialises in providing aged care for people who are at risk of homelessness or who are homeless. Mr Bryan Lipmann AM, Wintringham's Chief Executive Officer, stressed that there is a real lack of supply of appropriate housing in Australia, stating that Wintringham sees itself as a 'housing provider into which we put aged care'. He explained that Wintringham currently has 1500 people on its waiting list, all of whom will 'progress towards aged care far quicker than if they were living in housing'.[49]

15.1.3 Information, navigation and assessment

Counsel Assisting canvassed with the second panel the key features of a redesigned aged care system from Consultation Paper 1, relating to information, navigation and assessment, including the role of a 'care finder' in such a system.

Professor Mark Morgan, Chair of the Royal Australian College of General Practitioners' Expert Committee – Quality Care, highlighted the advantages of older people being able to access face-to-face aged care services in a timely manner:

> I think there needs to be multiple access points to any face-to-face service...And the sort of access points we're talking about would be the personal carer themselves experiencing an unmet need, a health provider, like a GP [general practitioner] or hospital provider, recognising that there will be an unmet need or there is an immediate unmet need.
>
> And if all of those potential providers of services can access a face-to-face navigation, that's going to lead to a quicker approach than having a multiple staged model where you have to go through a series of triage, assessments and meeting[s] before getting that face-to-face help that you need to get started.[50]

Professor Morgan suggested that the most effective way to achieve this may involve a structured online or over-the-phone questionnaire delivered by a health practitioner, for example, and that would 'provide the necessary information for the next stage, which is the actual provision of [a] face-to-face navigator'.[51]

National Seniors Australia, in response to Consultation Paper 1, submitted:

> Information, assessment and system navigation are essential services and are a high priority for improvement to allow people to meet their needs without paying navigators and overburdening carers. People are only empowered to make choices when they have adequate information. The difficulty previously expressed aptly by National Seniors members is that 'you don't know what you don't know' when it comes to aged care…[52]

Professor John McCallum, Chief Executive Officer of National Seniors Australia, further explained this contention. He described older people as 'information poor' and highlighted the very negative perception of aged care in Australia. He explained that 'it would be hard to make radical reform without a change in that mindset' and summarised his organisation's preferred approach as an attempt to 'combine service issues with an information issue'.[53] Professor McCallum referenced a number of 'lazy policy assets', such as the age 75 plus medical assessment, that are currently undersubscribed or not well used as helpful mechanisms to inform older people about their aged care planning options.[54]

We were told about 'no wrong door' policies to assist with navigating the system. Dr Ricki Smith, Chief Executive Officer of Access Care Network Australia, described the 'no wrong door' feature of the Western Australian model, a policy where 'a service provider, a trusted advisor, a carer, a neighbour, could facilitate access to assessment' for an older person.[55] In a submission in response to Consultation Paper 1, Professor Kathy Eagar of

the Australian Health Services Research Institute detailed her preferred approach of offering multiple entry points into the aged care system via a 'no wrong door policy', rather than assuming a single national entry point or gateway.[56]

15.1.4 'Care finder' or navigator

Dr Nicholas Hartland PSM, the Australian Department of Health's First Assistant Secretary, In Home Aged Care Division, addressed the proposal to introduce 'care finders'. He said that 'aged care as a whole needs to have a much greater face-to-face presence'. Dr Hartland considered that the role of a care finder should be viewed as 'a way of drawing people into the system…[who] otherwise might not approach a formal system'. He explained that the concept of the 'care finder' needs to be flexible enough to accommodate various means for older people to interact with the aged care system, including face-to-face services as well as a shop front, call centre and online services, all 'geared to quickly getting people to assessment, so that you can start to think about what services that person needs'.[57]

When addressing the issue of older people with diverse needs, Ms Samantha Edmonds, Managing Director, Ageing with Pride and Chair of the Aged Care Sector Committee Diversity Sub-Group, highlighted the importance of sourcing the care finder or navigator from a trusted entity, that is, an organisation with whom the person already has developed a 'confident and comfortable relationship'. Ms Edmonds stressed the importance of the care finder workforce being comprised of workers either from the same diverse group as the older person, or those who are very skilled and educated with the necessary personal skills to deliver culturally safe, trauma-informed care. This is so older people with diverse needs will feel comfortable interacting with the care finders.[58]

In its response to Consultation Paper 1, COTA Australia advanced the combination of the care finder role with assessment services. Under the heading '*Assessment and Case Management – a combined wrap-around approach*', COTA Australia submitted:

> One of the criticisms of the current assessment process is its transactional nature. The system is also rightly criticised for fragmentation and duplication—where an 'assessor' completes the care plan, only for it to be ignored/changed by a 'case manager', only for a new assessment to be completed by a 'service provider' in relation to the individual services. COTA proposes that Case Management services be combined with Assessment Services from the earliest point of intervention. We believe that such an approach would transform consumer experiences from a transactional commencement into a relational one from the very beginning.
>
> …
>
> The 'assessment and case manager' works with the older person in a consumer directed approach to optimise the experience; to guide and support the consumer's decision-making about care options and choice of service provider; and to support the older person to gain maximum benefit from the aged care system, acting as an advisor, coach and system navigator. Case managers also have a critical role in connecting older people with supports outside the aged care system that support their broader health, well-being and social needs…[59]

Mr Yates explained that one of the main benefits of combining assessment with the case management / care finder role is that an assessment will also result in 'real-time bookings' with available aged care services according to people's assessed needs, thereby avoiding

unnecessary delay.[60] Dr Smith agreed with COTA Australia's approach of combining the role of a care finder with the assessment process, however she did not see the need for a care finder prior to assessment taking place.[61]

Should assessors be independent of service providers?

Mr Yates and Dr Smith both expressed support for the proposition that the care finder / assessor role should be performed by an independent workforce to avoid any potential conflicts of interest.[62] Dr Smith explained that in Western Australia, the workforce conducting aged care assessments was totally independent of any aged care providers, primarily to ensure that equity of access to aged care was maintained for all older people.[63]

Mr Lipmann agreed that as a general rule approved providers should not be operating assessment services. However, he noted that there are certain groups of vulnerable people that may only trust a provider with whom they have developed a relationship. He spoke of the importance of this existing relationship, and said that it will be important to have that provider involved in any interactions with the aged care system.[64] Mr Lipmann explained the process adopted by Wintringham to address this conflict, as an aged care provider to people who are homeless or at risk of homelessness:

> We have attempted to resolve that tension, because it is clearly a tension, by partnering with a local ACAS [Aged Care Assessment Service] team to have one of our workers embedded in the ACAS team. So the ACAS team still makes the final decision but the assessment is, I guess, filtered or informed by the intimate knowledge of the particular client with the provider, which is us. I can see the dangers of that throughout the system but in our particular case, it's worked well…[65]

Ms Edmonds agreed with Mr Lipmann, stating that often people from 'diversity groups' feel more comfortable if a member from the Aged Care Assessment Team is from their 'diversity group'. She emphasised that 'we also need to recognise that in some areas there won't be that pool of people to call on and that's where we need to look at, well, what do we do where there aren't trusted entities that people can access?'[66]

Professor Michael Fine, Department of Sociology, Macquarie University, expressed the view that generally keeping the assessment role separate from providers will ensure that good businesses do not get 'tainted by the accusation that they're over servicing or providing services where they're not needed'. However, he also agreed that the situation may be different for those older people from diverse backgrounds who may have 'very few people to speak up for them'.[67]

Assessment for aged care services

Mr Sean Rooney, Chief Executive Officer of Leading Aged Services Australia, emphasised that any assessment undertaken with an older Australian needs to be 'timely, accurate and consistent'.[68] He stated:

> So accuracy or time limits with regards to not just assessment, but the triggers for reassessment: accuracy, because that will inform care planning or change to that care planning, and then consistency, using standardised tools and having a skilled assessment workforce that can actually apply those tools, these are the attributes that you would see to be contributing to—well, be fundamental to contributing to the system that's being imagined.[69]

In a submission in response to Consultation Paper 1, National Seniors Australia proposed that existing health care services could be incorporated into part of the assessment process, suggesting 'check-ups' could be conducted at regular age intervals or as requested by an individual or health care professional. This would encourage older people to start thinking about their care needs earlier rather than later.[70]

Professor Morgan explained that the current assessment process is complex and not well standardised. He stated that there should be a marrying together of the primary health and aged care systems to prevent 'wasteful duplication'.[71] Professor Morgan cautioned against the creation of significant wait times for assessments:

> I think if you've got a system that relies on a gold standard, home-based comprehensive assessment process as the only access point, then you're going to have waiting lists and great difficulty with access. So what I'm envisaging is a system where simpler basic needs that emerge can be managed through the already existing assessment processes that happen in primary care and general practice and almost a triaging process for the more complicated people that need that.[72]

Mr Versteege agreed that Australians experience 'an enormous information deficit' when it comes to accessing aged care. He described the current system as difficult to navigate, not as a result of the information being complex, but rather because it is obscured from older people. He said that when people first access the aged care system, through My Aged Care or elsewhere, they 'should be given an outline of what is actually available realistically in their area', or detailed on-the-ground information for their local area.[73]

Dr Smith explained how Access Care Network Australia has adopted an active assessment model with the 'concept of reablement starting at assessment' to understand the older person's triggers for the assessment, their needs and their goals in accessing aged care services. She confirmed that factors such as social connectedness and wellbeing were 'absolutely' included in the assessment 'because we have to look at the whole person'.[74]

Dr Smith went on to explain that Western Australia's active assessment approach had demonstrated:

> significant benefits to the individual for independence but there's also significant benefits to the taxpayer. Helping somebody improve for a short period of time might mean that they don't go to ongoing services.[75]

Dr Smith detailed how such an approach can assist in identifying 'people who need short-term intensive time to improve' which may prevent them from requiring ongoing services.[76]

Professor Morgan commented on the lack of any 'built-in evaluation' of how well current services are performing:

> If you build in that evaluation of how well those services are performing to achieve the goals for that purpose, then the system becomes self-balancing and if you discover that actually the supposedly simple situation is not performing well, that opens you up to the need for the more detailed assessment and broader range of services.[77]

Tiers of assessment

Professor Fine said that a multi-tiered assessment approach is 'very strongly supported in the literature'. However, the person completing the follow-up or check in with the older person does not necessarily have to be an 'assessor'. He gave the example of this role being performed effectively by home nursing services under the Home and Community Care program, where services would be ramped up or scaled back over time as needed.[78] Professor Fine stressed the importance of services having this element of scalability:

> If we don't, then services quickly fill up. When they are at 100 per cent, you can't let more people in. But if we can have some turnover, then some of the turnover can be through reducing need. Some of the turnover will be people moving on to higher level services. But unless we have turnover, actually all our services become full and can't accept the new referrals and that's the situation we are in at the moment.[79]

Dr Hartland told us that assessments should be viewed on a 'continuum', as a suite of 'integrated assessment services, calibrated to need' that are available to older people. He explained that such a continuum may see a relatively light touch assessment suitable for some people, while others with higher needs may require a comprehensive assessment. Dr Hartland believed that such an approach is required to ensure not just that opportunities for data collection and reablement interventions are not missed, but also to minimise the assessment and reassessment burden on individuals who may require services under more than one 'stream'.[80]

15.2 'Entry-level support' (or basic services) stream

The third panel addressed the proposed basic services stream, which was titled 'entry level support stream' in Consultation Paper 1. The topics addressed by the panel included the scope of services that might be appropriately encompassed by that stream, what eligibility processes should apply for older people to access those services, and how those services should be coordinated with services addressing more complex needs.

What constitutes basic aged care services?

In its submission in response to Consultation Paper 1, COTA Australia stated:

> Once an older person requires individual supports such as domestic assistance, laundry or meal preparation requests for these services should be considered more than entry level supports…
>
> COTA Australia would suggest that the services identified by the Royal Commission under 'help at home' are better treated in the same manner as other 'care' services...[81]

Ms Jane Mussared, Chief Executive Officer, COTA SA, further explained that:

> basic services don't always mean basic need. It is the first point at which a person says, 'I need help'…and we shouldn't waste that as an opportunity.[82]

Ms Mussared acknowledged that there may be a need for a short-term intervention 'to get somebody over a hump on a more basic level', which should be accompanied by somebody independent of service 'actively working…to make sure that that person's agency, that person's choice and decision making is not overridden' with respect to the services that they receive.[83]

Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care, agreed with Dr David Panter, Chief Executive Officer, ECH, and Ms Mussared that people need to be able to access additional service when needed. Mr Sadler explained:

> I think part of our problem with this particular group of services is describing them as entry level is a bit confusing in that context. They're really a group of services that are around social participation and help around the home and I think if you conceive them in those terms, they're absolutely worth people getting access to quickly and easily, although I thoroughly agree…that what we also want to do is get people into a service system where they're going to be able to get additional service, including reablement, when they need it.[84]

Professor Fine said that there is real value in low-level services, which have been found to reduce death rates among older people.[85] He highlighted the importance of building 'capacity for flexibility and innovation' into the entry level stream. He suggested the adoption of a 'functional description' of entry level services that highlights the 'need to combine personal and domestic support with social integration and in ways which will encourage integration of a range of different services' because 'if we get too specific under tasks we actually exclude services'.[86]

Mr Sadler explained that housing services for the homeless, currently funded from the Commonwealth Home Support Programme, are missing from Consultation Paper 1 and definitely need to be included in the 'new world' of entry-level services.[87]

Access, assessment and screening

In its response to Consultation Paper 1, the Local Government Association of South Australia submitted that it would 'be supportive of a simple screening for entry level support rather than full assessment, so as to ensure ease of access for clients and reduced administrative processes for providers'.[88]

Counsel Assisting asked the panel about the merit of a simple screening process to access these services and what key features would be required for implementation. This included the possibility of regular 'check-ins' to ensure that services are suitable and fit for purpose.

Mr Sadler said he believed that these 'check-ins' would be a good role for the care finder, drawing on the navigator trials which are underway within the current system. He stated that 'there is merit in providers having responsibility here [in this role], but it does…depend…on what happens with the service provision system under a new model'. He drew distinctions between a funding model where a person receiving care opted for a single provider, and the provision of services by multiple providers through the use of a voucher service.[89]

Ms Mussared outlined COTA Australia's opinion on the importance of maintaining independence of the individual in the care coordinator role.[90] Dr Hartland raised concern about the potential opportunity for providers to unnecessarily accelerate the intensity of care, but acknowledged that special needs communities need separate treatment.[91]

Dr Hartland estimated that the top 10% of Commonwealth Home Support Programme users consume approximately 50% of the resources, which could mean that an uncapping of subsidies or any relaxation of assessment processes would see a cost blow-out.[92] Professor Fine added that as Australia is one of the lowest spenders in home care in the Organisation for Economic Cooperation and Development, an effective screening system would likely see an increase in demand for home care services to meet older people's needs.[93]

Dr Panter said that there 'has to be a part of the system that has that ongoing relationship with the individual receiving services' this is so that 'as their needs change, then services change accordingly'.[94] He outlined the importance of 'not just care coordination but active care management' if the system is going to provide benefits of early intervention.[95]

Counsel Assisting asked Mr Graham Aitken, a Yankunytjatjara descendent and Chief Executive Officer, Aboriginal Community Services, for his views on whether Aboriginal and Torres Strait Islander communities were a group where it would be appropriate for the service provider to be involved in the assessment process. Mr Aitken agreed and explained that 'any diverse group is not really suited to the mainstream processes… We know our community. Our community are happy to come to us'.[96]

Delivery mechanism

In response to Consultation Paper 1, COTA Australia submitted that the 'unmet demand' in the Commonwealth Home Support Programme 'has not attained the same national attention caused by the home care package queue'. COTA Australia stated that:

> only basic client statistics have been published in regard to CHSP [Commonwealth Home Support Programme], with no demand insights or comparisons between number of funded services in a region, compared with the number of 'approved services' not yet 'commenced' via My Aged Care.[97]

COTA Australia criticised the current Commonwealth Home Support Programme as 'largely not consumer directed' and suggested that it provides 'limited choice and control for consumers'.[98]

Dr Panter also spoke about the limitations of the current system, explaining that the Commonwealth Home Support Programme funding model does not allow for ECH to respond adequately to consumer choice:

> as a provider, you know, we have got about $7 million worth of contracts, if you like, for CHSP in my organisation, which goes back to a set of agreements now over five years old with unit prices which haven't changed. We have got a whole load of restrictions about what we can and can't do within that and yet we see, as we've tried to respond more and more to clients' choices, that those boxes no longer fit.[99]

Dr Panter expressed the view that there is a need for stronger emphasis on services that address social needs to combat mental health issues common amongst older people.[100] He also stressed the importance of 'early adoption of these services' and the risk that if this is not achieved 'people will decline and be in even greater need'.[101]

In response to Consultation Paper 1, National Seniors Australia surveyed members' views on what currently works well and what would be aspects of an ideal aged care experience.[102] Professor McCallum said that 'there was a strong and passionate support of' the Commonwealth Home Support Programme. There was, he said, evidence that 'it works pretty well for some groups', particularly 'community groups like multicultural groups'.[103] However, Ms Mussared stated that there is not enough understanding about the Commonwealth Home Support Programme in both a quantitative and qualitative sense.[104]

The possibility of a voucher system for delivery of entry level services was explored with the panel. Dr Panter agreed that these services could be provided by a voucher-type scheme which enables the older person to choose between providers, adding that the brokering services model does not mean that information cannot be fed back to the aged care provider.[105] Professor Fine agreed that the use of a voucher for the provision of basic services can be very empowering, but advocated for some flexibility in the funding:

> a voucher can be very empowering but what's good for a service sometimes is not to just have a fee for service where they get the fee for cleaning and if they don't clean they don't get it, but to have sometimes other forms where the funding is flexible, where they can perhaps persuade instead of two hours of cleaning, let's have one hour of cleaning and one hour let's get you out of the house for that time, join a club.[106]

Mr Aitken told us that there were advantages to block funding for basic level services which may be lost through a voucher system:

> we believe that the block funding, the community home support approach enables us the flexibility to provide services both individually and in group settings, which [with] individualised funding probably wouldn't be able to be achieved…[107]

Mr Aitken said that block funding also has a strong impact in remote areas 'where a lot of service types or purchasing of services is not an option'.[108] He stated that there were benefits to the former Home and Community Care system, as low level services could be delivered by agencies that were not necessarily approved providers. He explained that this should be the model for the future for Aboriginal and Torres Strait Islander services as there are Aboriginal aged care projects which are 'very good at looking after elders in their communities' but which face challenges with compliance and some administrative processes.[109]

Ms Mussared spoke of the importance of holistic care and choice for the older person:

> So it seems to me that in the pursuit of reablement, we have to make sure that we retain the choice and control, which should be the overarching principles here.[110]

Ms Mussared proffered that brokering arrangements, such as the use of a debit card for basic services, may be more effective because it allows the individual to 'be in charge of that and to make decisions about what works best', thereby fostering people's control and choice.[111]

Dr Hartland agreed that the 'ability for a consumer to [choose] providers…should be a fundamental aspect of the new system'. However, he raised concerns at the prospect of uncapping services without first obtaining a good understanding of the true state of demand.[112]

15.2.1 An 'investment stream' for respite and restorative interventions

Consultation Paper 1 explained that the objective behind the introduction of the investment stream was to 'help restore functioning, provide respite and delay or prevent progression to more intensive forms of care'. The title 'investment stream' was intended to convey the principle that restorative interventions would delay progression to higher and more costly care.[113]

In the fourth panel, the witnesses discussed key potential design features including agile access to interventions, potential funding mechanisms, effective means of evaluating interventions, and availability and innovative models of respite care.

Investment as a separate stream

Dr Panter told us that while the principle of the investment stream is 'great', the whole process of accessing aged care services must be 'as seamless as possible' for older people. He explained that older people should not have to worry about whether their funding comes from 'this pot or that pot' stating 'that is what frustrates people enormously at the moment and prevents them getting the service'.[114]

Dr Gill Lewin, from Curtin University's School of Nursing, Midwifery and Paramedicine, emphasised that interventions under an investment stream need to be fast and responsive to a precipitating event or a person's sudden change in need:

> assessment isn't at one point in time in a restorative intervention; it's ongoing, because as somebody regains capabilities and confidence, then the input that they require can be quite different and they can actually move on to completely different goals. So that it's certainly not a set and forget. It's a dynamic process when somebody is attempting to regain, relearn, be able to function more independently again.[115]

Access to restorative and reablement aged care services

Ms Sparrow told us that the assessment process for older people needs to be a single process able to draw in specialist assessment services when necessary to ensure that people can benefit from earlier reablement opportunities and the use of assistive technologies. However, comprehensive assessment also creates the potential for older people with urgent immediate needs to experience delays. Ms Sparrow explained that to

meet this urgent demand, capacity must be built into the system for certain services, such as meals, transport and emergency respite. She believed there should be ways to refer people to such entry level services which may only last for 'a few weeks' to provide time for the 'wrap-around assessment' to be performed.[116]

Dr Lewin agreed with Ms Sparrow that assessments need to be 'reablement-focused from the beginning' to optimise function, and that the composition of assessment teams needs to be flexible to reflect the care needs of individuals.[117] Dr Lewin said that this can be about working with someone 'around their own expectations, belief, confidence'. She stated that when someone is receiving ongoing support and 'then has a triggering event that causes significant loss of function…they have a much greater understanding of the reablement opportunities and the system generally'.[118]

Ms Sue Elderton, Chief Executive Officer, Carers Australia, stated that comprehensive assessment needs to include 'a better assessment of the carer's needs'. She explained that currently when assessments occur, the carer is often not present nor encouraged to attend, and so the carer's needs often do not get considered as part of the assessment process.[119]

Dr Lewin agreed with Ms Elderton on the importance of 'significant others, be they considered carers by the individual or not', being 'involved in the assessment process as the individual's advocate, as someone taking notes, as somebody who is also absorbing the information so that they can help the older person'.[120] Dr Lewin expressed a strong preference that 'these sorts of episodes of care should be free to the individual, rather than them [the individual] having to choose to take it out of a package or whatever. I think that provides totally the wrong incentives'.[121]

Funding of aged care services

Dr Henry Cutler, Director, Centre for Health Economy, Macquarie University, told us that when discussing different models for funding aged care, it is important to have a set of guiding principles which will help drive decisions, combined with 'a good understanding of what your funding model is trying to achieve'. He explained that the other important element is to identify incentives that will assist in achieving those outcomes. Dr Cutler described the 'outcomes-based funding' model adopted by Australia's health care system, which requires robust data measures to evaluate outcomes and wellbeing, and potentially attach funding to those outcomes.[122] For aged care, he explained:

> there should be some consideration around developing and publicly reporting a robust quality performance framework in Australia that not only looks at clinical outcomes, but all other areas that impact our wellbeing, so, for example, social inclusion.[123]

Dr Panter considered that there was potentially a need for both block funding and individualised funding, and that funding mix would need to be consistent with consumer directed care principles. He supported the comments made by Dr Cutler around the need to ensure funding is directed to health outcomes, highlighting the need to remove the historic 'silo' approach which impacts on both the health system and the primary care

network (hospitals). Dr Panter expressed the view that unless steps are taken to pool funding at the local level across historic silos, 'we will still end up with people at the end of the day getting potentially a poor experience and taxpayers getting a poor deal'.[124]

Dr Lewin told us that the funding mechanism for the proposed investment stream needs to support fast assessment and rapid response to sudden changes in need, describing the process as 'dynamic' and 'certainly not a set and forget'.[125] She expressed a strong preference for investment stream services to be funded outside of an individual's allocated budget.[126]

Dr Panter described ECH's decision to move away from residential aged care and invest in research to 'pursue the goal of enabling people to live at home independently'. He expressed frustration about the limitations of available national datasets to report outcomes, explaining that we need a funding system which 'does incentivise those outcomes, as opposed to counting the inputs'.[127]

Mr Jaye Smith, the First Assistant Secretary in the Residential and Flexible Aged Care Division of the Australian Department of Health, agreed that there should be incentives built into the system to encourage services focused on reablement. He said that there is an assumption in the new aged care classification system that if services provided increase a person's ability, such that the cost required for care is reduced, that cost can be retained or reinvested by the provider. He stated that the Aged Care Funding Instrument also provides these incentives, but conceded that there are other perverse incentives within that system which override that benefit.[128]

An evaluation of investment stream

Dr Cutler said that effective evaluation of services under the investment stream would require the development of guidelines or guiding principles 'that allow people to determine whether someone should get access to services, based on the likelihood of them achieving better outcomes or avoiding costs down the track'. He stated that in his view, a cost benefit assessment should be conducted 'at a program level rather than at an individual level' when determining the cost effectiveness of certain interventions.[129]

Professor Julie Ratcliffe, Caring Futures Institute, Flinders University, further explained that any evaluation needs to carefully account for both the costs and the benefits delivered by a program funded under the investment stream:

> it's not just about the least costly intervention…an intervention may be more costly, but it may be delivering a much higher quality service. And, therefore, we need to be able to measure the outcomes, because if a new service is more costly but it's delivering, you know, much greater benefits in terms of quality of life and wellbeing outcomes and it's having a real improvement in terms of being able to avoid people having to go into hospital, for example, unnecessarily, then that might be a very good investment.[130]

Respite and support for informal carers

Ms Elderton described respite 'as probably one of the most underdone areas of aged care' and explained that:

> looking at respite and the carer's constriction as an investment in the system provides a rationale—a strong economic rationale for it being properly resourced and delivered, not just treated as the tail end of the aged care system.[131]

On the first day of the hearing, Mr Rees described the issue of providing adequate, innovative models of respite care in the community as 'terribly complex', stating:

> My view is you need a separate funding stream for respite. Take it out of residential care. Take it out of where it is at the moment in home care. I would have one funding stream and I would ensure it gets the priority it needs, in terms of care and needs, and I would focus on respite in residential care purely on that transitional element that helps an older person move into aged care in as graceful way as they can in terms of residential care.[132]

Ms Elderton highlighted the importance of capital funding for existing dedicated residential respite facilities, such as those operated by HammondCare, to maintain their ongoing residential respite places. She explained that these dedicated out of home facilities remain the 'preferred form of respite' for many families, yet 'block funding - capital funding is not available to them at all'. She detailed 'how few cottage respite or dedicated respite facilities are actually available in Australia', describing the situation as a 'massive undersupply' partly due to the large up-front costs borne by providers in establishing these facilities.[133]

Ms Sparrow's words echoed this view:

> we need to have the funding for ongoing respite which is often delivered in home or in other forms of community settings, but there is a difficulty in getting some of the other more innovative and smaller forms of accommodation that provides respite because there is a lack of capital and for residential care providers, some of the ways they have to manage respite, there is quite a lot of an administrative impost on them. It's almost as if a person is coming in for ongoing care. So I think we need to make it easy for that form of respite to be available through capital [funding] and also through looking at how the administration, etcetera, is done to make sure that residential respite can also be available more easily.[134]

Ms Elderton said that respite is important as it 'gives you a break every now and then from what can be an incredibly intensive role'. However, she warned that while increasing the availability of respite is obviously very important for older people, it is 'not everything in terms of the sustainability of care' for somebody with a carer.[135] She explained that the submission by Carers Australia cautioned against assessors taking into account the care and support provided by informal carers when assessing the needs of older people.[136] Ms Elderton said that this approach can diminish the budget and supports allowed to the older person. She gave the example of transport needs for appointments, where external assistance may be sought to relieve the burden on a carer's own life commitments.[137]

When giving evidence on the fifth panel, Professor Morgan was asked for his views on Ms Elderton's evidence and how the assessment process ought to address circumstances where an informal carer is assisting to care for an older person. He supported the inclusion of the needs of the carers in the assessment process.[138]

15.2.2 A care stream

Consultation Paper 1 proposed a system change to 'create a care stream for services delivered either in the home or in more flexible and less institutional forms of residential care'.[139]

Attributes of the proposed care stream included an entitlement to the efficient cost of individualised care that is reasonable and necessary, of high quality and safety, and delivered in the location of the older person's choice.[140]

In the fifth panel, witnesses gave evidence about consumer experience and choice, the need for care, the care setting, funding and oversight for care.

Consumer experience and choice

Several witnesses referred to the importance of the 'consumer experience' of aged care and an older person's freedom to exercise choice in the care they receive.

Professor Deborah Parker, Chair, Ageing Policy Chapter, Australian College of Nursing and Professor of Aged Care (Dementia), University of Technology Sydney, told us that consumer choice in how care is delivered should be 'fundamental to the redesign of the system'. She emphasised that choice can be relative depending on an individual's 'health literacy', as well as the availability of options, which may be limited in certain geographic areas or for certain marginalised groups.[141]

Professor Parker explained that often a conflict exists between dignity of risk and choice, which requires a conversation with the older person to discuss their options in assisting them to make an informed decision.[142] She considered that 'choice can be built into a coordinated case management service that should be offered from entry into the system'.[143]

Ms Maree McCabe, Chief Executive Officer, Dementia Australia, agreed that a person's level of choice is unique to their circumstances, and not necessarily available in all settings.[144] She gave the example of those living with dementia, which progresses so that eventually people are unable to make choices about their care.[145] Ms McCabe highlighted the assumption that people can 'vote with their feet' when relying on market-based forces to deliver care. She told us that for people living with dementia, 'that's actually not possible'.[146] She went on to explain that Dementia Australia 'absolutely supports consumer-directed care', but many people living with dementia cannot speak for themselves and do not have carers or advocates who can speak for them. She explained that the system needs to be 'flexible enough to take into account the unique challenges that many people are faced with'.[147]

Ms McCabe considered that dignity of risk is not well understood in the aged care sector and that people's awareness and understanding of aged care needs to be elevated to enable choice.[148]

Dr Hartland said that the reason why the aged care system has been looking at consumer-directed care for a long time is because of the positive impact consumer-directed care has on the wellbeing of the people receiving services. He referred to a trial by COTA Australia which demonstrates positive results from giving people control over their lives. He emphasised the need to remember the 'link between having control over what happens to you and your sense of wellbeing'.[149]

Professor Morgan considered that there is a need to 'enshrine' feedback processes into a person's care setting to shape their ongoing care needs. He explained that as part of a person's assessment and initiation process into aged care, goals should be set and feedback mechanisms established for the person receiving care with their provider. The person should be asked at regular intervals whether their bundle of care services, either self-managed or bundled through a provider, is appropriate to meet their needs.[150] Where there is a problem with the level of services being received, he submitted that the 'ultimate funder' of the services will need to receive that feedback so that it can work with the various providers to reshape that person's care delivery.[151]

The need for care

Professor Parker highlighted that aged care often involves managing complex care needs that may be neither stable nor long term. Accordingly, she emphasised that aged care services 'need to be wrapped around very quickly for many people' to prevent rapid deterioration.[152]

The Federal Secretary of the Australian Nursing and Midwifery Federation, Ms Annie Butler, questioned whether care delivery could realistically be 'agnostic of setting', as there may not be enough services available and many older people may not be able to manage individualised funding implicit in such a system.[153] Mr Mersiades envisaged a complete restructuring of the system could allow for each region to have two or three large providers that provide a comprehensive range of services which would be far more efficient than the current system and prevent people from 'having to shop around' multiple providers to access the services they require.[154]

Professor Morgan raised an important question of principle about the assessment of need, and of the scope of funding to provide care and support to meet assessed needs, where an informal carer assists in caring for an older person. Professor Morgan queried whether, in a redesigned aged care system, the assessed need for care of an older person would be based on met or unmet need. He gave the example of a person with a carer who may have greater need, but less unmet need, than another person without a carer.[155] He considered that a 'broad view of unmet need of the carers is the more logical way' to assess need, otherwise there may be a risk of driving informal care away by allocating a smaller budget to people with dedicated carers.[156]

Dr Hartland also queried the application of a 'reasonable and necessary' test to assessed need. His view was that it will be necessary for us to define a 'normative standard' of care, which will assist to answer the question of what may be 'reasonable and necessary' to fund that defined standard of care.[157]

The setting in which aged care is provided

Mr Nick Mersiades, Director of Aged Care, Catholic Health Australia, said that it is generally more efficient for government to have people cared for in their own home, which often aligns with a person's preference. However he acknowledged that 'there will come a point when the pressures on the family carer will be such that some sort of congregate care arrangement will be necessary'.[158]

Mr Mersiades said that 'in a congregate living arrangement the costs of delivering a given amount of care and personal nursing care will be less than if the care is delivered to locations which are distributed and dispersed' due to the travel time.[159] He emphasised the need for a conversation between the care provider and the person receiving care about how much the person values their independence and their current living environment, versus the risks of remaining in their home.[160]

Mr Matthew Richter, Chief Executive Officer, The Aged Care Guild, highlighted that the dichotomy of 'home care' and 'residential care' is a problem. He considered them to be 'almost independent systems' that do not 'interrelate at all', and that there is not much in between.[161] He explained that there should be incentives 'to grow and develop something in the middle', as well as incentives for the aged care systems to coordinate better so that opportunities to develop creative solutions are not missed.[162]

Mr Richter was of the view that retaining 24 hour seven day per week residential care settings is 'very important' but they do not 'need to be the primary part of the system'.[163] He argued that there is a need to incentivise the system to 'grow the bits that are missing' in the 'intermediary setting'.[164] Mr Richter considered this could not be left to the market alone and there is a very important role for capital grants, especially in rural and remote areas.[165] He further emphasised the need for policy stability to encourage providers to enter those intermediary areas and build and develop the services.[166]

The United Workers Union's Executive Projects Coordinator and National Office Development and Industry Coordinator, Ms Melissa Coad, agreed that the demand for 24 hour seven day per week residential style care will continue into the future as there will be a limit for some people to remain in their own homes.[167] Ms Coad stated that the 'flipside' of people staying in their home longer is that 'while that is the person's home it's also other people's workplace and those places can become unsafe' for the home care workforce 'if they deteriorate'.[168] She also noted that remaining in the home may not be an option for future generations due to increasing rates of non-home ownership, meaning that people may not have a choice to remain at home unless housing systems also change in the future.[169]

Funding in the care stream

Dr Hartland considered that funding in the care stream would require careful consideration of what is being funded is an actual reflection of need:

> if you are going to move to a needs based system which is what you are envisaging in your consultation paper, you are going to have to give separate consideration to the funding of care because it will be the most expensive part of the system. [170]

Professor Parker considered that it should be a matter for providers to navigate the different funding streams and that there is no need for the aged care client 'to know which stream that they have been assigned or that they are now in or out of their designated stream'.[171]

Ms McCabe considered it most important that 'funding should follow the care recipient'.[172]

Individualised budgets

A number of witnesses voiced concerns with the prospect of individualised budgets within the redesigned aged care system.

Ms Butler said that the Australian Nursing and Midwifery Federation strongly supports the need for people receiving aged care services to have a degree of choice and control. However, she was not convinced individualised funding would achieve this because there was is no evidence that quality and safety will be improved. She raised concerns that people without 'strong supports' would find it difficult to manage individualised budgets. She also explained that individualised funding creates risks for an already compromised workforce.[173]

Ms Coad considered that unbundling in aged care could lead to fragmentation of jobs into single tasks which would potentially have consequences for attracting and retaining suitably qualified and trained workers.[174] She considered fragmentation was a greater problem for smaller providers or where providers only supply parts of a person's care.[175]

Professor Parker said that the Australian College of Nursing does not support the separation of personal care from nursing and allied health or medical care.[176]

Ms Coad considered that sometimes consumer-directed care is conflated with individualised funding and stated that she does not think the two concepts have to go together. She explained that you can have consumer-directed or person-centred care without the need for an individualised budget.[177]

Ms Coad detailed the experience of the United Workers Union with individualised budgets in the National Disability Insurance Scheme which only allow for face-to-face support time:

> So our members in the disability sector no longer have paid team meetings, paid training or supervision, buddy shifts, all of those things that are integral to them being—having quality jobs and being able to deliver quality supports all disappear because the individualised funding only pays for that direct one-on-one support…[178]

Ms Coad explained that, in the experience of United Workers Union, even if such costs were built in to individualised budgets, there is a risk that over time when 'costs get squeezed', those organisation-wide support services, such as paid meetings and buddy shifts, are the first to 'go'.[179]

Dr Hartland considered that older people are a different care recipient population from people living with disability, who often have stable conditions. He said that, with approximately 800,000 assessments of older people each year, the services delivering aged care must do the care planning.[180]

'Unbundling' residential care

Ms Butler considered that it does not make sense to unbundle care in a residential setting and require a person to make their own bundle. She considered that residential care providers have oversight and capacity to deliver the range of services required and the bundling is 'worth more than the sum of the parts'.[181] She considered unbundling may create a risk to holistic assessment leading to risks for the client not being supported and the worker not being satisfied with meaningful work.[182]

Professor Morgan acknowledged that unbundling services may work well in certain situations for those with 'high end needs' in residential aged care. He considered that general practitioners are already effectively unbundled in the current system.[183] He suggested that there may be potential benefits from also unbundling nursing at the high care end to allow cycling through of nurses with hospitals, to build closer connections between residential care and the acute sector to provide more seamless care. He said a potential advantage of unbundling nursing care is that it may make medical care a priority within a clinical governance framework, rather than another form of care delivered out of a bundled package.[184]

Professor Morgan stated, however, that in a general aged care setting 'ideally, you want a more holistic approach to care needs with everyone working at their full scope of practice, rather than doing just one little piece of a jigsaw puzzle to look after a person's needs'. He characterised the latter as 'a recipe for disaster'.[185]

Professor Parker said she cannot see how the 70% of unregulated aged care workers who work under the supervision of a registered nurse would be able to operate where nursing care is unbundled in an episodic way.[186] She explained that people with advanced dementia, and those who require end-of-life care, need a skilled workforce who know the residents and their needs. She stated that care needs to be delivered by a comprehensive team including allied health.[187]

Professor Parker acknowledged that general practitioners' services are unbundled, but said that they were professionals in their own right. She considered that in the same way nurse practitioners could potentially perform some similarly unbundled aged care services.[188]

Dr Hartland queried what the effect would be of allowing unbundling in residential care where the cost of care is calculated based on the efficient costs of care which are themselves based on a bundled congregated setting.[189]

Mr Mersiades advocated for a 'compromise position' between individualised budgets and bundling of care. He suggested that funding could be allocated based on a 'classification system' rather than a completely individualised budget.[190] Catholic Health Australia's submissions in response to Consultation Paper 1 envisaged a classification system along the lines of the Australian National Aged Care Classification model.[191] Mr Mersiades explained that in this 'compromise' a person should be able to choose whether they purchase services using the allocated budget or whether they enrol with a provider who works with them to meets care needs out of the budget as these fluctuate over time. He considered that in this way 'you still get a degree of choice in there but you don't have the complexity of individual budgets and everything that goes with it'.[192]

Oversight and responsibility for care

As we have noted, Professor Parker expressed doubts about the separation of the care stream from the basic support stream, stressing the importance of maintaining the oversight of people receiving basic services, and assisting people to step up to other streams and services as their needs change. She cautioned 'that we do want to make sure that people are getting the right assessment, the right care delivered by the right people at the right time'.[193]

Ms McCabe considered it to be:

> essential that we make sure that clinical governance is a high priority as part of the care stream proposal, and that it's something that really facilitates the care of residents and particularly people with specialty needs such as people living with dementia.[194]

Mr Mersiades noted that there are thousands of home-based care providers and compared that against a system with two or three large providers in each region who can meet 'across the board requirements' which he said would be a far more efficient system which would meet people's needs better rather than them 'having to shop around'.[195] Mr Mersiades did not think that the government should be selecting the 'winning' providers for each region, but rather ensuring individuals and their families have a choice and 'over time that will work itself out'. Mr Mersiades further considered that large well-organised providers with good governance and support systems can supply better data for a more evidence based and efficient system.[196]

15.2.3 Transition and implementation

Witnesses in the sixth and final panel of Adelaide Workshop 1 discussed key features of the transition to and implementation of a redesigned aged care system.

The key objectives of an aged care system

Dr Cutler stated that 'first and foremost' the need within a 'reform agenda or a transition agenda is to make sure that there is a robust quality performance framework to pick up on any trends that may be occurring due to structural change'.[197]

Mr Rooney agreed with Dr Cutler, highlighting the importance of having 'clear expectations around what we want the system to deliver', supplemented with 'indicators and measures so we can track what's happening at the system level so we have assurance that we have a high performing national system that's delivering good value for money'.[198]

Mr Bonner highlighted the need for 'evaluation and measurement of performance at the system level', stating that there needs to be a 'clear line of sight and transparency of reporting' to measure whether the reforms are delivering the outcomes that are sought.[199]

Ms Sandra Hills OAM, Chief Executive Officer, Anglican Aged Care Services Group (which trades as Benetas), stated that one of her first reactions to reading Consultation Paper 1 was the need to undertake a 'risk assessment' of the current aged care sector that would 'expose what the risks are' and then to look 'at what the mitigation strategies are'.[200]

Mr Bonner continued with the example of workforce reform to stress the need for 'enforceable mechanisms' to clearly tie 'funding flow to particular workforce outcomes' ensuring that 'visible and transparent arrangements…actually lead to improvements in the wages and working conditions of people in the sector'.[201]

Expanding on the topic of accountability of the aged care sector on receipt of government funds and on sector accountability, Mr Rooney stated:

> So I think you've hit the nail on the head insomuch as there has been investment in the system where it's been loosely termed, 'Well, here's some money to do something.' But there never really—in my short period of time in the system, there's never really been an appropriate or an effective mechanism to monitor and determine whether that investment has delivered on the intended outcomes.
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> …
>
> So I absolutely acknowledge that if there was more investment coming into the sector, that would come with clear expectations around what performance and what outcome would be delivered. And that needs to be measured and monitored. And, you know, if you're not meeting that, you need to be held to account.[202]

Data

In his submission in response to Consultation Paper 1, Mr Mark Cooper-Stanbury, a former employee of the Australian Institute of Health and Welfare, provided suggestions regarding improved data and research to support the planning, provision and evaluation of aged care. Mr Cooper-Stanbury submitted that there are four categories in which data and research can be improved to assist the operation of the Australian aged care system to:

- re-orient the data collection systems around the consumer
- make better use of the data and research already available
- improve the range, quality and timeliness of data to fill important gaps
- improve the scope, quality and availability of metadata (that is, information about the collection, structure and meaning of data).[203]

Both Professor Ratcliffe and Dr Lewin touched on issues concerning data when they gave evidence on the fourth panel.

Professor Ratcliffe spoke about the importance of a robust data collection mechanism to improve the evidence base and enable effective evaluation of investments made under the investment stream:

> we need to make better use of routinely collected data and we also need to introduce new data collection mechanisms. So we're collecting the right data and we should have public reporting of that data. And I think it's very important…that we measure outcomes. But I think these should not only be clinical indicators of outcome but they should also be outcomes that we know matter to older people and their families and their carers, which are really focused on quality of life and wellbeing.[204]

Dr Lewin agreed with Professor Ratcliffe, stating that 'there ought to be a minimum dataset that is collected across aged care'. However, she explained that this is not straightforward:

> it takes a lot of skill in terms of designing the measures that are actually clinically useful, because if workers on the ground or clinicians are being asked to collect data that they don't think is meaningful to what they're doing, to be quite honest, it's likely to be rubbish.[205]

Immediate reforms

In its written submission in response to Consultation Paper 1, Leading Age Services Australia submitted that it:

> supports fundamental reform of Australia's age services system, but the reform agenda should also account for how to quickly address the most urgent problems, including home care wait times, the growing gap between residential care costs and funding, and the need for resources to support better care in areas where frequent failures have been identified.[206]

Mr Sean Rooney explained 'the point we were making is that where we can act to make the system better right now, we should'.[207]

Dr Cutler acknowledged that complexities exist in implementing immediate reforms in the short-term 'which may be harder to turn around once the recommendations from the Royal Commission are implemented over the longer term'.[208] However, he agreed that there are well-documented elements of the current aged care system that require immediate attention:

> there is a fundamental structural need within the aged care system for change. And I think the skills and the training of the workforce has been identified on a number of occasions over the last 10 years, and in prior reviews, for that to continue to increase. So I do believe that there are some changes that can be made now.[209]

Mr Bonner also highlighted potential unintended consequences if key areas of reform are not implemented in the short-term. When addressing the current shortage of Home Care Packages available for older people, Mr Bonner stated:

> if we do not act now, then there are people either trapped without services and deteriorating without care and support at home, or alternatively, they are escalating because of chronic health breakdown and turning up at the emergency departments, stuck in our teaching hospitals and incurring massive cost and human suffering through that process.[210]

Dr Hartland expressed the view that in deciding what immediate reform actions to take, if any, the decision makers should be looking through 'the lens of the consumer and what would be of most immediate benefit to them [the consumer]'.[211]

Longer-term reforms

Counsel Assisting asked the panel to consider what the long-term agenda for aged care reform may involve, particularly the concepts of uncapping supply, implementing individualised budgets, and consumer-directed care that is agnostic of setting.

Dr Cutler suggested that an important measure to introduce would be a type of 'quality report card' so that 'any identified change in transient quality can be picked up through the reform process'. Dr Cutler stated that the Australian Government must ensure continuity of care for older people, while also being prepared for potential closures of under-performing aged care facilities, as a result of uncapping demand opening up competition in the aged care market. An evaluation of the funding mechanism for aged care providers will also be required to ensure that providers are not being constrained in obtaining the desired quality improvements sought as a result of the reforms.[212]

Mr Bonner expressed the view that 'moving to a system of client-focused consumer-centred care planning, assessment and then service provision' is key to future reforms, as that kind of progression 'is relatively well understood' by the sector. He viewed the concept of individualised budgets as an additional complexity that could be added in to the system 'down the track' once the above reforms have been bedded down. He said that 'from our perspective, it's the attachment of the money and what happens in terms of that accountability that is the fundamental problem with the model that's on the table now'.[213]

With regard to a staged-approach to implementation, Mr Rooney said that it is important to consider the 'integration with the health and social services sector'. Mr Rooney explained that consumers are:

> not really concerned whether it's the aged care system or any other system; they have a suite of needs which can cut across primary care, acute care, social services, aged care. At the end of the day, they just want something that's going to meet their needs in their community. And the system needs to be able to deliver that. And we need to be ensuring that we're delivering the outcomes that that person is actually requiring.[214]

15.2.4 Conclusion

The evidence received at Adelaide Workshop 1 and the submissions received in response to Consultation Paper 1 have informed the conclusions and recommendations made in Chapter 2: Governance of the New Aged Care System and Chapter 4: Program Design, in Volume 3 of this report.

Endnotes

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16. Adelaide Hearing 3: The Future of the Aged Care Workforce

16.1 Hearing overview

16.1.1 Introduction

We held a public hearing in Adelaide, South Australia, on 21 February 2020. The primary purpose was for Senior Counsel Assisting to make submissions about the future of the aged care workforce. Counsel Assisting's submissions were published later that day.[1]

In summary, Senior Counsel Assisting made the following submissions:

- An approved provider of residential aged care services should have to meet mandatory minimum staffing requirements, with staffing levels reported to the Australian Department of Health.
- Registered nurses, including nurse practitioners, should make up a greater proportion of the care workforce than is presently the case.
- All aged care workers should receive better training.
- Unregulated care workers—that is, personal care workers in home care and residential aged care—should be registered and hold a minimum mandatory qualification as an entry requirement.
- The value of the aged care workforce should be recognised and correspondingly, better remunerated and entitled to expect that they work in safe workplaces.
- The approved providers of aged care workers should be better managed and governed.
- The Australian Government should provide practical leadership to the aged care workforce.[2]

We invited public submissions in response to Counsel Assisting's submissions on the aged care workforce and received approximately 22 submissions in response.

We heard evidence from two witnesses on the subject of the aged care workforce:

- Professor Charlene Harrington, Professor of Sociology and Nursing, University of California, United States
- Dr Katherine Ravenswood, Associate Professor in Employment Relations, Auckland University of Technology, New Zealand.

16.1.2 Professor Charlene Harrington

Professor Harrington is an elected fellow of the American Academy of Nursing and the National Academies of Medicine and a registered nurse. She holds a Doctorate in Sociology and Higher Education and has been involved in many and various research projects regarding aged care and training for aged care.[3]

16.1.3 The need for adequate staffing levels in residential aged care

Professor Harrington gave evidence about the importance of adequate staffing levels for quality and safe residential aged care. She said that staffing is 'the number one issue and the failure to set minimum staffing standards is fundamental to all of the quality problems we're having'.[4]

Professor Harrington told us that there are numerous studies which show a 'strong positive impact' of higher registered nurse staffing levels on the quality of care. Research also shows that higher registered nurse staffing levels can lead to a reduction in emergency room use and rehospitalisation.[5] She stated that higher nursing levels are associated with:

> better resident care quality in terms of: fewer pressure ulcers; lower restraint use, decreased infections; lower pain; improved ADL [activities of daily living] independence; less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rates.[6]

Professor Harrington explained that mandatory minimum staffing levels may also alleviate workforce supply shortages due to the strong relationship between inadequate staffing and high turnover. We heard that workforce supply is currently constrained because of low wages and benefits and heavy workloads. Minimum staffing levels would encourage residential aged care providers to increase benefits and working conditions to recruit enough staff.[7]

16.1.4 The relationship between staffing levels and quality of care

Professor Harrington described staffing levels as the 'best indicator' of measuring and rating quality aged care. She said that the research shows that residential aged care facilities with low staffing numbers have higher numbers of deficiencies.[8]

We also heard about the relationship between low staffing levels and retention of aged care workers, with 'missed' care being found to cause job dissatisfaction and burnout. Professor Harrington said that missed or omitted care can lead to issues such as residents having pressure ulcers, medication errors, intravenous leaks and residents developing new infections.[9]

Professor Harrington stated that mandated minimum staffing standards, which increase as resident acuity levels increase, are required to sufficiently regulate staffing levels in residential aged care and that this should be a 'central part of the regulatory oversight'. She added that sanctions should be imposed for facilities which do not meet these minimum standards.[10]

We heard that in the United States, very few sanctions are imposed for inadequate staffing levels despite a requirement for residential aged care to have 'sufficient' staffing. However, without clear staffing standards, inspectors face difficulties identifying inadequate staffing.[11]

16.1.5 A requirement for minimum staffing levels for registered nurses

Professor Harrington told us that it is important for minimum standards to include a minimum staffing requirement specifically for registered nurses. We heard of the risks involved in simply providing a minimum staffing requirement for all aged care providers without specifying a minimum level for registered nurses.[12] Professor Harrington cautioned that if only total hours of care are mandated, there is a risk that residential aged care providers may simply hire less expensive staff. She told us that registered nurse hours are the 'strongest predictor of high quality of care'.[13]

We heard that the Centre for Medicare and Medicaid Services, which is a part of the federal Department of Health and Human Services in the United States, has developed a 'nursing home compare' system which gives nursing homes a rating for both registered nurse staffing levels and total staffing levels. This rating system has had a positive impact by encouraging nursing homes to increase their staffing levels. Professor Harrington cautioned that initially data was not considered to be accurate as it was self-reported as part of an annual survey, and facilities could increase staffing levels prior to the survey.[14]

In 2019, researchers found that discharges to nursing homes with higher star ratings led to 'significantly lower mortality, fewer days in the nursing home, fewer hospital readmissions, and more days at home or with home health care within the first 6 months'.[15] While this illustrates that the rating system works, Professor Harrington told us that it is not always considered in choosing a nursing home as this choice is often based on other factors such as location.[16]

16.1.6 A requirement for minimum staffing levels for allied health

Professor Harrington explained that the Centre for Medicare and Medicaid Services rating system has no provision stipulating a minimum staffing level required for allied health within residential aged care. This is because the minutes required for allied health are 'so low that they're not measurable' and it is not possible to 'differentiate well between facilities'.[17]

She considers that allied health staff ratios are less valuable than nurse ratios because 'allied health are supplemental workers that come in during the day to provide different therapies'.[18] She explained that in some circumstances the funding system in the United States has led to an unnecessary increase in allied health therapies, stating:

> In our situation, it is complicated because our reimbursement system for the therapy staff is quite complicated…But the allied health payment system was set up so that the more therapy, higher the payment. So the concern was that some patients were receiving too much therapy, even in their last weeks of life they were being given therapy. So the government has tried to correct that situation and it may have gone the other way.[19]

16.1.7 Dr Katherine Ravenswood

Dr Katherine Ravenswood, Associate Professor in Employment Relations, Auckland University of Technology, gave evidence about labour standards in aged care. She told us that:

> The state is the dominant power in the public supply chain of aged care facilities. Therefore, it should be able to influence labour standards with little argument…While the government could determine labour standards and funding models, this is often perceived as an increased cost to aged care providers, the health system and an imposition on the autonomy of providers to manage their business and workforce—attitudes best described as neoliberalism (Douglas and Ravenswood, 2019).[20]

Dr Ravenswood said that the low standards and wages of aged care are in part a result of care work being perceived to be 'low skilled, low valued and low worth'. Further, people receiving aged care services are 'perhaps not prioritised either in society or in health care'.[21]

16.2 The role of government in setting labour standards

Dr Ravenswood and Associate Professor Sarah Kaine, University of Technology Sydney, have argued that 'the role of government in the employment relationship needs to be reconceptualised to recognise its agency as an indirect employer, and its consumer power, in public procurement'.[22]

In her written statement, Dr Ravenswood stated that the:

> government must place more emphasis on its role as an indirect employer in the domestic supply chain. This would mean a greater focus on labour standards in the supply chain, in addition to the existing focus on care provision and client outcomes.[23]

She added that aged care funding is 'based on a model that does not acknowledge the skill, experience, and time involved in delivering the desired quality of care', as funding is based on the assessment of client dependency. As such, the funding is based on a model to contain costs, with outsourcing used to gain services for a lower cost. Dr Ravenswood stated that:

> If labour standards were funded and required in national agreements for…aged care… then accreditation would be a significant mechanism for monitoring and enforcing good labour standards, as providers would be unable to provide aged care if they did not achieve accreditation.[24]

In Dr Ravenswood's view of the reconceptualised aged care system, the role of government would 'be more than a funder and approver of aged care provision' and the government would place employment considerations on an 'equal footing' with funding concerns.[25]

16.2.1 The New Zealand Pay Equity Settlement for care workers

We heard about a case in New Zealand which has led to increased wages for aged care staff. In 2012, an aged care worker, Ms Kristine Bartlett, supported by her union, brought a claim under the *Equal Pay Act 1972* (NZ) and argued that low wages were the result of systemic historic gender discrimination. Ms Bartlett sought equal value for equal work.[26] She was successful in her claim and, following a number of appeals, in June 2017 government bodies, employer representatives and employee representatives reached a settlement.

Subsequently, the *Care and Support Workers (Pay Equity Settlement) Act 2017* was passed. This resulted in a pay rise for aged and disability residential care and home and community services workers of between 15% and 50%, depending on their qualifications and experience.[27]

Dr Ravenswood stated that the settlement and subsequent legislation 'marked a change' to the New Zealand Government's otherwise 'distant approach' to domestic supply chains regarding workforce standards.[28] The legislative change:

> introduced unprecedented changes to New Zealand aimed at addressing historical gender discrimination…that had resulted in low wages and conditions for care and support workers in a traditionally female dominated workforce.[29]

Dr Ravenswood added that the settlement had a positive impact on the workforce, with improved confidence of workers who had 'long felt the low social status of their work'.[30] She told us that managers agreed that workers deserved a pay increase and better wages led to clear benefits for workers. Some reported that they were now able to save for holidays, they could work less and spend more time with their families, and that some basic choices were now within reach, such as going to the dentist or buying a pair of glasses.[31]

A negative consequence of the pay rises was that the increased funding provided to account for increased wages did not take into consideration the increased administrative and reporting burden placed on employers. This led providers to implement cost cutting measures, including in training and recruitment of care workers. The increased wages have not necessarily led to workers feeling more appreciated by their employers. Workers also reported feeling that they were expected to do more in the same amount of time.[32]

Other consequences have included employers reducing the hours for higher qualified workers due to their higher pay bracket, in some cases leading to a reduction in overall income for those workers.[33] Employers have also recruited less qualified employees in a lower pay bracket. Some workers were also indirectly restricted from changing employer because wage levels were based on experience with their current employer and were not transferable between providers.[34]

While the increased pay recognised the value of work, Dr Ravenswood stated that the perceptions of aged care workers have not changed. She told us of an attitude that is developing about aged care workers in New Zealand, which assumes that as they are now paid more, they 'should take on more responsibilities or a higher workload'.[35] Care workers are sometimes required to complete tasks previously carried out by registered nurses and enrolled nurses. Dr Ravenswood told us of reports that other staff members, including nurses, kitchen and cleaning staff, often felt resentful of the pay increase to aged care workers as they were not included in the settlement.[36]

An evaluation of the outcomes of the settlement has recommended that a culture of value for care and support workers needs to be established through government led campaigns.[37]

16.2.2 The role of funding models and accreditation processes to support quality aged care

We heard that a combined approach of funding models and accreditation processes supporting good labour supply, rather than an industrial relations approach, would better provide the required quality of care. As noted above, Dr Ravenswood said that the current funding model is 'based on a model that does not acknowledge the skill, experience, and time involved in delivering the desired quality of care'.[38]

Dr Ravenswood told us that the state is the dominant power in the supply chain for aged care services and so is in a position to influence labour supply.[39] She said that national agreements between the government and providers of residential aged care and home and community care should recognise the labour standards that are required in aged care. She explained that labour standards should be given the same level of importance in these agreements as funding arrangements. By doing this, governments would then be in a position to enforce good labour standards through the accreditation of aged care service providers.[40]

Dr Ravenswood stated that the key barriers to reforming the terms of engagement of the aged care workforce appear to be a reluctance to increase funding and reluctance to 'include employee representatives in key funding and service provision mechanisms in residential aged care'. These issues stem from negative social attitudes towards aged care work and labour standards not being on an equal standing with financial and profit concerns. Dr Ravenswood suggested that government led social campaigns aiming to change attitudes towards aged care work, and an 'alignment of care, staffing and safety requirements in the current regulation with realistic minimum staffing levels' would help to address these issues.[41]

Endnotes

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5 Exhibit 15-1, Adelaide Hearing 3, Annexure to Statement of Charlene Harrington, RCD.0011.0042.0003 at 0003 [2].
6 Exhibit 15-1, Adelaide Hearing 3, Annexure to Statement of Charlene Harrington, RCD.0011.0042.0003 at 0003 [2].
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8 Transcript, Adelaide Hearing 3, Charlene Harrington, 21 February 2020 at T7839.41–45.
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18 Transcript, Adelaide Hearing 3, Charlene Harrington, 21 February 2020 at T7846.7–9.
19 Transcript, Adelaide Hearing 3, Charlene Harrington, 21 February 2020 at T7846.9–17.
20 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0007 [7].
21 Transcript, Adelaide Hearing 3, Katherine Ravenswood, 21 February 2020 at T7851.34–46.
22 Exhibit 15-3, Adelaide Hearing 3, general tender bundle, tab 8, RCD.9999.0293.0251 at 0251.
23 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0003 [2].
24 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0005–0006 [5]
25 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0003 [2].
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28 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0003 [2].
29 Exhibit 15-3, Adelaide Hearing 3, general tender bundle, tab 10, RCD.9999.0293.0157 at 0161.
30 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0008 [8b].
31 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0008 [8b]; Transcript, Adelaide Hearing 3, Katherine Ravenswood, 21 February 2020 at T7853.8–16; Exhibit 15-3, Adelaide Hearing 3, general tender bundle, tab 10, RCD.9999.0293.0157 at 0180.
32 Transcript, Adelaide Hearing 3, Katherine Ravenswood, 21 February 2020 at T7853.25–28; Exhibit 15-3, Adelaide Hearing 3, general tender bundle tab 10, RCD.9999.0293.0157 at 0179–0180.
33 Transcript, Adelaide Hearing 3, Katherine Ravenswood, 21 February 2020 at T7853.34–7854.13.
34 Transcript, Adelaide Hearing 3, Katherine Ravenswood, 21 February 2020 at T7852.36–45.
35 Transcript, Adelaide Hearing 3, Katherine Ravenswood, 21 February 2020 at T7854.15–19.
36 Exhibit 15-3, Adelaide Hearing 3, general tender bundle, tab 10, RCD.9999.0293.0157 at 0183.
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38 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0006 [5].
39 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0007 [7].
40 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0006 [5].
41 Exhibit 15-2, Adelaide Hearing 3, Statement of Katherine Ravenswood, RCD.0011.0043.0001 at 0010–0011 [11].

17. Adelaide Hearing 4: Future Aged Care Program Design

17.1 Hearing overview

We held a public hearing in Adelaide, South Australia, on 4 March 2020. The purpose was for Senior Counsel Assisting to make submissions about the future design of aged care. Counsel Assisting's submissions were published on the Royal Commission's website later that day.[1]

Counsel Assisting's submissions were informed by:

- approximately 170 public submissions received in response to the Royal Commission's Consultation Paper 1—*Aged Care Program Redesign: Services for the Future*
- consultations on aged care redesign conducted by Counsel Assisting and staff of the Office of the Royal Commission during December 2019 and February 2020
- evidence obtained during Adelaide Workshop 1, 10–11 February 2020.

Counsel Assisting's submissions outlined proposals for a redesigned aged care program. This included a number of noteworthy changes which Senior Counsel Assisting stated 'in combination would achieve a fundamental overhaul of the aged care system'.[2] These included:

- needs-based entitlement to aged care through linking funding to the actual cost of care and uncapping the supply of funding packages and places
- reorientation of the aged care system towards wellbeing and independence
- improving a person's access to aged care services, including through a new 'care finding' and case management service
- increased innovative accommodation models directed at enabling people to remain at home or in appropriate alternative accommodation
- improved data collection and analysis
- improved local strategies to promote equitable access to aged care irrespective of a person's background or where they live.[3]

Senior Counsel Assisting outlined proposals for changes to 11 aspects of aged care program design: life planning; information and contact points; care finding and case management; informal carer support services and respite; assessment; wellness, reablement and rehabilitation; diverse needs; home support and care; innovative accommodation models; residential care; and standardised data collection and analysis.[4]

We invited public submissions in response to Counsel Assisting's submissions of 4 March 2020. Twenty-six submissions were received in response to Counsel Assisting's submissions. We have taken those submissions into account in preparing the recommendations contained in Volume 3 of our Final Report.

Endnotes

1 Submissions of Counsel Assisting the Royal Commission, Adelaide Hearing 4, Program Redesign, 4 March 2020, RCD.0012.0062.0001.
2 Submissions of Counsel Assisting the Royal Commission, Adelaide Hearing 4, Program Redesign, 4 March 2020, RCD.0012.0062.0001 at 0002 [13].
3 Submissions of Counsel Assisting the Royal Commission, Adelaide Hearing 4, Program Redesign, 4 March 2020, RCD.0012.0062.0001 at 0002–0005 [13].
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18. Adelaide Workshop 2: Research, Innovation and Technology

18.1 Workshop overview

18.1.1 Introduction

We held our second hearing in the form of a public workshop, Adelaide Workshop 2, on 16 and 17 March 2020 in Adelaide, South Australia. We received evidence about innovation in aged care, including in educating and training workers, translation of research into practice, and the use of technology to improve the lives of older Australians.

In preparation for Adelaide Workshop 2, staff of the Office of the Royal Commission developed 10 propositions which were published on our website.[1] Counsel Assisting used these propositions to explore ideas about aged care-related research, and innovation and technology with panel witnesses. We assembled five panels to facilitate discussion about the propositions.

We also heard from three direct experience witnesses, and from a witness in Canada about a Canadian aged care service and education model.

In response to the COVID-19 pandemic, we offered all witnesses the option to appear via audio visual link. The workshop was closed to members of the public, although it was broadcasted on our web stream.

18.1.2 Panel One: Supporting technology and innovations in aged care

The first panel focused on the use of technology and innovations in aged care. The witnesses on this panel were:

- Dr Tanya Petrovich, Business Innovation Manager for the Centre for Dementia Learning, Dementia Australia
- Ms Jennene Buckley, Chief Executive Officer, Feros Care and Aged Care Industry Information Technology Council board member
- Ms Daniella Greenwood, Consultant, Daniella Greenwood & Associates
- Professor Sue Gordon, Chair of Restorative Care, a co-funded position between Flinders University and ACH Group, and Chief Investigator, Australian Research Council Digital Enhanced Living Hub.

The witnesses considered four propositions concerning technology in aged care and funding for technology and innovation in aged care. Their responses spanned the full range of technological considerations, including the technological experience of older people, personal care workers and providers, and the need to offer technology solutions suited to these groups' needs and wishes if innovations are to be successful.

The role of technology in aged care

Counsel Assisting asked each witness about the role of technology in aged care from their different perspectives. Ms Buckley emphasised the importance of the role of technology in the business of approved provider Feros Care.[2] Professor Gordon said that technology is 'massive in terms of what it can do for improving aged care'.[3]

Dr Petrovich acknowledged that technology has limitations for people living with dementia. She explained how dementia changes on a daily basis, so technology that works today may not work in a month's time.[4] Dr Petrovich said that technology does not detract from the need for genuine human to human care.[5]

Ms Greenwood said that it is vital to separate innovation and technology:

> If you ask any Australian if they dread moving into a residential aged care home, most of them will tell you yes. There's something that we're doing that isn't right.[6]

She continued:

> I think now is the time for Australia to come together and to say how do we want to grow old together. It's that sort of innovation, going right back to the baseline, not tinkering around the edges with robots—and none of those things are wrong, they are all brilliant and fantastic ideas, but they are still all serving to put a band aid on a problem, a deeper problem…wouldn't it be exciting if it's Australia that had that conversation. How do we want to grow old together and how can we not dread moving into residential aged care. What might that mean. Starting innovation from knowledge and then getting back into the other parts of technology and innovation.[7]

In response to the question 'how do we want to grow old?' raised by Ms Greenwood, Dr Petrovich explained that people want to have the best quality of life that they are able to at that point.[8]

Ms Buckley's words echoed this point, adding that Feros Care's mission is to help people 'grow bold' by staying independent, socially connected and living the best life they can. She said to do this you need to understand what 'living your best life' means for an individual by ensuring you understand their life goals and not just their health goals. Ms Buckley added that Feros Care's 'company values are based on that and that's what keeps our staff with us, because they know that that aspiration of ours is genuine'.[9]

An aged care standard on technology

Counsel Assisting canvassed the benefits of using technology in aged care, and asked the panel whether it is necessary to introduce an aged care quality standard on technology.

Dr Petrovich said that 'technology is an enabler' and a tool that can be used to improve quality of care outcomes. She emphasised that 'it's not technology for technology sake, it's for improving the quality of care and quality of life'.[10]

Professor Gordon said that technology has to provide a value proposition that improves providers' efficiency and their quality of care. She said that it is a matter of harnessing the technologies that are going to be most effective in providing value to workers, adding that technology itself is not going to improve care; it is 'how it's embedded in the delivery of services'. Professor Gordon explained that the Aged Care Quality Standards are moving to a person-centred care approach, which she thinks is a good thing. She said that this is the opportunity to capitalise on the standards.[11] Professor Gordon added that:

> technology really needs to be embedded in those standards to actually achieve the outcomes that are needed. Thinking of technology as a separate thing is not going to work.
>
> I would be looking to embed best practice technology to support the attainment of those other eight aged care standards.[12]

Ms Buckley said that a standard on technology in aged care will be needed in the future, but imposing a standard at the moment is not the first step. She explained that the first step is to understand the digital maturity of the sector:

> Understand with all the service providers that are providing support and care, how mature are they, are they still using paper, where are they at? And we need to understand the digital literacy of our staff and, from that, we set ourselves a vision and a strategy on how we're going to improve the industry's capacity or confidence in using technology and do a little bit of a roadmap working out how we are going to fund that. And that is not just one-off grants.[13]

Ms Buckley emphasised that if failure to comply with the standard was to have serious consequences, 'then that would just put more and more pressure on providers who are already at a very, you know, at a very difficult point at the moment in operating services'.[14] Ms Buckley used the example of Feros Care's residential facilities. She said that they do not have a sophisticated client management system, but provide a wonderful service. She said that it does not make sense to say 'just because you don't have that piece of technology you are not providing the best life you can for our residents'.[15]

Ms Greenwood said that there should be more sensible boundaries to entry as an approved provider and that providers who do not commit to a technology plan should not be approved.[16] She asked:

> why are we still giving licences to people who are going to build areas for people living with dementia that we know they're going to get distressed in. Why are we still handing out licences to bad design when it's not even more expensive…[17]

Dr Petrovich agreed, adding that 'buildings are being built which we know are not enabling, yet these are places that are being funded to be built…it should not be allowed'.[18]

Professor Gordon said that if a standard around technology in aged care was introduced, there would need to be a transition plan. She suggested that based on her experience with other standards for processes, one way to address the transition would be to require

providers who do not meet the standard to have a plan to implement it over one to two years to bring them up to a minimum standard of technology.[19]

Professor Gordon highlighted the importance of remembering that the aged care provider is a consumer of the technology. She said that you cannot expect an aged care provider to take responsibility for aspects of the technology they might use, such as cyber security, privacy, how the data is collected, and where the central repository is for the data.[20] Ms Greenwood said that there needs to be standards to guide the information technology industry. She said that the information technology industry develops technology that has not considered human rights issues such as privacy.[21]

Funding to support approved provider innovation

The witnesses considered a proposition concerning funding to support innovation, with the aim of removing financial risk for providers in pursuing innovation.

Professor Gordon said that the 'thing, of course, is always going to be money. We're talking about a sector where 51 per cent of aged care providers are in the red'.[22]

Ms Buckley referred to a submission by the Aged Care Industry Information Technology Council which compiled a list of technologies that would be expected in an aged care organisation. She explained that in that list, the Council estimates that aged care organisations with 500 employees should spend between $25 million and $50 million on technology over five years.[23] Dr Petrovich said:

> I think that the industry as a whole in general is risk-averse and is not open to innovation in residential aged care. …They need to be encouraged to be more innovative. I understand there's monetary constraints but actually I think there are things that can be implemented now that would make a significant difference to aged care and it doesn't require a lot of money.[24]

Ms Buckley said that she does not think that there is an incentive for providers to innovate, but Feros Care has an aspiration to help the industry become better.[25] She said:

> We need to make sure the funding model and the pricing model of all aged care services allows an organisation to invest in technology and to invest in quality and we were lucky as an organisation…that…our board has supported us to use reserves to build our technology capability. We still have some work to do in residential care in relation to client management systems, but if you asked me today could I afford to invest this amount of money, if I had to start today, my answer would be no, that the funding models at the moment and the pricing models of care does not allow us to innovate.[26]

Ms Buckley described the effort that goes into an approved provider using technology:

> A piece of technology off the shelf, that's already been developed, comes into our service, there is so much work for a service provider to do to put that innovation in the hands of a client. We need to test it. We need to make sure we understand its limitations. The risks around the technology, who can it help, who can't it help. Then we have to develop assessment tools and guidelines and training material. There's a lot of work involved in just one small piece of technology. So we need to be able to create the ecosystem for that technology to be evaluated but then we need funding and systems to be able to allow providers to actually implement that innovation. It's not so simple.[27]

Ms Buckley explained that the true cost of operating a business requires more than a 10% administration fee. She added that an analysis by Deloitte found that the average investment in technology by businesses is over 3% of revenue and that innovative organisations spend 7% of their income just on technology innovation.[28] Ms Buckley said:

> We couldn't possibly do that with a 10 per cent admin fee. I think we need to understand that there's a cost to running a business and…the pricing needs to be much more mature and it needs to acknowledge that we want to be an aged care industry that can be innovative, that… more than meets standards and that we want to be innovative and provide a quality service. And that really does come at a price.[29]

The importance of co-design

Ms Greenwood said that transferring technological ideas to practice is not as easy as it may sound at the aged care provider board level. She said that developers work to create something but they do not spend enough investment in the person who will end up using the technology. Ms Greenwood said that the technology needs to be developed for the 'front-end user' and the 'front-end user' needs the training and support. However, she emphasised the difficulty of co-design with residents who are no longer using words to express preferences.[30]

Dr Petrovich said that co-designing with the aged care worker is absolutely paramount. She explained that there needs to be an understanding of what the end user needs and an understanding that the industry has a lot of personal care workers who come from non-English speaking backgrounds. She gave an example of this where Dementia Australia identified an issue with care workers' note-taking and English writing, and developed targeted notetaking software using icons.[31]

Professor Gordon said that there are technology industry driven products that are 'basically put under the noses of aged care providers' that do not match with what the user actually wants.[32] She told us that the active role that co-design plays in her work cannot be underestimated. It goes beyond co-design and is more of a quality cycle that includes co-production, co-implementation and evaluation. She stated the question to ask is:

> Has the technology that we have developed actually answered the problem, addressed the issue. So it's not just at the get-go. This is a long-term relationship that you need to really implement technology effectively to get the outcomes you want.[33]

Ms Buckley said that Feros Care staff members sat down with their clients in their homes and developed a journey map. They then created Feros Care's roadmap of innovation. Ms Buckley said that their clients play a role in 'prioritising our innovation, helping us design the innovation and telling us whether we have got it right or wrong'.[34] She said:

> to go into the client's home and listen to what they had to say about our services was very confronting because we thought we were doing a good job and we realised there was a number of things as a provider we had to do differently. And I even went, in one situation, undercover CEO and sat for two hours and listened to the stories and I really then understood that if we do not work with our clients, then they will not stay with us, that we need to absolutely listen to them.[35]

Technology as part of assessment

Professor Gordon said that technology should form part of the aged care assessment of older people, through questions such as 'what is there in technology that can actually assist this person to have a better life?'[36] She described a recent focus group with older people, telling how the older people said that they don't use 'apps', but when asked how they did their banking, they responded that they do it on their phones. Professor Gordon said that people need to understand what technology is and the different types of technologies. She said that there needs to be training around digital literacy and how to use assistive technologies, because people are scared of them.[37]

In contrast, Ms Buckley said that older people are hungry to learn. She explained that Feros Care was funded for three small innovation grants under the Commonwealth Home Support Programme, and piloted a program called 'Let's Get Technical' with one of these grants. As part of this program, Feros Care employees provided clients with up to 10 one-on-one training sessions about using technology in the client's home. Ms Buckley said that Feros Care was overwhelmed by the number of people interested in the program. She said, 'they're absolutely keen to learn, absolutely'.[38]

Technology-based learning

Counsel Assisting explored the benefits of using immersive and virtual reality technology in the education of personal care workers with the witnesses.

Dr Petrovich said that face-to-face education is still the gold standard, particularly in relation to person-centred care, but acknowledged this is not always possible. Dementia Australia has developed an artificially intelligent avatar that gives workers an online 'digital experience'. Dr Petrovich said that Dementia Australia conducted a survey of staff who had used existing online training, and the results showed that they were able to recall very little of what they had learnt online. However, after using an artificially intelligent avatar online, staff were better able to recall key information learnt. Dr Petrovich said that staff want the experience, so that is what Dementia Australia is working on—trying to give them an experience digitally.[39] Professor Gordon agreed that the education and training needs to be immersive.[40]

Dementia Australia has invested in and developed immersive technology and virtual reality technology education. Dr Petrovich explained that the cost of delivery of technology to providers is quite minimal, but they find that the cost of workers attending the session is the issue.[41] For example, Ms Buckley said that a two hour training session for Feros Care's 180 staff members would cost around $10,000. She said:

> we need to think about understanding the true cost of operating an aged care business and make sure that funding is appropriate for them to be able to train and innovate and build capacity.[42]

Professor Gordon emphasised the need to consider who the next generation of people moving into aged care are going to be, saying that 80-year-olds are not digital natives, but 70-year-olds are. She said that a big barrier is the digital literacy of consumers and the workforce. She explained 'unless this is addressed…it's not going to happen'.[43]

Dr Petrovich said part of the issue is that personal care workers do not feel comfortable using technology. She told of an evaluation by Dementia Australia where personal care workers said they could not use a computer, but knew how to use their mobile phones. Because of this, Dementia Australia is developing technology using mobile phones, as this is the device the personal care workers are familiar with.[44] Ms Buckley said Feros Care community care workers use a tablet, mobile phone or laptop, depending on their role and their technology of choice.[45] Ms Greenwood said that product usability and how it is implemented in terms of change management is everything.[46]

Where do we start?

Counsel Assisting concluded the first panel by asking each witness what the first step is and what should be done as an absolute priority.

Professor Gordon said that the first step in developing the industry is to 'get everybody in the room to figure out what the priorities really are'.[47] She suggested a way of bringing the information together at the beginning could be a research centre, including a cooperative research centre, to understand the perspectives of aged care providers and consumers.[48]

Ms Buckley said that the first step is to understand the maturity and digital literacy of the industry.[49] Dr Petrovich agreed and said the starting point is understanding what people want.[50]

Professor Gordon was part of the project team that developed the Aged Care Industry Information Technology Council's *Technology Roadmap for Aged Care in Australia* and the 2017 *Literature Review* that informed that roadmap. She added that the Roadmap was 'adopted with bipartisan government support but it hasn't actually been implemented', yet the recommendations are all there. Professor Gordon said that taking it on board and looking at how to implement it across the sector would be a 'real positive step'.[51] She emphasised that there needs to be a partnership to lead these reforms, together with a strong consumer voice, saying that the first priority is a conversation to bring together technology, evidence, older people and staff to discuss what will work in the aged care sector.[52]

Dr Petrovich said that the government has a significant role to play, as it needs to provide the guidelines. These guidelines would help determine how technologies should or should not be developed.[53] Ms Buckley agreed that the government has a role, saying 'I think we need a shared vision and a strategy that both industry and government agree on and…a strategy is put in place so that we have grassroots, broad innovation happening from all.'[54] She continued:

> So we need to create the environment to allow aged care providers to innovate with their clients and their staff, if we really want to see a change. It's not going to happen from one body because we need all providers to be able to innovate.[55]

Ms Greenwood said:

> I think we need to start again and I think we can throw it all up in the air and work out moving beyond judgment and asking staff to separate from their own humanness when they have these professional clinical relationships.
>
> I think that clinical focus, the judgmental focus is what we need to move beyond, if we really seriously want to change this.[56]

18.1.3 Panel Two: Aged care data and research

The second panel focused on aged care data and the following four witnesses gave evidence:

- Dr Robert Grenfell, Director of Health and Biosecurity, CSIRO's Health and Biosecurity Business Unit
- Ms Louise York, Head of Community Services Group, Australian Institute of Health and Welfare
- Associate Professor Maria Inacio, Director of the Registry of Senior Australians, South Australian Health and Medical Research Institute
- Mr Benjamin Lancken, Head of Transformation, Opal Aged Care (Opal).

Counsel Assisting asked the witnesses to consider propositions concerned with the reporting of data by providers and responsibility for aged care data.

Mandatory minimum dataset

Current capture of aged care data by the Australian Government

Since 2013, aged care data collected by governments has been compiled by the National Aged Care Data Clearinghouse.[57]

The Data Clearinghouse is managed by the Australian Institute of Health and Welfare and is the Australian Government's aged care data repository. It contains aged care data which can then be reproduced as reports and made available online. The Australian Institute of Health and Welfare can link datasets and examine the connection between programs, such as the interfaces between the Pharmaceutical Benefits Scheme, Commonwealth Home Support Programme data and hospital data. The GEN aged care data website provides public access to interpretations of information from the Data Clearinghouse.[58]

Ms York told us that data in the Clearinghouse report on activity in the aged care sector or numbers of people receiving care, and where they are receiving that care. She said that data are linked to analyse 'really important safety and quality aspects, such as prescribing rates', although she added that more could be done.[59] Associate Professor Inacio said that the Australian Institute of Health and Welfare can make linked data available to researchers after clearance through its ethics committee.[60] Such data, Ms York said, are available free of charge.[61]

Researchers such as Associate Professor Inacio use the Australian Institute of Health and Welfare datasets for research to support aged care policy analysis. In 2018, for example, the Registry of Senior Australians made contributions to the understanding of the effect of wait time for aged care services on the health of older people, and the prevalence of dementia in the aged care population and its effect on mortality and increasing pervasiveness of pain in this population.[62]

Barriers to access to datasets for research

Ms York said that governance, administrative load and privacy are barriers to making aged care data accessible. She explained that a lot of aged care datasets are of sensitive personal care information which do not necessarily need to be shared to run an aged care system that is safe and of high quality. Ms York explained that consent is important to personal information, however information may often be de-identified and then released to inform a safer system without contravening privacy law.[63]

Associate Professor Inacio told us that when the Registry of Senior Australians requests information from the Australian Institute of Health and Welfare, the latter must confer with the original data custodians within government. She said that while the Australian Institute of Health and Welfare merely houses the datasets, they are 'not in charge of the collection process'. The Australian Institute of Health and Welfare hold records such as State hospitalisation records 'only in the capacity that we have asked the States then to give permission for them [the Australian Institute of Health and Welfare] to link to the datasets'.[64]

Ms York elaborated, saying that the Australian Institute of Health and Welfare holds 'several years of linkable State / Territory hospital data'. However:

> long-term hospital data resides with the States and we [the Australian Institute of Health and Welfare] generally act as a curator for all of that data but then need to go back to the original source in order to get it released to researchers or, indeed, to ourselves for analysis.[65]

Ms York added that likewise, in the case of Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data, the Australian Institute of Health and Welfare needs approvals to release the data.[66]

Ms York said that the main delay in accessing data at present is getting approval from the data custodians for its release. She explained that the custodians are working in an environment where they are attempting to discharge their role 'according to what they perceive' are the legislative requirements applicable to them. She stated that the Australian Institute of Health and Welfare had a 'vision' of:

> enduring and regularly linked information where...approvals have already been given upfront… to build…linked data and infrastructure once for use by multiple people, research community, governments, for projects that are considered to fit with the research and analysis agenda with the outcomes framework and with everything you're trying to achieve.[67]

Ms York explained that timeliness is currently an issue with all aged care data. She told us that transactional data, such as Aged Care Funding Instrument data, might be ready six months after the fact for curation, whereas hospital data might take eight or nine months and similarly for Medicare data.[68]

All panellists agreed that there are serious and inexplicable time delays in receiving data. For example, aged care eligibility assessment data has not been made available since 2016. Associate Professor Inacio considers that there is no excuse for a four year delay where assessors collect this information every year. She said that the information is 'incredibly valuable' to understanding individuals at their point of entry and that the delay represents a 'missed opportunity'.[69]

Associate Professor Inacio described the Registry of Senior Australians' experience in obtaining data from the Australian Institute of Health and Welfare as 'an incredibly demanding and trying process'. She explained that a research project does not usually receive grant money to support the administrative burden of ethics and governance approvals processes. She agreed that this could put a 'dampener' on her research work and said the Registry of Senior Australians' work would have been affected if not for the financial support it received. Associate Professor Inacio acknowledged that this problem has been recognised by the Academy of Science and the Academy of Health and Medical Science and it is something that the Australian Institute of Health and Welfare is working towards improving.[70]

The applications of aged care datasets

Dr Grenfell said it is important that providers understand how data they may collect will be used and how it may be fed back to them. He explained the principles of datasets, one being 'interoperability, that is, do the systems talk to each other'. He said that this is 'a technical challenge' that has not yet been fully resolved between the acute and the primary care settings. He said other challenges with data include privacy and governance provisions. Dr Grenfell noted that the aged care data 'domains' are not linked, not readily sourced and not readily searchable. Therefore, he said, 'curation of these datasets is vital just as the accuracy of collection and stratification' of them.[71]

Ms York stated that most sectors will eventually have an 'outcomes framework' for data governance which:

> sets out all of the outcomes they are trying to achieve and then under that a series of indicators or measures that will measure success in the direction of that area and then a minimum dataset of things that need to be collected in order to derive those indicators.[72]

Dr Grenfell highlighted the importance of having an understanding of the level of granularity needed in the system as well as the timeliness of data collection. He said that 'a digitised health system requires immediate feedback to the right person at the right time and that's in fact actually the data journey'.[73]

Aged care mandatory minimum dataset

The panel gave evidence about the content, rationale and applications of a minimum mandatory dataset.

Ms York said that a minimum dataset should be the 'core number of data elements that are captured as a by-product of the activity that's going on for clinical or other transactional purposes'. She explained that the data should be useful for looking at both the individual service provider level and the system level, and said that while a lot of that data is in the system at the moment 'it just needs to be more timely and linked more regularly to get a better picture'.[74]

Dr Grenfell emphasised that there are multiple facets to a minimum dataset in terms of what each person engaged with the dataset may want from it and what the dataset actually delivers. For the client or the engaged participant, they have to understand what they will 'get from it by allowing their data to be collected'. He noted that in acute and primary care they are looking at a 'new science' of 'patient recorded outcome metrics'.[75] By way of example, Dr Grenfell acknowledged that loneliness is a known antecedent cause for ill health. Referring to the evidence of Ms Barbara Hamilton Ramsay, a home care recipient with a Level 3 Home Care Package, he indicated that 'loneliness is a metric that would mean something to her' and 'was something that we should measure'.[76]

Associate Professor Inacio emphasised that a minimum dataset and data collection needs to 'serve a specific purpose' and accordingly, the contents of data collected for a dataset 'depends on what the purpose is'. She noted that a dataset designed to give a 'population-level understanding' of services and outcomes is a different dataset to one designed to address financial questions.[77]

Associate Professor Inacio explained that in her work for the Registry of Senior Australians, looking at population level data, 'there is a very specific number of minimum data elements that is important'. She confirmed that a lot of the data elements that the Registry of Senior Australians use in their work are already available from aged care eligibility assessments and Aged Care Funding Instrument assessments, with some limitations. Associate Professor Inacio considered that bringing those datasets and information together would allow examination of matters not been previously undertaken.[78]

Ms York told us that 'there's great potential of linked up data to provide information about the risks that are being experienced' by people receiving aged care. She said hospitalisations, prescribing rates, complaints and accreditation status could be linked and would be 'much more valuable and meaningful if it could be risk adjusted for the profile of the people using those services' through regular assessment and assignment to classification levels. She considered 'that sort of information could conceivably be linked in to provide more information about the quality at the service level'.[79] Associate Professor Inacio agreed that compliance and accreditation information would be 'incredibly valuable in the future to understand performance of facilities'.[80]

Mr Lancken agreed that there is a lot of data being collected but that currently it is 'very siloed and difficult to link together'. He told us that, for Opal, the most important aspect of data was making sure that they were 'measuring…the views of people living in our care and the families'.[81] He considered that there is a lot of data around quality of care, but not necessarily enough around quality of life and subjective wellbeing for those living in care. Mr Lancken told us he thinks there is an opportunity to capture that data and to make it 'more transparently available' to assist consumer choice.[82]

Associate Professor Inacio pointed out that, unlike people living in residential care, people receiving home care do not have any assessments in place and that it would be wonderful to have a needs-based assessment implemented for such people. She also told us that consumers involved with the Registry of Senior Australians tell them that quality of life measures and consumer experience measures 'would be the most important things to monitor' from their perspective. She added that it would be 'wonderful' if data was collected regularly and systematically. For example, she explained that if Aged Care Funding Instrument assessments happened more periodically, and not just after somebody had a change in health care needs, this would provide information about potential improvements over time in regards to their functional activities and things that are affecting their lives.[83]

Ms York agreed that capturing data from regular assessments over time would be valuable to the quality of information about people's functional status. She also agreed that quality of life and self-reported experience in addition to data about workforce and quality of services are missing from the current picture of aged care.[84]

Associate Professor Inacio said that workforce data should include the level of education of staff, the training received and workforce per number of resident bed days.[85] However, Associate Professor Inacio advised that 'as a first step…you should focus on what you can do [already] and then build on that' with quality of life estimates, workforce data and 'all the other stuff that's not currently publicly available'.[86] She considered that we already have a lot of data, but we need to put in place the infrastructure to extract it.[87]

Design of an aged care minimum dataset

Associate Professor Inacio said that:

> to collect enough information that we can understand what's happening so we can make inferences about it to improve what's going to happen in the future…[there] has to be partnership between the regulators and the providers.[88]

She added that if the providers are not part of the definitions created, then you will get data that is not useful. Based on her experience working in data registries over 20 years, she said that the 'consumers [of registry information] were always the providers because those were the ones asking to change the behaviour' and she said 'they have to be the ones that lead and accept that part of it'.[89]

Dr Grenfell said that when developing a minimum dataset, it is necessary to think about who needs to be at the table to achieve the outcomes sought and direct the development.[90] Mr Lancken emphasised the importance of involving consumers and

consumer representative groups in designing what the dataset would look like. He said 'a human-centred design approach' should be applied to decide what information is most required, and how to most effectively enable team members to capture the information most important to them to deliver great care. He said this information would not only be clinical indicators, but also things such as how residents like to spend their time, and their favourite foods and activities.[91]

Ms York said that the Australian Institute of Health and Welfare 'has a legislated function of designing such datasets in conjunction with relevant stakeholders'. She said what the Australian Institute of Health and Welfare would normally do is:

> work with clinicians, policy makers, academics, people involved, consumers, customers, older people and potentially the ICT [information and communication technology] sector, workforce, to work through…what they want to know, what's already available and then how we would go through the painstaking work of working out how to actually isolate those core pieces of information that need to be collected to really get that regular measurement over time of what we're trying to achieve.[92]

Dr Grenfell said that he would also support 'a higher governance' dataset for 'actually doing the directorial approach' for the aged care system.[93]

Aged care data management

Curation of an aged care minimum dataset

Ms York told us that the Australian Institute of Health and Welfare currently 'curates' the aged care datasets.[94] Dr Grenfell referred to 'curation' tasks as including linking data and making them available and searchable to users.[95]

Associate Professor Inacio considered that currently only the Australian Institute of Health and Welfare had the ability to link the various Commonwealth and State aged care datasets. She said that having essentially one holder of that information severely limits the access, and timeliness of access, to aged care data. She added that there are also prohibitive costs associated with having only one place to access data. Associate Professor Inacio also suggested that more options for access will be needed in the future.[96]

Aged care data governance

Dr Grenfell considered that curation is one function of data management and that the Australian Institute of Health and Welfare is performing that role for health care datasets very well. He suggested that the actual governance of data should probably be separate to curation.[97]

It was clear to us that the panellists considered that no group or entity exists currently that is adequately performing data governance functions for aged care data.

Mr Lancken stated that it was important that there be an independent body looking at data management from a governance perspective and said that Opal would support such a move.[98]

Dr Grenfell noted the failed attempts to set up Cooperative Research Centres in aged care because the industry is 'not engaged' in the 'idea of actually doing the research'. He said some form of overarching structure was needed.[99]

Ms York and Dr Grenfell spoke of managing information sharing and privacy law as current barriers, as well as dataset governance issues that need to be worked through.[100]

In terms of data governance and feedback, Dr Grenfell emphasised that data governance requires 'some degree' of responsibility for meeting governance targets 'right at the top level'.[101] He drew a comparison with the work on data as part of the Council of Australian Governments' *Closing the Gap* agenda. He said in that process there is a national report card which put responsibility back on those in power to act on differences or lack of action.[102]

Aged care data custodian

The panel examined the question of who should have responsibility for holding and releasing aged care data.

Associate Professor Inacio considered this question difficult to answer. She explained that data should be easier to access and there should be 'an opportunity to have independent bodies to do the monitoring of that information'.[103] She could envision 'a centre that focusses on aged care quality and safety in general' which also holds and manages necessary aged care data.[104] She considered the United States National Institute of Health could be a model for an independent body of this type. She considered that a body like the Australian National Institute of Dementia Research would be 'incredibly helpful' in aged care, subject to its success and sustainability, about which she could not comment.[105]

Mr Lancken considered that it is important to design the system without any duplication, and saw a need for current custodians and contributors to be involved to avoid duplication. He said data should be collected once but able to be used across the system.[106]

Ms York said that it would be sensible for an existing body with legislation and infrastructure already in place to link, curate and make data accessible through secure research environments to have responsibility for data in aged care. She stated that, within privacy constraints, aged care data should be 'opened up' so that it is useful to government and researchers. She added that there should be a continuous measurement of metrics, but was agnostic as to who would get to measure them as long as they are developed in a 'multi-party way'.[107] Mr Lancken emphasised that it would be important for the custodian to have an understanding of what has been done in the past so as not to 'throw the baby out with the bathwater' and duplicate effort.[108]

Dr Grenfell explained that there would not likely be a single data custodian but rather, each data custodian would collect data relevant to their financial or compliance functions, and an entity like the Australian Institute of Health and Welfare would bring the custodians' datasets together.[109] Ms York agreed with Dr Grenfell that this would be the purpose of a minimum dataset. She said that compliance agencies and service providers would capture

the information they need to perform their roles and it is a 'minimum component of each of those pieces that comes together into a curated set that's then made available for these multiple purposes'. She added that this does not replace the original datasets.[110]

Aged care data standards

Ms York said an important part of a minimum dataset is a need for 'information standards' to collect comparable information to assist in the running of aged care services and feed back into the entire service system.[111] Mr Lancken said that it is important to have a 'standard around data' so providers can 'with confidence invest in digital transformation based on those standards' and 'build our systems to enable the collection of that data'.[112] He said that 'the lack of data standards creates a bit of a barrier for innovation in the technology space' as the information technology industry needs standards to 'give them confidence to go ahead and build products that can service' the aged care industry.[113]

Collecting aged care data

Dr Grenfell said the biggest barrier to a minimum dataset is the workforce and their understanding of why they should collect the data and 'what it does to help them do the wonderful work that they actually do'. He said that 'They won't shift otherwise'. He said he has experienced this with the most eminent clinicians in the acute care sector saying that 'if they don't believe they need to collect it, they will not collect it and your datasets will be meaningless'.[114]

Mr Lancken said that anything governments can do to make submission of data easier, including establishing a direct digital interface between providers and government, will help providers collect data for a minimum dataset. He acknowledged that providers will also have a role in 'empowering our team members with the ability to be able to capture data at the point of care, again, to help try and reduce that burden of administration'.[115]

Associate Professor Inacio spoke about the indicators of quality and safety, such as pressure injuries, use of physical restraint, and malnutrition and weight loss, which have been collected directly from providers since 1 July 2019. She told us that two of those indicators can be collected from other sources, such as hospital admission data, which 'would not be as sensitive as collecting directly from the providers'. Associate Professor Inacio acknowledged that pressure injuries would be under-reported if data is collected from hospitals, but the more severe cases of pressure injuries would still be captured.[116]

Mr Lancken spoke about administrative burden being one of the 'symptoms' of the new National Quality Indicators when they were brought in. He said that the format or standard required for submission to the National Quality Indicators are different to the way in which Opal was already internally collecting data about those indicators. Opal has had to 'realign' their systems and processes to enable National Quality Indicator data to be 'collected as part of a delivery of care and trying to avoid it being done as a manual process'.[117] Opal's initial focus was on ensuring the quality of the data reported and it is now attempting to integrate data collection back into daily care.[118]

Mr Lancken told us about software that Opal has developed which not only captures complaints and feedback to allow for a quick response, but also captures organisation-wide trend data. He also told us that Opal is launching new customer surveying technology across all of their care homes 'designed specifically to enable accessibility for older people'. Information is captured by residents on a tablet device and aggregated in real time for managers to see 'straightaway in terms of what are the things they can focus on and improve', particularly in relation to improving quality of life aspects of resident experiences. Mr Lancken agreed that this data could be 'generated directly out of the system' if required and used to report to the Aged Care Quality and Safety Commission when assessed for complaints.[119]

Associate Professor Inacio told us that she considered the data collection process quite independent in terms of transactional data, Aged Care Assessment Team assessments, data from providers and hospital data, and trusted they were being collected just to describe what happened. She considered that there may be some bias in Aged Care Funding Instrument data given its purpose.[120] Mr Lancken considered that an organisation charged with aged care data should take a person-central approach with the data, starting with the individual and 'working out from there'. He said a lot of the data in the system is episodic and fragmented. If the data collection was designed from the person out, it would provide a better picture of the outcomes that are most important to people.[121]

Risks or limits with minimum dataset

The panel considered the risks or limits associated with a new minimum dataset.

Dr Grenfell reiterated that the biggest risk in setting a minimum dataset is disengaging the people it was supposed to serve, including aged care workers.[122]

Ms York considered there are risks in not specifying the outcomes the dataset would try to achieve, by trying to achieve too much, and not using the data that is already available and building on that.[123]

Dr Grenfell expressed concern around the privacy and governance of aged care data. He considered that this is a problem faced by the National Health and Medical Research Council across all health and medical research. He considered the problem to be 'disruptors' moving into the research sector not having the same understanding as health practitioners about the sanctity of the data that people give them. Dr Grenfell spoke about trials of innovative digital and interactive technologies such as chatbots to combat loneliness and sensors to see how someone is performing to prevent hospital admissions. He said studies conducted within the National Health and Medical Research Council would be subject to ethics review, but he could not attest that this is occurring with others coming into the digital sector. He considered standards of how to use information collected by these digital technologies 'is actually quite vital'.[124]

Mr Lancken stated that there are limits when setting a minimum dataset in making sure it is agreed and implementable. He said there is a need to acknowledge challenges of digital maturity and interoperability in the sector, and to be realistic about where the sector is at today and where it needs to be in the future. He advised the focus needs firstly to be understanding where the sector is at now and then building steps to where the sector needs to go.[125]

Capacity to implement a new mandatory minimum dataset

Ms York stated that the Australian Institute of Health and Welfare does not currently have the resources to curate a mandatory minimum dataset including existing datasets, workforce and quality of life, but that the it has a model which can 'build on what we already do, and scale that up to include additional data sources'.[126]

Ms York also told us that the Australian Institute of Health and Welfare is 'half appropriation funded and half funded by special purpose grant…so normally we can stand up new teams or new work programs quite quickly in response to requests'.[127]

Ms York said the time that ought to be allowed to curate a mandatory minimum dataset 'largely depends on whether the first stage of that would be to collate everything that currently exists into a linked dataset that makes most use of what's currently available'. In the example of building a big national disability dataset, she told us the core could be brought together over a period of two years. However, bringing in new data would require 'a bit more work with all of the players who we have been talking about today to define what should be brought into the mandatory dataset'. She said that work could happen at the same time as curating existing data to try to start getting more useful data together.[128]

Time to implement reform

The panel was asked how long reform would take to implement changes such as Proposition 9 and 10, which addressed consistent reporting of data by approved providers, and creating an entity responsible for aged care data respectively. Dr Grenfell said 'we should look at digital transformation in a 10 year sort of cycle and say what would we like to achieve in a staggered approach and what would be the ideal system that we would be aspiring for over a 10 year period'. He said it is ambitious to say 10 years. He noted that in the acute and primary sectors they had 'probably failed' as they had been under digital transformation for his entire career, but the mistakes 'actually tell us what we shouldn't do'.[129]

Ms York agreed that a 10 year period would be 'fair', noting that people may think 'we had good information about primary care and we don't'. She considered that to obtain trust and have information in a format where you could link it, 'to really look at how the person is experiencing that move between aged care and primary care, I think 10 years would be safe – safer'.[130]

18.1.4 Panels Three and Four: Innovation education and training of aged care workers

Two panels gave evidence on education and training of aged care workers. The first panel of witnesses to give evidence on this topic was:

- Dr Kate Barnett OAM, Managing Director, Stand Out Report
- Ms Megan Corlis, Director of Research and Development, Helping Hand Aged Care (Helping Hand)
- Ms Helen Loffler, Manager of Student Participation, Helping Hand.

The second panel comprised:

- Professor James Vickers, Director of the Wicking Dementia Research and Education Centre (Wicking Centre), Dean of the Tasmanian School of Medicine and a board member of the Glenview Community Services, an approved provider of residential and community care
- Professor Andrew Robinson, Professor Emeritus, Wicking Centre.

Counsel Assisting assembled these two panels to consider a proposition concerning the introduction of a Teaching and Research Aged Care Services model.

Teaching and Research Aged Care Services Program

The Teaching and Research Aged Care Services Program, which ran in Australia from 2012 to 2015, was designed based on the 'teaching nursing home' model which operates in Scandinavian countries, the United States and Canada.[131] The teaching nursing home model involves strategic partnerships between aged care providers, educators and researchers. The model originally began in veterans' nursing homes in the United States and was developed further in Scandinavia. The model provides 'an opportunity for the aged care workforce to be trained in a setting designed to meet the needs of older people'.[132]

The then Australian Department of Health and Ageing commissioned the Australian Institute for Social Research to undertake a scoping study in 2011 to 'examine critical enablers and barriers to establishing and operating a Teaching Nursing Home (TNH) in Australia...and to identify the range of models and key characteristics that contribute to excellence within Teaching Nursing Homes'.[133]

The Teaching and Research Aged Care Services Program was defined as providing:

> aged care services that combine teaching, research, clinical care and service delivery in one location to operate as a learning environment to support clinical placements and professional development activities in various disciplines.[134]

The overarching goals of the program were:

- increased involvement for education and training providers in ageing and aged care research that is based on clinical experience
- increased involvement for aged care providers in research and clinical practices that enhance quality of care
- enhanced learning opportunities for students, based on clinical experience with a Teaching Research and Aged Care Services affiliation, and
- improved quality of care for aged care consumers and their families.[135]

The Australian Government provided $8,161,027 (excluding GST) to 16 partnerships between aged care providers and universities, from 2012 to 2015, to implement the program.[136]

The Australian Institute for Social Research considered these partnerships to be fundamental to the Teaching Research and Aged Care Services model. Of all the projects undertaken, 86% were based on existing partnerships between an aged care provider and a university. Those based on entirely new partnerships were found to experience the most significant challenges in progressing the project aims.[137]

The 2016 National Evaluation of the Teaching Research and Aged Care Program, *TRACS to the Future*, concluded:

> The TRACS [Teaching Research and Aged Care Services] Program sought to enhance the capacity of the aged care sector and education and training sectors to partner, and national evaluation findings confirm that this outcome has been achieved.[138]

Teaching program development—Helping Hand

The Teaching and Research Aged Care Services Program funded student placements with aged care provider, Helping Hand, in partnership with the University of South Australia.[139]

Ms Corlis gave evidence that, prior to the Teaching and Research Aged Care Service funding, Helping Hand facilitated student placements if education providers approached a particular facility directly to negotiate the placement. Because each individual facility had responsibility for placements, this resulted in a lack of consistency of approach and used significant resources. With the funding provided under the Teaching and Research Aged Care Services Program, Helping Hand was able to centralise its model for student placements through one service, and so facilitating the distribution of student placement throughout the organisation.[140] Ms Corlis said that once the model was centralised, Helping Hand began employing people with relevant expertise and was able to develop new opportunities for innovative ways to work with students.[141]

Over time, Helping Hand moved from straight clinical placements requiring one-on-one student supervision by someone in the same profession to an inter-professional model of placements. Ms Corlis stated that the inter-professional placements allowed for registered nurses to supervise first year physiotherapy students and second year pharmacy students.

She said that 'it developed a really nice model of getting people to be more holistic in their approach to older people, which…from our perspective, is really critical because of the complexity of our environments'.[142]

Ms Corlis stated that Helping Hand focused on vocational education and training students studying their Certificate III with the funding it received from the program. She explained that when this funding ceased, Helping Hand was able to sustain its teaching programs with the support of its Board, considering the 'enormous benefits' which resulted from the program. The Board decided to maintain Ms Loffler's role as Manager of Student Participation and has been able to fund other student facilitators through funds received from nursing and allied health programs run by universities.[143]

Ms Loffler said that the organisation aims to illustrate the complexities of aged care to the students through placements. She said that 'that idea of actually making a difference to us and to the residents' wellbeing is really key for that engagement and, I guess, that ongoing partnership and sustainability of the program'.[144]

Teaching program development—Wicking Centre

Professors Robinson and Vickers explained to us their work on teaching placement programs and eventual involvement with the Teaching and Research Aged Services Program. The Professors established the Wicking Centre in 2008 and the Wicking Teaching Aged Care Facility Program in 2011.[145]

Professor Vickers told us that one of the reasons the Wicking Centre was established was because research and evidence indicated that there were significant deficits in knowledge regarding dementia care for family members, those who develop the condition, aged care workers and health professionals. To address this issue, the Wicking Centre developed 'Massive Online Open Courses' (short-term free online courses) centred on understanding dementia, as well as providing undergraduate courses and postgraduate courses.[146]

Professor Robinson outlined numerous research projects he was involved in from 2002 onwards involving student placements in aged care facilities. These projects were initially established in response to complaints regarding a lack of placements for nursing students.[147]

The first project entitled *Making Connections in Aged Care* involved a partnership with two providers. This was then extended through further funding from the Department of Health to six facilities in Tasmania in the *Building Connections in Aged Care* project. The Wicking Centre participated in further programs entitled *Modelling Connections in Aged Care,* which was Australia-wide. From these projects, the Wicking Centre developed an evidence based *Best Practice Model of Clinical Placements in Aged Care* in coordination with a number of investigators.[148]

Professor Robinson explained that following these projects the 'funding dried up' in aged care and the Wicking Centre moved to research projects in different areas. Upon moving back to working in aged care, the Centre found that there was no footprint left of the work completed in those research projects, outlined above, involving student placements.[149]

Professor Robinson said that this led to the design of the *Wicking Teaching Aged Care Facility* project, which involved a 'whole of organisation change'. He explained:

> So instead of just having…a student project which was about putting students [in placements] and developing groups of mentors to support them, we had a second stream which was about building organisational capability for leadership and to become a learning organisation.[150]

This program had a different focus, increasing the required student intake from four students to a placement of 80 students in a 140 bed facility. The placements were inter-professional with students expanded from nursing to include medicine and paramedicine. Initially this program ran with two facilities in Tasmania. In 2012, with the Teaching and Research Aged Care Services funding, the program was expanded to partner with additional aged care providers in Tasmania, one provider in Western Australia and two in Victoria.[151] Professor Robinson added:

> So our intent in that was to look at the applicability of the model across these different sorts of environments, and…we have an evidence base that primarily relates to the impacts for residents, students and staff.[152]

Professor Robinson stated that the Wicking Centre has had 17 papers published internationally, illustrating evidence of how the 'project was organised and configured to make it successful' and 'the impacts for residents, students and staff'.[153]

Outcomes and learnings from Teaching Aged Care Services

Benefits for quality of care

We heard evidence on the beneficial impacts that teaching aged care facilities has had on the quality of care provided to older people. Ms Loffler stated that Helping Hand considers not only meeting the university's needs through the student placements, but also ensures the placements result in a benefit for the residents.[154] Using the example of its partnerships providing placements for speech pathology students Ms Loffler explained:

> We see that around 50 per cent of our residents have a dementia-related illness and we know that with dementia illness, people are losing their words. And so…communication seemed to be a gap that perhaps we could be doing more for our residents and so the idea of thinking about a student placement that could offer us perhaps some additional low risk communication services for…our residents, but also that the need to learn about communication techniques for a speech pathologist is also a need that they have. So it was about matching the need we have with the students that we possibly could partner with.[155]

Ms Loffler said that offering this placement allowed them to see the benefit of having an onsite speech pathologist. This led to a speech pathologist joining their allied health team, with Helping Hand seeing benefits both from a health perspective and as a business decision.[156]

Professor Robinson spoke of the beneficial impact of their large scale teaching programs on quality of care within the facilities. He said:

> When we first started and we said we're going to have 80 students come in, everybody without exception said 'Patient care or resident care will suffer, because we'll be spending all our time looking after the students'. When we produced the evidence that showed that, really, the students supported each other a lot, and...it worked—actually worked really well, and the facilities became alive, and the quality of life of residents in their eyes, and the eyes of their families improved.[157]

We heard evidence that once the flow-on benefits of student placements are apparent to senior management, this can lead to organisational change. Professor Robinson stated that:

> If something that is happening that is really good for residents and really good for staff, then the board will absolutely buy into that and they did what Helping Hand did.[158]

Professor Vickers said that the student placements had a positive effect on the facilities in a way that is similar to what occurs in teaching hospitals:

> One of the reasons that teaching hospitals are really great places is because they do have medical students, and medical students have this way of keeping the health professionals and the other doctors on their toes, because they don't necessarily want to be caught out on a particular clinical scenario by the medical student. So this is, sort of, a virtuous cycle, if you like, between students on placement and, really, the quality of care that's provided by the whole medical team.[159]

Improving students' attitudes towards aged care

We heard about the positive impact that placements can have on student attitudes to pursuing careers in aged care. Dr Barnett told us that health sciences students are often unlikely to consider a career working with older people due to the lack of funding and dedicated teaching programs in aged care services. She highlighted that although we are living with an ageing population, 'if you look at the structure of most health sciences courses, if indeed there is an aging component, a module, it's never compulsory'.[160]

Dr Barnett explained that often prior to commencing their placement, students will show a 'high level of fear of working with older people' due to a lack of familiarity. They may also have received 'negative messages from health sector professionals about working in the aged care sector' that can also impact their attitude.[161] However, Dr Barnett also told us that students who were surveyed as part of the Teaching and Research Aged Care Service Program evaluation experienced a change in attitudes towards the sector on a 'statistically significant level'.[162]

Ms Loffler told us that Helping Hand's student induction process highlights the complexities of aged care. Students often hold a belief that aged care is going to be 'too simple'. She said that she has seen a difference in students' attitude towards working in aged care upon completing placements at Helping Hand. She explained that 'what we have been able to do is turn quite a number, particularly in the allied health area, of those student placements into potential employees'.[163] Professor Robinson said that for the Wicking Centre's project, *Making Connections in Aged Care*, there was an increase

from 30% to 90% of students considering a career in aged after completion of their placement.[164]

Dr Barnett said that following the Teaching and Research Aged Care Service Program, the student surveys also illustrated 'a change in understanding of older people's needs and confidence in working with them'.[165] Professor Vickers stated that their program is an excellent learning experience for medical students providing them with an opportunity to have 'meaningful engagement' with residents. He told us that the students:

> got to be involved in assessing their needs, reviewing their medications, really, a much more… holistic approach to care…that you don't often see in teaching hospitals, because everybody's very busy.[166]

Dr Barnett spoke of the general importance of education about aged care services and the gap in most health sciences courses:

> if you look at the structure of most health sciences courses, if indeed there is an aging component, a module, it's never compulsory and yet we're living with an ageing population and whether or not our health science graduates end up working in aged care, they're going to be working with older people and they're going to be working with older people with complex and chronic health conditions and they need more than acute care preservice learning experience, I believe, to be able to work in that way when they graduate.[167]

Importance of leadership

Professor Robinson spoke of the importance of leadership capability to ensure the sustainability of a teaching program in residential aged care. He emphasised:

> You really have to have the board…the CEO [Chief Executive Officer] and all the senior leaders actively engaged in an arm of the project, because to support the large-scale inter-professional placements in that complex environment…the organisation will have to change…We changed the way staff were allocated. We changed all manner of organisational attributes in the organisation in order to enhance the placements, which, in turn enhanced the quality of life of residents, as our evidence demonstrates.[168]

Professor Robinson identified that by and large universities 'have no real meaningful engagement with the aged care sector' and such change requires a 'massive reallocation of resources and a massive reallocation of interest'. He said that 'acute care and aged care are like ships in the night' and 'the university is on a different ocean'.[169] He explained that in those circumstances you need an orchestrator who is able to delve into the detail and 'you need a lot of structures and processes to support yourself' to make the system work.[170]

Professor Robinson explained that the Wicking Centre was able to achieve its whole of organisation change through engaging with senior management. He said the Centre did not engage with providers unless it could engage with senior management and the board.[171] Professor Robinson spoke of the importance of facility leaders being able to make changes to accommodate student intakes:

> To have 20 students in a 140-bed nursing home on one day, people can't get into the tea room. They can't get into the office…These facilities aren't designed for that. If you look at a teaching hospital they are absolutely designed for that.[172]

Professor Vickers expressed his belief that as well as the importance of core leadership ability, the commitment to being a learning organisation is paramount, ensuring that all levels of the workforce are committed including administration staff, the board and management team.[173]

Importance of student support

Dr Barnett spoke of the importance of having a specified member of staff to fulfil the role of student coordinator in teaching programs in residential aged care:

> if you haven't got resources dedicated to someone designing a program of education, working with Vocational Education and Training providers and higher education providers to tailor that to their course learning goals, having added to that a commitment to people being trained in supervision and having some backfill, so that they've got time to support students, it's most unlikely it will happen.[174]

Dr Barnett stated that a course coordinator provides an important role in bridging between the aged care sector and the education sector, where there may be differences between budgets and goals.[175] Ms Loffler added that the role of student coordinator is more than being a student facilitator. She said that there is a lot more to that role to 'develop something that results in a win for both the placement and the resident'.[176]

Professor Robinson referred to the importance of sufficient planning of student placements:

> we would have meetings to plan the placements of students. That would be chaired by the Director of Care of the organisation, and all the universities would have to have their senior people come to attend those meetings, the coordinator. So this was a high level meeting to plan everything and how it was going to happen.[177]

Engagement with the vocational education and training sector

Ms Loffler said that Helping Hand has two streams of vocational education and student training programs. She described a partnership stream which operates similarly to the program involving tertiary students. An important consideration for Helping Hand when building relationships with Registered Training Organisations is whether their training strategies align with those of Helping Hand. Ms Loffler told us that Helping Hand has created partnerships with some key Registered Training Organisations where they have this synergy.[178]

Helping Hand has a vocational education and training student program which has been set up 'specifically to offer additional training in some of the areas we know that perhaps are not quite so well covered from RTOs [Registered Training Organisations]'.[179] Ms Loffler stated that at Helping Hand:

> we do feel a sense of also concern for many, many hundreds of students who approach other training organisations where perhaps that level of training isn't perhaps at an area where—that we think it should be and that it isn't necessarily meeting industry needs.[180]

This course involves an online application system in which students participating in a vocational education and training course apply and undergo a screening. During the screening, Helping Hand considers whether their values and attitudes align with those of the organisation. Ms Loffler said that if so, they then 'offer some gap training in that space and we believe it's worthwhile to do that'.[181] She added that this provides benefit to Helping Hand as it may lead to potential recruitment.

Professor Robinson said that the Wicking Centre does not currently engage with Registered Training Organisations for their programs as there was limited funding.[182]

Recommendations for a future model

The witnesses on both panels were asked to consider any changes that they would recommend if the Teaching and Research Aged Care Services Program was to be reinstated. Dr Barnett said that the program should involve vocational education and training providers as well as tertiary education providers. Second, the program should be extended to include home and community care. Third, the program should consider building partnerships with health care, particularly acute care.[183]

Dr Barnett said that, most importantly, a new model should replicate the 'hub and spokes' model used in Norway. She explained that this model involves a dedicated number of teaching facilities being funded on a regional basis. These teaching facilities act as the 'hub' and are funded to support other aged care providers in the region who are the 'spokes'. She said that the hub facilities 'provide mentoring and are the centre for best practice in teaching' through partnerships with research providers.[184]

Dr Barnett suggested this model would allow an opportunity to fund specialist centres to address needs for certain cohorts, such as culturally and linguistically diverse, dementia-specific or rural and remote.[185] Professor Robinson was in favour of a hub and spokes model with hub facilities strategically located and partnered with a university.[186] Professor Vickers outlined how a hub and spokes program could be funded and designed based on the Commonwealth Rural Health Multidisciplinary Training Program:

> that was developed in response to the need to do, really, two things. One is to improve everybody's knowledge of how to provide high quality health care in rural environments, but also to bring along and develop those rural sites as excellent sources of clinical placements. And to bring in students from those regions into those health care courses…
>
> So the parallels with the teaching aged care facility concept…are pretty good. So that would be my recommendation into the future, is the Commonwealth could look at funding teaching aged care facilities along the same way they already fund and accredit and evaluate that kind of model.[187]

Ms Corlis stated that co-design is required not only with older people but also with service providers. She said that 'we can actually design things that make it very attractive for students to come in and be part of what we do. So I think that that's really, really important'.[188]

Dr Barnett recommended a future program should only be available to established partnerships:

> If I was to redesign the program as a funder, I would say that it had to have a partnership that had been established for at least a year. And you can prove that by having worked together on, say, NHMRC [National Health and Medical Research Council] research funding or that you have an MOU [memorandum of understanding] regarding your research and education.[189]

Professor Robinson agreed with Dr Barnett that organisations with existing partnerships were the most successful in relation to teaching initiatives, as it takes a lot of preparatory work and negotiation to be able to make arrangements for teaching facilities.[190]

Professor Robinson said that engagement with universities at a senior level is required as 'universities by and large are relatively unfamiliar with aged care'.[191] He added that similar to residential facilities, a successful program requires 'a massive change [for universities] and a massive reallocation of resources and a massive reallocation of interest'.[192]

Professor Vickers told us that the commitment to being a 'learning organisation has to be paramount' for teaching aged care facilities, with the same involvement in lifelong learning and promotion of professional development as in teaching hospitals, including postgraduate degrees, continuing professional development and involvement in research.[193]

He said that he would be aiming for a model of teaching aged care facilities similar to teaching hospitals with a focus on provision of quality care and having staff involved in teaching students to help 'promote a virtuous cycle between providing an education, but also…having that feedback from the students and their meaningful engagement providing some part of the care of that older person'.[194]

Professor Vickers said that the accreditation process undertaken by the Australian Commission for Safety and Quality in Healthcare for teaching hospitals could be appropriately adapted for aged care. He suggested that this process could be overseen by a relevant statutory body or potentially built into the accreditation standards.[195]

Dr Barnett proposed that for a facility to be a teaching centre for allied health students, allied health workers should be members of the facility's core workforce. She explained that there is benefit to an inter-professional learning model 'to teach students about a holistic approach to the care of older people' moving away from a 'workforce model that has brought allied health in more as sessional members of the workforce'.[196]

Required funding for future model

Dr Barnett considered that any funding for a Teaching and Research Aged Care Services Program should be considered 'more of an investment than a cost'. She explained:

> it's more like seed funding. People, if they're committed and most people are and they want to work on this model, provide huge in-kind support if they haven't got money but often add in financial and other resources. So it's a model that is not going to be a bottomless pit of financial need. It's one that will generate and it will generate a lot of learning and if we are talking about

> redesigning [a] quality aged care system I believe particularly education of our current and future workforce has to be central. And so I would also want to see it funding existing workforces as well as preservice workforce education.[197]

Professor Vickers said that the program would need to be substantially funded, requiring greater funding than a usual university budget.[198]

Professor Robinson spoke of the importance of recurring funding similar to the model in Norway:

> the funding is a real issue, and it needs to be recurrent and then you need it to be able to have these specific people employed, but then you need the capacity to also pull staff out of their day-to-day care to engage in professional development and to have ongoing activities where they're looking at how students are going and how they're best supported, etcetera. Yes. So it's a very different—and a teaching hospital will account for that. You look at that infrastructure at a teaching hospital, there are so many people employed, you know, to facilitate research, to facilitate teaching, all of that sort of stuff.[199]

Dr Barnett highlighted ageism as causing 'prevalent issues in our community' and questioned the disparity between funding for teaching hospitals and teaching aged care facilities. She said:

> Why is it perfectly acceptable to have a network of teaching hospitals but for the aged care sector it's a bit of a luxury and a bit of an add-on. Why isn't it a central part of an evidence-based quality system of care.[200]

Dr Barnett said that the lack of funding is 'a pity because there's huge scope…if we want to break down silos between health and aged care'.[201]

Professor Robinson suggested a process for developing the aged care sector using teaching facilities, commencing with improving dementia literacy:

> So dementia literacy is a core. The second element is dementia friendly communities. The third element is…developing the learning organisations which are the teaching aged care facilities, and our view was that once you've got them, you put in big lumps of students, which stress the organisation and they had change to cope with that and then exploit that, they became research ready, because you—they were always having access to the data… Then you get to the point where you can then go and investigate new models of care.[202]

However, he suggested that it was 'perverse' that currently 'all the funding' goes to the area of 'new models of care', saying:

> we fund first what should be funded last, and…hence the problem with sustainability of innovation.

Professor Vickers stated it is important that these multidisciplinary sites be prepared to 'undertake the task meaningfully', as there is a danger that if placements do not provide a good experience, more health professionals would develop negative views about working in aged care.[203] Professor Vickers added that this requires substantial additional funding outside the normal university budget.[204]

18.1.5 Panel Five: Translating aged care research into practice

The final panel in Adelaide Workshop 2 focused on translation of aged care research into practice. Five witnesses with expertise and experience in the aged care and health research sectors gave evidence:

- Dr Judy Lowthian, Head of Research, Bolton Clarke. Dr Lowthian has adjunct appointments at Monash University, the University of Queensland and Queensland University of Technology
- Professor Briony Dow, Director, National Ageing Research Institute
- Professor Alison Kitson, Vice-President and Executive Dean of the College of Nursing and Health Sciences, Flinders University and Foundational Director, Caring Futures Research Institute
- Ms Julianne Parkinson, Chief Executive Officer, Global Centre for Modern Ageing
- Professor Steven Wesselingh, Executive Director, South Australian Health and Medical Research Institute, and Chair, National Health and Medical Research Council.

Counsel Assisting asked them to consider propositions on the topic of translating research into practice.

Fundamental importance of co-design

The five witnesses in this panel were unanimous about the fundamental importance of co-design for the successful translation of research into practice. Ms Parkinson described co-design as bringing together 'the existing or the aspirational end users who would consume a product or service', which in the aged care context includes people receiving aged care, aged care workers, friends and family.[205] She told us that by involving the end user in the development of the product, it is more likely that the product will meet 'the end user's real needs and wants'.[206]

Professor Wesselingh observed that the importance of co-design in the development of research and technology is a relatively recent phenomenon, occurring over the last 10 years or so. In his view, co-design may be used not only in product development, but also in 'research that's being co-designed so that the questions are co-designed as well as the process to lead to answers to those questions'.[207] Professor Kitson agreed that co-design is a relatively recent phenomenon in the area of clinical trials and research. She explained that accepting co-design has required a change in thinking 'because it challenges the paradigm of what objectivity is' through allowing input from the people who use the services, including those with intellectual and physical disabilities. Her opinion was that if you are aiming to translate knowledge into practice, then 'involving stakeholders right at the beginning is the most important factor for success'.[208]

Professor Dow told us that co-design is one of the key principles by which the National Ageing Research Institute operates. She gave the example of a co-designed training program for home care workers on providing dementia care. In designing that program, the National Ageing Research Institute consulted with people living with dementia and their carers to determine what they wanted included in a training program. They consulted with home care workers to find out what they wanted to learn and how they wanted to learn, and with providers to find out what was practical from a provider perspective. She acknowledged that this may lead to a compromise, but in adopting a co-design approach, 'you end up with something that's practical and usable and is more likely to be taken up by the end users'.[209]

Need for industry collaboration

Dr Lowthian referred to the numerous providers and universities that are engaged in small projects across the country, and suggested that greater coordination of those projects and the development of national projects with partnerships across the sector would go a long way to improve things for the industry. She told us that Bolton Clarke's strategy for disseminating its research includes peer reviewed publications, academic and clinical conference presentations and symposiums, community talks, community presentations, industry talks and publications, and 'getting out there in the media'.[210]

Types of research required

Professor Dow explained that it is important to determine what older people want from aged care. She said that after conducting interviews and literature reviews, the National Ageing Research Institute concluded that older Australians take the clinical elements of care for granted as a 'basic expectation'. What they are looking for is relationship-oriented care, having choice and control over their own care and, most importantly, being enabled to have meaningful participation in the life of their community and their centre.[211] Dr Lowthian agreed with Professor Dow, saying that 'it's all about relationships, social connection and wanting to have meaning and purpose in…life right until the end'.[212]

Centre for Growth and Translational Research

The panel considered whether a dedicated centre for growth and translational research is required by reference to its possible functions: priority setting and coordination of research, and funding allocation and peer review.

Importance of clear funding priorities

As the Chair of the Research Committee of the National Health and Medical Research Council, Professor Wesselingh has oversight over the allocation of health and medical research funding. Senior Counsel Assisting asked Professor Wesselingh whether the National Health and Medical Research Council did enough to fund aged care research. Professor Wesselingh responded that in the last 10 years, the National Health and Medical Research Council has spent about $86 million on research into quality aged care, in contrast to $1.8 billion in neurological disease. He described the research into quality and safety of aged care as receiving 'relatively little funding' and attributed this to a lack of research capacity in the aged care sector—both in the number of researchers applying

for grants and the quality of the applications (compared with other medical research applications).[213] He gave an example of the Dementia Initiative, where specific funding was allocated to dementia research, so there was less competition and the National Health and Medical Research Council was able to engage in capacity building with the sector.[214]

Professor Wesselingh said 'you essentially get what you measure and get what you pay for'. He continued, 'so if you decide what you want and what you're going to measure, the research community will respond to that and deliver that'.[215] Professor Wesselingh told us that the National Health and Medical Research Council is a peak funding body for medical research, and the peak peer review body in the country. He said that the research that it funds has, until recently, been driven predominately by what ideas researchers present to it. For example, it awards funding based on the quality of applications received, not based on an overall priority framework. Professor Wesselingh suggested that what is needed was not a new funding body, or a new peer review body, but a more strategic view of aged care research. He said that if there was a strategically directed initiative into issues around ageing and aged care, the National Health and Medical Research Council would be able to adopt that and achieve high quality outcomes.[216]

Professor Dow agreed that there is a lack of capacity in the sector, which she attributes to a lack of investment associated with the 'value' attributed to older people and a general societal view that aged care is not 'particularly important' and so 'hasn't ever been a priority'. She said that the problem is circular: societal attitudes filter down, aged care research is not seen as a particularly attractive area by educators and researchers, and this is 'reinforced by a lack of funding'.[217]

Professor Dow explained that the traditional means of assessing the quality of medical research means that aged care research has an inherent disadvantage. She pointed to the National Health and Medical Research Council funding researchers with a track record based on their academic publications and their ability to attract research, and the scientific quality of the research design. Professor Dow explained that in contrast, 'co-design type work' which is outcomes focused, is 'not the type of research that lends itself to higher level academic publications'. She said that an unavoidable effect of adopting the co-design process with end users is that you do not have ultimate control over your research design. She also said that if you are researching for quality of care or quality of life outcomes, these are not capable of being flawlessly measured, as compared to blood pressure, for example, which is capable of objective measurement.[218]

Professor Dow added that there needs to be a coordinating point, where all of the research that is being done nationally is brought together in a body which has a 'priority setting role'. She also said that we need 'industry-driven priorities' and priorities that are driven by the end users. She explained that priorities need to be set by the end users, and then the role of researchers should be 'how to best carry out that research'.[219]

Dr Lowthian agreed that this body should have a role in priority setting and coordination, but she did not think that there is a need for a new funding body:

> but I just think that the priorities need to be set by this centre by those people who know what's needed, know who is needed to conduct the research and how it's needed to be conducted and then government can delegate the funds according to those priorities…[220]

She said she was unsure whether the National Health and Medical Research Council is best placed to administer the funding, sharing concerns with Professor Dow that while the peer review process is high quality, it was not necessarily effective for aged care research.[221]

Professor Kitson suggested that there first needs to be a fundamental change in thinking in relation to care for older people in terms of how older people and their care is valued and perceived. Her view was that aged care should not necessarily be separated from health care more generally, and that the concept that aged care is 'an entity in itself' is a social construction that is 'probably two generations out of date'.[222]

Sector coordination

Professor Dow saw the key role of a new research organisation as one of coordination, or bringing together all current research and setting priorities. If that centre was to be involved in allocating funding, then it should look into funding new innovation and models of care that would not otherwise be funded by organisations such as the National Health and Medical Research Council.[223]

Dr Lowthian agreed that any coordinating body needs to have at its centre the end users of the system, including older people, members of the community, families and informal carers. She said it should also be governed by a range of stakeholders, including 'clinicians, researchers, educators, government, consumer advocacy groups, community members and perhaps different funders like philanthropic or private donors'.[224]

Sensor technology in home care

Ms Denise Griggs, a Relationship Manager with home care provider ECH Inc., and Mr Damien Harker gave evidence together. At the time of the workshop, Mr Harker's father, Mr George Harker, lived at home by himself. Mr George Harker was then 89 years of age and was living with reasonably significant dementia since his diagnosis in 2016. Mr Damien Harker and his brother lived in Adelaide within 15 minutes' drive of their father's house.[225] Mr George Harker's Level 4 Home Care Package was provided through ECH. Mr Damien Harker told us that his father received personal care twice a day, including help with meals and medication, domestic assistance once a week, nursing visits twice a week, gardening services every three weeks, physiotherapy every fortnight and some podiatry visits.[226]

Ms Griggs explained that she worked with around 40 ECH clients and their families to 'provide services to meet their needs and goals, to remain living confidently at home and remain connected socially to their communities as well'.[227] Prior to her role as a Relationship Manager, Ms Griggs was an enrolled nurse at ECH. During this time, she provided care to Mr George Harker in his home.[228]

'Billy' application

Mr George Harker accessed the 'Billy app' through his Level 4 Home Care Package. Mr Damien Harker could use the Billy app on his phone to observe and follow how his father was going throughout the day. Mr Damien Harker explained that up to six sensors have been strategically placed throughout his father's house and the data from these sensors are sent to the Billy app. Sensors could be placed by the front door or the fridge door or areas that will lead into the bathroom. These sensors obtain data as a person walks past them. The sensors also record the temperature in that location. Mr Damien Harker said it is helpful, especially on hot Adelaide days, to know whether his father has the air-conditioning on or not.[229]

Mr Damien Harker said that:

> based on all these inputs, the Billy app has a number of routines that are set up on a per user basis and that can give you some feedback about what is generally going on in the house for Dad.[230]

Ms Griggs and Mr Damien Harker explained that the daily routines are developed in consultation with families to work out what they feel is the best use of the six sensors to allow families to have the information they need on the app about their loved ones.[231]

According to Ms Griggs, the Relationship Managers who oversee the operation of the Billy app can identify any activities outside of normal parameters and contact the family if there are any anomalies.[232] The sensor on the entry to Mr George Harker's bathroom has identified that he averages eight bathroom visits per night.[233] Ms Griggs explained:

> If that's a normal pattern for George, then that would be okay, but if he normally goes less than two, but he's averaging eight bathroom visits that night, then we would be having a discussion with the family regarding that and possibly looking at getting a urine sample from George and testing that…it could be very indicative of a urinary tract infection if someone is going to the bathroom eight times a night.[234]

Before the Billy app

Prior to having the Billy app, Mr Damien Harker had received telephone calls from police, ambulance or hospital to say that, 'We have your dad in with us and, you know, can you come and meet up and work through the issue'. Mr Damien Harker said that this was very unsettling and that he had concerns for his father's safety and wellbeing. Despite care workers from ECH seeing his father every day, Mr Damien Harker said that his lack of knowledge about his father during the time when no one was there was concerning.[235] He explained:

> we were just unaware of what things were going on, you know, as far as his eating habits, his going to the toilet, you know, having sleep, you know, what was his sort of general patterns, his routines around the house. We just had really no idea and because when we got there, unfortunately with his dementia he was really unable to communicate succinctly what was going on whether or not he actually had any issues during that period of time.[236]

Before the Billy app, Mr Damien Harker was concerned about his father wandering the streets and had considered moving him into residential aged care. However, he said that the Billy app gave him the confidence to have his father stay at home, knowing that he was not in any danger. Mr Damien Harker explained that the Billy app 'just provided so much assistance to us and peace of mind that, you know, we feel we can better manage dad's health care'.[237] Ms Griggs said that she has had similar positive feedback from her 10 clients who use the Billy app.[238]

Mr Damien Harker said that his father's dementia is reasonably significant, so his father is not 'expressly aware' that the Billy app system is in place.[239] Ms Griggs said that privacy was a concern for a couple of clients, finding those who still have reasonable cognition feel that the Billy app is an invasion of their privacy. Ms Griggs added that 'while the system works well for some people, for others they just, they don't like their privacy invaded'.[240]

During the first panel, Ms Daniella Greenwood, aged care consultant, explained that residents may not want people to know their 'private stuff'. Despite this, technology is used to 'keep everyone up to date', even though the older person may not want this information discussed with others.[241] Ms Greenwood said that for managing people at the intersection of technology and aged care, there needs to be 'clear principles drawn from rights-based instruments…We can't just give up on them [people with dementia] and say they've fallen through the cracks, because they can't consent. We have got to do better and we can'.[242]

Staying socially connected via technology

As noted, Ms Barbara Hamilton Ramsay had a Level 3 Home Care Package, delivered by Feros Care. Ms Hamilton Ramsay gave evidence via audio visual link from her home in Robina, Gold Coast, Queensland. Ms Hamilton Ramsay has a carer who helps with housework twice a week for three hours at a time and also helps with her shopping.[243]

Through Feros Care, Ms Hamilton Ramsay also accesses the 'Virtual Social Centre'. In her words, the Virtual Social Centre is the gathering of seniors 'for areas in instruction, physical movement, some challenges, which are good to keep us mentally well…with a tablet and…a presenter for the various sessions'.[244] Ms Hamilton Ramsay listed a number of different sessions that are available through the Virtual Social Centre, such as art, including dot painting; Chair Chi, a program teaching Tai Chi exercises from a seated position; evening meditation; book club; French for beginners; and healthy cooking. She also described sessions where the presenters virtually took her to a destination. For example, a couple living at Lightning Ridge went for a swim in the mineral pool and told the viewers about the opal mining there. There was also a session where the presenter visited a farm near Dorrigo and showed the viewers the goats and chickens.[245]

Ms Hamilton Ramsay said that:

> Feros have done everything that needs to be done…when we did dot painting, even provided us with the stones to dot paint on and some paint. When I've done exercise in the past and Tai Chi, they've provided the bands to do the stretching. So they've been amazing.[246]

Feros Care also provided training to help Ms Hamilton Ramsay become comfortable using the Virtual Social Centre.[247]

Ms Hamilton Ramsay said that when you book into a session, you get a text message reminder. She said that Feros Care are 'great. They realise we forget things'.[248] There is also a 'catch-up' feature of the Virtual Social Centre. She explained that if she cannot attend the session, then she can watch it at her leisure with catch-up.[249]

Ms Hamilton Ramsay said that she loves the Virtual Social Centre, saying 'a lot of oldies in inverted commas, could benefit from this'.[250] She explained that she has suffered quite acutely from depression.[251] She said that the Virtual Social Centre:

> (a) sometimes it gives me a reason to get out of bed; (b) if you are lonely…It's lovely to have someone call you by your name in the morning
>
> …
>
> I find that very cheerful and that helps me a lot because my days are a lot better if I start them off in a cheerful way.'[252]

She said that 'it's company, if you're by yourself'.[253]

Ms Hamilton Ramsay thought it was 'pretty special' to be connected to a person in Western Australia and that she has met new people through the Virtual Social Centre. She can chat face-to-face on the forum with other attendees if she wishes to.[254] Ms Hamilton Ramsay told Senior Counsel Assisting:

> Yes, it's great. You see each other. You see your lips moving. You know, just like you're seeing me. We do that. As though we're sitting in the lounge room together, but we're not.[255]

Ms Hamilton Ramsay explained that she was not very good with technology before the Virtual Social Centre but has found that the Virtual Social Centre has helped with this:

> Help is just a call away. We've got a place on the screen where we can get help whenever we want it and there's somebody there who can, if we've got a hiccup, they can iron it out for us.[256]

Ms Hamilton Ramsay is also involved in Feros Care's 'Let's Get Technical' program. She said that the program is a forum where she can learn things, which interests her a lot:

> I want to stay abreast of what's going on, within what I can do…within my possible experience. That's what's of interest to me.[257]

Ms Hamilton Ramsay described how in the past she would travel to Robina Town Centre to go to the bank. She would have to queue, which she said 'with my legs isn't that much fun. The bank was upstairs in those days, and wait, you know, it was a special trip and everything.' She said that she is very grateful for understanding how to do other things on the internet, like internet banking, and that her access to technology with Feros Care has helped her enormously with this.[258]

Ms Hamilton Ramsay explained that being able to manage her affairs electronically makes her feel competent and helps her mental state:

> It makes me feel a bit competent…because that's something else you lose with old age. You feel inadequate quite a bit, and that I haven't got to ask my children. I haven't got to ask for help, because I know what to do now. Feros has helped me a lot in that way. …Helps my mental state quite a bit. …it is good to—when you're old to have your intellectual side, you know, kept alert. I really like that. And the physical side I need, so I'm very grateful for that.[259]

Ms Hamilton Ramsay said she had not 'spent a penny' for the cost of accessing the Virtual Social Centre.[260] Following the workshop, Ms Buckley clarified that Feros Care obtained a Dementia and Aged Care Services Innovation Fund grant in 2017 for a mobilisation unit. Feros Care invited Ms Hamilton Ramsay to join the pilot of the Virtual Social Centre. Feros Care has since started transitioning participants in the Virtual Social Centre pilot over to Home Care Package and Commonwealth Home Support Programme funding, in line with the funding guidelines of those programs.[261]

18.1.6 Schlegel Villages, Ontario, Canada

Dr Veronique Boscart, gerontological nurse, Clinical Chair of Nursing, Research Institute for Ageing, Executive Lead for the School of Health and Life Sciences at Conestoga College and President, Canadian Association on Gerontology, appeared via audio visual link from Ontario, Canada, to give evidence about the Schlegel Villages.[262] The Schlegel Villages is an organisation that provides 'nursing home care or long-term care, but in a continuum of care, so they also provide assisted living and retirement living'.[263]

The Research Institute for Ageing

The Research Institute for Ageing is a not-for-profit organisation that is funded through the Schlegel family. The Schlegel Centre's Research Institute for Ageing has three main objectives:

- to develop innovative research, approaches and education across the sector for aged care
- to carry out advanced knowledge dissemination about learnings into the workforce through collaboration with the villages
- to accelerate these findings by influencing and supporting policy decision-making.[264]

In the third capacity, Dr Boscart explained that the Schlegel Centre is 'lobbying for nurse practitioners to be part of long-term care [residential aged care] and to cause staffing changes in nursing homes, which are much needed'.[265]

Dr Boscart said that about three years ago, the villages indicated that they had a very high transfer rate of residents to hospital, often happening on the weekend and at night. Dr Boscart and Dr George Heckman, a geriatrician and cardiologist, found that most of these residents had heart failure. The residents would have a few minor instances before a sudden cardiac event. Dr Boscart and Dr Heckman provided a teaching session and

clinical assessments with the neighbourhood nursing aides (personal care workers). Dr Boscart reported that she found very quickly that the nursing aides had a good understanding of what was happening, but did not have the right documentation systems to indicate an impending problem. Dr Boscart developed an intervention protocol as a quality improvement project. Last year, the nursing aides presented this at the Canadian Cardiological Conference.[266] Dr Boscart said:

> nothing can drive engagement and being very proud of what you can do for a nursing aide than actually standing in front of a whole auditorium of cardiologists saying, 'This is absolutely amazing'.[267]

Dr Boscart gave this as an example of a research project which turned into a quality improvement project.

Continuums of care / villages

Dr Boscart told us that there are 23 different 'continuums of care', also called villages, at Conestoga College. There are about 7000 employees taking care of about 9000 residents across the continuum. The 'neighbourhood model' is comprised of units, each with 32 residents. There is a dedicated, cross-functional team that provides care to those 32 'neighbours'. These teams remain consistent with those neighbourhoods, but at times a little bit of extra support is necessary, if for example, the complexity of the neighbourhood increases or decreases.[268] Dr Boscart explained

> And depending on the level of functionality of that neighbourhood team, those teams will do anything all the way up to staffing, planning and budgeting and providing care. And so they are very much involved in the quality of the care delivery and in protecting that quality from a quality indicator perspective. We set the goals once a year of what quality indicators they want to achieve and then, as a support office, we help them achieve that.[269]

Dr Boscart explained that these neighbourhoods are built to mimic a village, with a café, library, restaurant, and some also having a movie theatre.[270] Some of the older neighbourhoods are more traditional, with long hallways and rooms. Separate living areas are created where people can watch television or play the piano by themselves. Dedicated dining areas with an open pantry mean that residents can smell the food or can participate in the cooking where possible. If a village is on the main floor, there are gardens where residents can grow their own vegetables, or walk without getting lost.[271]

The best fit

Dr Boscart explained that the waiting lists for nursing homes in Canada are not managed by the homes themselves. As soon as a bed becomes available, the local health integration network selects who on the waiting list is in need of a bed. The Schlegel Centre has high occupancy rates in its villages. When a bed becomes available, it takes somewhere between 12 and 16 hours before it has filled up again. Dr Boscart said that although they like to group people from certain cultures or different cultural backgrounds together in the same neighbourhood, at times this can be difficult.[272]

Dr Boscart said that people with some cognitive impairment or Alzheimer's disease are integrated in the regular neighbourhoods. But at times when that is difficult, the Schlegel Centre has a 'memory care neighbourhood' where there is a higher complexity and higher staffing. This all depends on what is the best fit.[273]

Recruitment and selection of staff

Interview panels are inclusive of residents' families, volunteers and 'anyone who will be in contact with that person…all have an equal say in deciding if that person will become part of the team'.[274]

Dr Boscart described this as 'speed-dating', where the applicants go around to all of the different people in the neighbourhoods and they have four to five minutes per person. Dr Boscart outlined the specific talents that the teams look for in the first interview:

- Are people interested in being meaningfully engaged on a team?
- Do people understand that their role is not task-focused?
- Do they understand and value the preferences of the residents and do they support autonomy for the residents?[275]

Once the applicants leave the room, the team sits together and discusses what they thought about each applicant and decide if that person will be invited back for a second interview. Dr Boscart said that the second interview might be more skills-focused or competency-focused.[276]

Dr Boscart explained that most people graduate with a certain level of skill competency, but if people do not have the right engagement or investment in being part of the Schlegel Village team, then they will not be deemed a good fit.[277]

Using the skills and competencies of the workforce

Although nursing assistants complete similar training, Dr Boscart said that each nursing assistant comes with a different set of competencies and talents. For example, some nursing assistants are great at organising events, while others have the utmost patience when providing a bath to a resident who really does not want to take a bath. These talents can have a great impact if they are utilised to their full potential within a team environment.[278] Dr Boscart said:

> If you give everybody the same job, no matter what, every day for a number of residents that they might or might not click with, that is not always—that doesn't always come across as a meaningful contribution, and so in every job there is components that you'll like and that you like a little less, I understand that, and I'm exactly the same, but if you can really build on how a nursing aide [personal care worker] can contribute to a team, as opposed to, 'You have to give four showers today or eight showers today', you shift that idea off, 'We count on you as a valuable team member', and all too often that nursing aide level has been left behind.[279]

Dr Boscart went on to explain how the teams at Schlegel Villages are cross-functional. She said that it does not matter if they are a Director of Care, a nursing assistant or a volunteer, they will work together:

> cross-functional means that we all have a core set of things that need to get done at the end of the day, but we are not afraid to overlap in each other's roles, and so as a result when I'm in a neighbourhood, it doesn't matter if I'm an executive dean or a researcher, if there is a spill on the floor I know where the mop is to clean that up, and I will do so…[280]

Living classroom

The 'living classroom' initiative is the product of a collaboration between Schlegel Villages, Conestoga College and the Research Institute for Ageing to address 'a variety of problems we had identified'. Dr Boscart explained that it is very hard to attract people who want to become nursing aides. She said that there was a stigma associated with long-term care in Canada and people were 'not interested in that any more'. She explained that because of this stigma, there was a mismatch between what they wanted to see in the workforce at Schlegel Village and the people they were attracting.[281]

To address this, Schlegel Village wanted to provide an education environment where there is an immediate relevance and application to the work—so the 'living classrooms' within the nursing homes were established. The students are notified when applying that they are not coming to a regular college campus, they are 'going to go to school in somebody's home'.[282] Dr Boscart explained:

> So we then have an integrated model of teaching in which faculty is teaching, team members from the village are invited to share some of their experiences and residents come in and out and participate in some of those learning experiences which, of course, for the students is a wonderful opportunity to really know why it's so important to understand what's written in that book, and then as soon as students have those concepts and principles understood, they then go and participate in the village.[283]

The students begin by observing what is happening in a neighbourhood, and by the end of the semester, the students are participating in actual care. She continued:

> By the time they graduate they have sat in on very difficult family conversations often, and have maybe participated or witnessed resident's passing. So it's a very integrated learning model.[284]

Dr Boscart said that over one thousand students have graduated from the living classroom. She said:

> we truly believe that they are the leaders for the workforce in the future, because they do come with a bit of a different concept about cross-functional teams and integrated learning and what is needed in these environments.[285]

Dr Boscart reiterated that while all of the graduates need to have a certain competency, she also finds that the living classroom graduates are a lot more comfortable with people who have dementia or an underlying symptom, and are also a lot more at ease when there is a conflict between team members or a family member. She finds they know how to prioritise and are better prepared to 'step into that field'.[286]

Dr Boscart acknowledged that, having worked as a nursing assistant herself, the work circumstances are not always ideal. Often she would have to work two jobs to meet the needs of her family. Dr Boscart said that pay is a difficult thing to change, but:

> if one can offer a meaningful job, that will make the difference, and so we try to, for our nursing assistants [personal care workers], not talk about a job, but we're talking about a career. So we are preparing somebody for a career in our organisation, and that means that there might be different components in which a person will grow.[287]

Staff at Schlegel Village can take a leadership course or they can participate in training of students or different components. In some organisations, we heard that nursing assistants, or personal care workers, have progressed all the way to becoming the general manager or assistant director of care.[288]

Staffing levels

Senior Counsel Assisting asked Dr Boscart about staffing levels. Dr Boscart replied there are expected minimum contact hours between residents and nursing assistants. The contact time expected is calculated across the resident group based on the complexity of residents, rather than on an individual basis. She explained that it is calculated on the interRAI data that is collected for a cohort of residents, so it is always a quarter behind. In general, Dr Boscart said that there is 'a certain number of complexity that requires a certain number of caregiver time'. The Schlegel Village works with their case indexes based on the interRAI data to calculate that. Dr Boscart said that this is mandated across Canada and there are certain minimums based on the complexity of residents.[289]

However, Dr Boscart added that this is flexible and work can be staggered to meet the preferences of the residents, giving the example of a resident she cared for who had been a farmer. She was able to shift her hours by starting her shift a little earlier, 'to make sure all of the care for that gentleman is done' and that he is ready for breakfast at 6.30am, 'because that's how things work for him'.[290] She told us:

> He has severe Alzheimer's disease, so he might not be able to express that, but if he would have to stay in his room until 6 o'clock, that would not work well for him. So by shifting the jobs, so to say, to what the resident's preferences and needs are, you see a whole mix and match of how personal care workers, kind of, bring all of that together, and as a result there is a lot more happening and a lot more collaborative practice on that neighbourhood.[291]

We heard that Schlegel Villages generally have 192 residents. So for a neighbourhood of 32 residents, there would probably be between four and five personal care aides on any given day shift, the same for night shift, and fewer during the evening. Dr Boscart said that 'the staffing is not very luxurious', and that 'As a registered nurse, I would be by myself and there would be two registered practical nurses for that group'. She explained that they do not have any more government funding than other nursing homes in Canada, nor do they pay their staff better. Dr Boscart said that 'the answer is investment in staff'.[292] She continued:

> if you invest in a team, which is a costly investment from an organisational perspective, this leads to better care, therefore it does lead to better care outcomes. And so very often when we want to have better care outcomes in relation to quality of the care and safety, we focus on the very specific care practice that needs to change. If you would look at falls, for example. But if you don't have a staff team that is going to exemplify that practice, you will not get to better care outcomes because change in care is not going to happen by one specific group. It needs to be a team approach.[293]

Dr Boscart said that consistency helps:

> It helps that we have dedicated or consistent assignments. So we have the same people on the neighbourhood every day that stay with the same group of residents overall. So everybody knows everyone well.[294]

Home care

Dr Boscart told us about home care scenarios that have been created within the college environment 'because it's very challenging for care provider students to go into somebody's home and learn all the tricks of the trade'. She explained that they work with older people within the community, who then become the 'actors' when they 'roll out these scenarios' and have the students go through them in a safe environment where they can make a mistake and then the faculty and the older person can give feedback.[295]

Dr Boscart said they have built apartments where a student is provided with a scenario:

> the student has to go to the front door and…the students get a care plan and they have to provide the care and then depending on the confidence level of the students, the actor comes with different challenges.[296]

Dr Boscart said this is very useful for bringing the reality into the students' perspective of thinking and encouraging problem solving. In home care environments, workers 'don't really have anybody else with them and they just have to figure it out on the spot and some of these situations are challenging'.[297]

Dr Boscart explained that there are different skill sets required to work in home care settings compared to residential aged care settings. Home care workers do not have the availability of other resources around them at all times. They need to be able to observe the situation and understand when they need to hand it off to somebody else. Dr Boscart said 'that decision-making and priority setting needs to be pretty sharp for somebody who is in a home care environment'.[298] She confirmed that establishing a 'living classroom' for the home care environment is 'on the to-do list'.[299]

Endnotes

1 Royal Commission into Aged Care Quality and Safety, *Adelaide Workshop 2 Propositions,* 2020.
2 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7936.9–11.
3 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7936.18–19.
4 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7938.23–34.
5 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7939.3–4.
6 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7955.6–11.
7 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7955.30–38.
8 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7959.19–22.
9 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7959.28–47.
10 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7936.24–30.
11 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7937.44–45; T7938.13–15; T7949.20–40.
12 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7937.45–7938.18.
13 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7943.25–33.
14 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7957.36–43.
15 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7958.7–15.
16 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7956.1–18; T7958.24–34.
17 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7956.4–7.
18 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7958.18–20.
19 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7958.41–46.
20 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7949.41–7950.2.
21 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7951.18–22; T7951.33–40.
22 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7938.4–6.
23 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7948.18–23.
24 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7944.6–12.
25 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7953.5–6.
26 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7943.35–42.
27 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7952.38–46.
28 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7948.43–46. See K Kark et al., *Technology budgets: From value preservation to value creation*, 2017, https://www2.deloitte.com/us/en/insights/focus/cio-insider-business-insights/technology-investments-value-creation.html, viewed 11 June 2020.
29 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7948.46–7949.4.
30 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7936.36–44; T7939.31–45; T7941.37–39.
31 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7940.6–17.
32 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7950.23–26.
33 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7940.24–31.
34 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7940.40–47; T7941.5–8.
35 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7941.21–26.
36 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7942.30–31.
37 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7942.32–40.
38 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7942.44–7943.5; T7943.13–17.
39 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7953.41–7954.11.
40 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7954.28.
41 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7953.39–41; T7954.19–24.
42 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7948.26–31.
43 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7942.22–28.
44 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7946.2–10.
45 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7946.17–19.
46 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7947.31–32.
47 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7950.11–14.
48 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7960.32–39.
49 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7960.43–7961.2.
50 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7961.6–10.
51 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7950.32–37.
52 Transcript, Adelaide Workshop 2, Sue Gordon, 16 March 2020 at T7960.32–39.
53 Transcript, Adelaide Workshop 2, Tanya Petrovich, 16 March 2020 at T7952.15–18.
54 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7952.28–32.
55 Transcript, Adelaide Workshop 2, Jennene Buckley, 16 March 2020 at T7952.33–36.
56 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7961.14–33.
57 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7976.45–47.
58 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7976.47–7977.6.
59 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7977.7–28.
60 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7978.1–17

61 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7977.7–8.
62 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 3, AWF.001.01773.01 at 0001 referring to: R Visvanathan et al., 'Prolonged Wait Time Prior to Entry to Home Care Packages Increases the Risk of Mortality and Transition to Permanent Residential Aged Care Services: Findings from the Registry of Older South Australians (ROSA)', *Journal of Nutrition Health and Aging*, 2019, Vol 23, 3, pp 217–280; SL Harrison et al., 'Trends in prevalence of dementia for people accessing aged care services in Australia', *Journals of Gerontology Series A: Biological Sciences and Medical Sciences,* 2020; Vol 75, 2, pp 318–325; M Inacio et al., 'Pain in older Australians Seeking Aged Care Services: Findings from the Registry of Older South Australians (ROSA)', *Journal of the American Medical Directors Association*, 2020, Vol 21, 1, pp 132–133; Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 4, RCD.9999.0298.0024; Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 5, RCD.9999.0298.0006.
63 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7990.9–28.
64 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7978.43–7979.5.
65 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7979.12–16
66 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7979.16–21.
67 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7990.42–1991.4; T7993.23–31.
68 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7991.18–26.
69 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7992.6–17.
70 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7992.29–7993.2.
71 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7979.28–46.
72 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7985.25–29.
73 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at 7991.30–39.
74 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7981.1–7.
75 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7981.19–27.
76 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7981.29–34. See, for example, Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7966.40–44.
77 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7980.7–14
78 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7978.5–12; T7980.14–29.
79 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7977.43–45; T7982.36–43.
80 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7978.17–19.
81 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7978.29–33.
82 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7978.33–38.
83 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7980.29–39.
84 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7981.9–15.
85 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7982.25–28.
86 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7986.41–45.
87 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T8002.43–47.
88 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7997.36–39.
89 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7988.33–39.
90 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7987.45–47.
91 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7988.13–29.
92 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7987.26–35.
93 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7999.32–35.
94 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7990.6–9.
95 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7979.37–39.
96 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7988.39–7989.5.
97 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7996.17–22.
98 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7998.7–9.
99 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7996.29–34.
100 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7990.9–13; Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7989.32–33; T7994.8–12.
101 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7989.44–45.
102 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7989.30–40.
103 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7995.5–7.
104 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7995.7–11.
105 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7995.16–24.
106 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7989.17–24.
107 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7995.33–42.
108 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7996.2–5.
109 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7997.35–11.
110 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7997.19–25.
111 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7982.45–7983.2.
112 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7983.26–30.
113 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7985.11–20.
114 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7988.1–9.
115 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7983.30–34.
116 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7985.41–7986.11.

117 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7984.35–43.
118 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7984.35–7985.8.
119 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7983.41–7984.20.
120 Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7998.31–37.
121 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7996.6–11.
122 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7989.30–32.
123 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7990.4–6.
124 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7994.8–44.
125 Transcript, Adelaide Workshop 2, Benjamin Lancken, 16 March 2020 at T7989.10–17.
126 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7999.43–44.
127 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7999.45–47.
128 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T8000.5–15.
129 Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T8001.9–18.
130 Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T8001.20–27.
131 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0034.
132 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0034.
133 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0034–0035.
134 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0035.
135 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0036.
136 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0012.
137 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0012–0013.
138 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0012.
139 Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0041.
140 Transcript, Adelaide Workshop 2, Megan Corlis, 17 March 2020 at T8030.39–8031.7.
141 Transcript, Adelaide Workshop 2, Megan Corlis, 17 March 2020 at T8031.9–12.
142 Transcript, Adelaide Workshop 2, Megan Corlis, 17 March 2020 at T8031.19–24
143 Transcript, Adelaide Workshop 2, Megan Corlis, 17 March 2020 at T8031.40–8032.7.
144 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8032.41–8033.4.
145 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8046.9–12.
146 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8047.13–32; T8048.1–7.
147 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8046.5–12.
148 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8048.41–8049.22.
149 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8048.41–8049.26.
150 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8049.26–33.
151 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8049.35–8050.2;
Exhibit 16-1, Adelaide Workshop 2, General Tender Bundle, tab 2, RCD.9999.0296.0001 at 0045.
152 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8050.2–4.
153 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8050.4–8.
154 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8032.19–22.
155 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8032.19–39.
156 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8033.22–27.
157 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8055.19–27.
158 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8055.36–38.
159 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8051.37–44.
160 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8035.38–40.
161 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8029.45–8030.6.
162 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8030.19–26.
163 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8033.46–8034.10
164 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8048.41–47.
165 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8035.25–45.
166 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8051.30–32.
167 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8035.39–45.
168 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8050.30–41.
169 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8057.44–8058.13.
170 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8054.11–33.
171 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8050.43–8051.2.
172 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8053.45–8054.7.
173 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8052.15–25.
174 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8036.19–23.
175 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8036.28–37.
176 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8037.1–7.
177 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8058.29–33.
178 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8037.21–30.
179 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8037.45–47.

180 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8037.32–35.
181 Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8037.32–43
182 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8058.21–26
183 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8039.4–13.
184 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8040.11–17.
185 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8040.19–26.
186 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8057.25–42.
187 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8059.7–27.
188 Transcript, Adelaide Workshop 2, Megan Corlis, 17 March 2020 at T8042.2–5.
189 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8039.32–35.
190 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8053.21–43.
191 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8054.11–28.
192 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8058.1–4.
193 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8052.15–36.
194 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8051.39–8052.5.
195 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8060.11–24.
196 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8040.2–8.
197 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8040.44–8041.5.
198 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8059.38–47.
199 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8063.14–21.
200 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8036.1–7.
201 Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8029.18–38.
202 Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8057.1–8.
203 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8059.30–36.
204 Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8059.46–47.
205 Transcript, Adelaide Workshop 2, Julianne Parkinson, 17 March 2020 at T8068.22–24; T8069.1–4.
206 Transcript, Adelaide Workshop 2, Julianne Parkinson, 17 March 2020 at T8068.38–40.
207 Transcript, Adelaide Workshop 2, Steven Wesselingh, 17 March 2020 at T8071.13–18.
208 Transcript, Adelaide Workshop 2, Alison Kitson, 17 March 2020 at T8071.29–38.
209 Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8072.1–33.
210 Transcript, Adelaide Workshop 2, Judy Lowthian, 17 March 2020 at T8074.9–15; T8074.32–44.
211 Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8085.42–8086.1.
212 Transcript, Adelaide Workshop 2, Judy Lowthian, 17 March 2020 at T8086.28–30.
213 Transcript, Adelaide Workshop 2, Steven Wesselingh, 17 March 2020 at T8077.16–22; T8078.33–43.
214 Transcript, Adelaide Workshop 2, Steven Wesselingh, 17 March 2020 at T8077.4–14.
215 Transcript, Adelaide Workshop 2, Steven Wesselingh, 17 March 2020 at T8085.8–15.
216 Transcript, Adelaide Workshop 2, Steven Wesselingh, 17 March 2020 at T8076.43–8077.26.
217 Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8079.39–8080.3.
218 Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8080.4–27.
219 Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8080.35–45; T8081.5–10.
220 Transcript, Adelaide Workshop 2, Judy Lowthian, 17 March 2020 at T8083.24–27.
221 Transcript, Adelaide Workshop 2, Judy Lowthian, 17 March 2020 at T8083.27–30.
222 Transcript, Adelaide Workshop 2, Alison Kitson, 17 March 2020 at T8075.22–26; T8076.1–9.
223 Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8080.40–44.
224 Transcript, Adelaide Workshop 2, Judy Lowthian, 17 March 2020 at T8083.11–18.
225 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7923.20–43; T7924.1–2; T7931.45–46.
226 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7924.7–8, T7924.31–37.
227 Transcript, Adelaide Workshop 2, Denise Griggs, 16 March 2020 at T7924.39–7925.7.
228 Transcript, Adelaide Workshop 2, Denise Griggs, 16 March 2020 at T7925.39–43.
229 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7927.19–47; T7929.19–22; Transcript, Adelaide Workshop 2, Denise Griggs, 16 March 2020 at T7932.35.
230 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7927.33–36.
231 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7928.6–12; T7932.35–37.
232 Transcript, Adelaide Workshop 2, Denise Griggs, 16 March 2020 at T7930.33–40.
233 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7929.44–7930.4.
234 Transcript, Adelaide Workshop 2, Denise Griggs, 16 March 2020 at T7930.13–22.
235 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7926.22–25.
236 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7926.45–7927.3.
237 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7931.28–36; T7932.4–19.
238 Transcript, Adelaide Workshop 2, Denise Griggs, 16 March 2020 at T7932.21–29.
239 Transcript, Adelaide Workshop 2, Damien Harker, 16 March 2020 at T7931.45–46.
240 Transcript, Adelaide Workshop 2, Denise Griggs, 16 March 2020 at T7933.6–11.
241 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7951.33–47.
242 Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7960.1–26.

243 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7962.36–39; T7963.8–21; T7963.41–43; T7964.23–39; Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 10, RCD.0011.0044.0001 at 0001.
244 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7963.30–31; T7966.16–20; T7968.15–27.
245 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7966.19–30; T7967.4–7; T7967.34–37; T7968.3–5; T7968.31–33; T7971.3.
246 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7968.31–34.
247 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7969.4–21.
248 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7971.40–45.
249 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7971.12–19.
250 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7973.12–13.
251 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7964.28–29.
252 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7966.40–7967.3.
253 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7971.18–19.
254 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7968.6–9; T7973.34–43.
255 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7974.4–6.
256 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7967.12–17.
257 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7972.19–35.
258 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7970.1–28.
259 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7970.33–7971.1.
260 Transcript, Adelaide Workshop 2, Barbara Hamilton Ramsay, 16 March 2020 at T7968.15–27.
261 Exhibit 16–1, Adelaide Workshop 2, general tender bundle, tab 10, RCD.0011.0044.0001 at 0001.
262 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8007.10–13; T8007.31–36; T8008.8–15.
263 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8008.43–46.
264 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8008.29–35; T8013.1–11.
265 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8008.35–37.
266 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8013.45–8014.31
267 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8014.32–37.
268 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8009.9–21.
269 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8009.21–26.
270 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8011.42–44; T8012.1–2.
271 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8010.45–47; T8011.2–13; T8012.5–7.
272 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8012.14–32.
273 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8012.21–25.
274 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8009.38–39.
275 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8010.16–18; T8010.32–36.
276 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8010.19–24.
277 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8010.36–39.
278 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8015.12–25.
279 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8015.26–34.
280 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8015.44–8016.15.
281 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8017.39–47.
282 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8018.9–15.
283 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8018.15–22.
284 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8018.24–28.
285 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8018.31–33.
286 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8019.8–17.
287 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8019.45–8020.8.
288 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8020.9–13.
289 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8022.31–45.
290 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8022.3–8022.15.
291 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8022.15–20.
292 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8023.1–23.
293 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8023.15–22.
294 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8022.26–29.
295 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8023.44–8024.4.
296 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8024.6–10.
297 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8024.11–15.
298 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8024.29–39.
299 Transcript, Adelaide Workshop 2, Veronique Boscart, 17 March 2020 at T8023.25–31.

19. Melbourne Hearing 4: Allied, Mental and Oral Health in Aged Care

19.1 Hearing overview

19.1.1 Introduction

At a public hearing held in Melbourne from 15 to 17 July 2020, we examined how mental health, oral health and allied health care could be improved for people using aged care services. The hearing drew upon and added to evidence from the Canberra Hearing, which examined the interfaces between the aged care system and the health care system.

This hearing was the first that we conducted under our virtual hearing model, in response to the COVID-19 pandemic. During the three-day hearing, we heard oral testimony from 27 witnesses, all of whom gave evidence remotely by video link. We received 42 written statements from 24 witnesses and took 24 exhibits into evidence, including 40 documents in the general tender bundle. Witnesses included a person receiving home care, and a woman whose mother lives in residential aged care. We also heard from allied, mental and oral health practitioners, representatives of advocacy bodies, and witnesses from the NSW Ministry of Health, South Australian Department of Health and Wellbeing, and the Australian Department of Health.

Witnesses gave evidence about the importance of allied, mental and oral health care for people receiving aged care, particularly those living in residential aged care. We also heard about some of the barriers faced by older people receiving aged care in accessing these health care services. The following themes were explored with witnesses in evidence:

- increased funding and alternative funding models
- incentives for health care professionals to provide services at an individual's home
- increased training for aged care workers
- clarifying the responsibilities of approved providers and implementing performance measures or performance indicators.

In preparation for this hearing, staff of the Royal Commission prepared a series of propositions exploring possible solutions to problems with the provision of mental health, oral health and allied health care services to people receiving aged care. These propositions were provided to a number of witnesses before they gave oral evidence. A number of witnesses provided written responses to the propositions, which were tendered into evidence. The propositions were tested by Counsel Assisting throughout the hearing.

This chapter summarises some of the evidence we heard.

19.1.2 Mental health

The focus of the first day of the hearing was on the relationship between mental health services and the aged care system. The inadequacy of mental health care for older people receiving aged care services has been raised in previous hearings. We received a number of submissions from peak bodies, health professionals, and people receiving aged care and their families that have identified issues with the mental health care available to people receiving aged care services.

Witnesses, including a person receiving aged care, a family member of a person receiving aged care, mental health professionals and representatives from mental health peak bodies, explained how older people with mental illness are cared for within the aged care system. It is clear from the evidence that there is significant work to do to improve their care.

Associate Professor Stephen Macfarlane, geriatric psychiatrist, Monash University, explained in his written statement that people within the aged care system who require mental health care fall into two main groups. The first group comprises people who have experienced chronic or enduring mental illness for much of their lives, and the second group comprises people who develop mental illness after they enter aged care.[1] The second group includes people who develop mental illness in combination with, or as a result of, dementia.

Poor mental health outcomes are particularly acute for people living in residential aged care. In his written statement, Professor Sunil Bhar, clinical psychologist and Professor of Psychology, Swinburne University of Technology, wrote that the 'prevalence of depression, anxiety and suicide ideation in residential aged care settings is estimated as more than twice that of older adults living at home'.[2] Director of Policy and Projects at Mental Health Australia, Mr Harry Lovelock, in his written statement, pointed to data from a 2017 study which found that 46% of people living in residential aged care had a diagnosis of depression.[3] Mr Lovelock also cited research which suggested that 'half of all clinical cases of depression amongst older people in RACFs [residential aged care facilities] remain undetected and untreated with the recognition of anxiety and other mental health problems also likely to be similarly problematic'.[4]

Associate Professor Macfarlane expressed similar concerns. He stated that 'the burden of mental illness among older Australians accessing residential aged is extremely high'.[5] Clinical psychologist, Dr Diane Corser, told us that in her experience of working in

residential aged care, the most prevalent mental health conditions suffered by people are depressive disorders, anxiety disorders and adjustment disorders.[6]

Dr Corser explained how, when entering residential aged care, people's independence is taken away with minimal time to adjust.[7] She commented on the impact of overstretched staff on poor mental health outcomes for residents who require assistance to move around:

> While on the surface this assistance appeared to be available to them, in reality the staff were too busy to accommodate this. People expressed that they felt like a burden and ceased asking to go places (e.g. visit the garden, go to the in-house cafe etc). Inactivity then led to further declines in mobility. A great sense of hopelessness developed, and depressive symptoms increased.[8]

Dr Corser explained how other factors associated with the transition into residential aged care increased the risk of poor mental health, such as isolation from community and a lack of social connections. These factors also included living with people with dissimilar interests, attitudes and cognitive or physical capabilities, which increased feelings of isolation and loneliness, and a lack of meaningful activities and lack of purpose.[9] Chief Executive Officer at Mental Health Australia, Dr Leanne Beagley, described the risk associated with this transition in similar ways and also noted the importance of how care is delivered in terms of wellbeing:

> transition to residential aged care can be associated with loss of autonomy, social connections, and personal identity—which significantly impacts subjective wellbeing. The way in which residential care services are delivered can either worsen or mitigate this sense of loss and associated costs to wellbeing.[10]

There was overwhelming evidence at the hearing that there are significant risks to the mental health of older people resulting from the transition into residential aged care. Mental health care must be provided in a way that acknowledges this risk. Clinical geropsychologist, Dr Alison Argo, said that 'every means possible should be used to identify and appropriately care for every resident's overall well-being'.[11]

We heard from Ms Beryl Hawkins, a 91-year-old woman who lives by herself in the community and receives home care services. Ms Hawkins told us that due to her lack of mobility, she requires assistance to go out, that she is only normally able to do this up to two hours a day, and that she finds this very frustrating.[12] In her written statement, she described her depression:

> It seems to me that if someone needs something physically, those needs are considered to be more important than mental needs. However, I don't understand the difference between mental care and physical care. When you get mentally sick, it's an illness.[13]

Barriers to access

There are a number of barriers to the provision of adequate mental health care for people accessing aged care services. These barriers include deficiencies in the assessment of mental health, a lack of preventative services, stigma about poor mental health, and the need for services to respond to the diverse needs of people receiving care.

In her statement, Dr Corser referred to problems with the assessment of mental health of people receiving aged care services. She said that:

> it became evident that mental health issues were being identified quite late or missed altogether. There was much variability in scores from the screening tool used for ACFI [Aged Care Funding Instrument] purposes as it was dependent on nursing staff's understanding of mental health.[14]

Dr Argo suggested that 'we need to create mental health assessment as just usual standard of care' and 'it's such an important element of people's quality of life and how they adjust and how they manage in later years'.[15]

We heard that mental health services are often focused on treatment rather than prevention. Associate Professor Macfarlane said that 'there are very few services that are available to maintain wellbeing or provide prevention and early intervention for mental illness for Australians accessing aged care services' and 'most services are geared towards providing care for those who have already developed an illness'.[16]

The attitudes of older people to mental health was also identified as a barrier to accessing services. A witness who gave evidence using the pseudonym UX told us that 'there needs to be a conscious effort to speak with people of my mum's generation, in language they understand, about mental health and the resources available to help them'.[17] Social Worker and Coordinator of the Wellbeing Clinic for Older Adults at Swinburne University of Technology, Mr Mark Silver, also addressed this issue in his written statement:

> The stigma attached to having mental health illness and the language around diagnosis and seeing professionals such as psychiatrists, psychologists and social workers, as well as the formality needed to be signed up to programs, necessary as they are, are found to be a major barrier in accessing mental health programs.[18]

Mr Lovelock described the importance of services for older people from diverse backgrounds and with diverse life experiences:

> The difficulties of obtaining appropriate assessment and treatment for older people experiencing mental health issues are compounded for people who experience other forms of marginalisation, including people from Culturally and Linguistically Diverse (CALD) backgrounds, Aboriginal and Torres Strait Island people, those living in rural and remote areas, and older gay, lesbian, bisexual, transgender and intersex people. Culturally responsive aged care and mental health services are vital to support the needs of all Australians.[19]

19.1.3 Oral health

The impact of poor oral health was described by many witnesses. Chief Executive of SA Health, Dr Christopher McGowan, told us that there is a substantial amount of evidence that poor oral health, both in the community and residential aged care, is 'associated with poor nutrition and general accelerating of the frailty process'.[20] Ms Hawkins, who receives home care, told us that she had not been able to eat a decent meal for a year due to issues with ill-fitting dentures.[21] She said:

> not having teeth and not able to eat, it means an awful lot to you. You lose your appetite. You don't eat as you should eat. It's very hard.[22]

Dr Kathleen Matthews, President of the New South Wales branch of the Australian Dental Association, told us that poor oral health is a significant risk for older people that can go unnoticed.[23] The majority of older Australians have their own teeth, but untreated decay and periodontal disease are increasingly prevalent due to barriers in undertaking oral hygiene self-care and accessing services.[24] We were told that there is poor awareness of, and a lack of interest in, oral health in the aged care sector.[25] The evidence we heard supports our broader understanding that people receiving aged care services, particularly residential aged care, are often unable to access the oral health care they need.

Barriers to access

There are unique issues that affect oral health outcomes in aged care. We heard that 70% of Australians aged over 75 years have moderate or severe gum disease which is largely preventable with adequate oral hygiene.[26] In aged care, the majority of daily oral hygiene must be performed by care givers.[27] Providing daily oral care is often a low priority for personal care workers and nurses, and a lack of knowledge on how to adequately provide oral care is often cited as a barrier.[28]

Dr Martin Dooland AM, former Adjunct Associate Professor in Oral Health at the University of Adelaide, told us that care workers have reported to him that they simply find it unpleasant and invasive to brush residents' teeth and do not have a good understanding of the consequences of not doing so.[29] Oral health literacy tends to be poor for aged care workers. Dr Matthews stated that the majority of caregivers do not 'speak the language of teeth'.[30] Common entry-level qualifications for personal care workers do not include any units that explicitly cover oral health care.[31] There are also no requirements for approved providers to ensure their staff have professional development training in oral health care. Dr Matthews told us:

> if you're not trained to look in the mouth, it is very intimidating and it's not very nice, especially if it's neglected. It's not nice.[32]

The current Aged Care Quality Standards make minimal references to oral health care.[33] Dr Matthews told us that the lack of oral health care references in the current standards is 'completely inadequate'.[34] Associate Professor in Oral Health, School of Health Sciences, Faculty of Health and Medicine, University of Newcastle, Dr Janet Wallace, said 'facilities need to take responsibility for holistic care for the residents and oral health is part of holistic care'.[35] We heard that aged care providers need to have more accountability for oral health outcomes.[36] Dr Dooland explained that oral health accountability can be easily measured:

> One of the nice things about oral health, it's highly, highly measurable, the oral health outcomes as well as the treatment patterns. And so if we have a simple checking-up of the undertaking of the oral health assessment, the suitability of the care plans, the implementation of the care plans, the oral health outcomes, the treatment profiles, those things are not new territory for oral health and could easily be implemented in the aged care sector, sometimes on an ongoing basis and sometimes on a sampling basis.[37]

A key issue related to oral health is poor access to dental practitioners for people in residential aged care and higher levels of home care. We heard that these people often cannot navigate their way through the dental marketplace in the same way that members of the general community can.[38] Physical and cognitive challenges can make it difficult for older people to travel for oral health care.[39] Many aged care residents with cognitive impairment find it very stressful leaving the facility in which they live and ideally outreach services should be available on site.[40] Their care needs can be complex and, as Dr Matthews told us:

> what we see is the inability of older Australians to access oral health expertise and oral health knowledge, and we see that the care systems that are around them also demonstrate a lack of oral health knowledge…But it's about getting that oral health practitioner in the door and getting the model of care driven and supported.[41]

Many people receiving aged care face financial barriers to accessing dental care.[42] Deputy Secretary for Health Financing, Australian Department of Health, Ms Penny Shakespeare, confirmed that, while the Australian Government subsidises private health insurance that includes preventative dental services, there is nothing specific to people in aged care.[43] We also heard that a disconnect between dental care and general health care has contributed to policy, organisational and system barriers to accessing care.[44]

Dr Matthews described her experience when she bought a dental practice in regional NSW and her patients began to transition into aged care. She said, 'what I started to notice was that their oral health was deteriorating before my eyes. And I realised that for something to change I couldn't be fixing one mouth at a time'.[45] Dr Matthews explained that she started to think about the systems that were supporting these older people, which led her to think about how she would change her practice and influence her community.

Professor Clive Wright, Clinical Professor, Centre for Education and Research on Ageing at the Concord Clinical School, University of Sydney, told us that the integration of oral health into the general health and aged care system is 'paramount'.[46] Dr Wallace emphasised this point when discussing access to her program, known as Senior Smiles, which provides older people living in residential aged care with oral health care. She said:

> Oral health is part of general health. Residents are not means tested to see if they get assistance with showering or toileting or giving them their medication. It needs to be part of core business within the aged care facilities on a day-to-day basis, delivered to everybody, part of holistic care for our—our residents in aged care facilities. Absolutely not means tested at all. It's for everybody.[47]

19.1.4 Allied health

The final topic examined was the delivery of allied health care to people receiving aged care services.

We heard about the benefits that allied health services can provide to older people, for their physical and mental health as well as their general wellbeing. The evidence indicates that many people receiving aged care do not have sufficient access to allied health services and are missing out on the many benefits that they can provide.[48]

Exercise physiologist and Chief Operating Officer of allied health provider Concentric Healthcare Services, Ms Angeline Violi, told us how Concentric's service delivery includes onsite services to people living in residential aged care facilities. She explained that increased access to home care has resulted in older people delaying their transition into residential aged care until they experience 'more complex health issues and require higher levels of care'. Ms Violi said that, as a result, 'residents within these facilities would benefit from regular participation in a range of allied health treatments, yet access to such treatments is extremely difficult'.[49]

Multiple witnesses described the importance of maintaining mobility and functionality for older people and the crucial role of allied health in achieving this.[50] Clinical physiotherapist, Dr Jennifer Hewitt, told us that maintaining function is 'a really common goal that we see' for older people.[51]

Maintenance of older people's functionality sustains their independence and quality of life.[52] Occupational therapist and allied health academic, Professor Esther May, and Chief Executive Officer of peak body Allied Health Professions Australia, Ms Claire Hewat, each emphasised the crucial role of allied health services in providing quality of life and dignity for older people.[53] Professor May described allied health within the aged care sector as 'more of a wellness model of maintenance…of life quality than it is about clinical services'.[54]

This view was echoed by the words of other witnesses, who spoke of the need for the aged care system to be one that focuses on wellness, reablement and rehabilitation, and one that extends beyond physical health to a multidimensional view of wellbeing.[55] Ms Violi explained that 'reablement can be described as an enabling approach, but it is one with certain features, the key being that it is relatively intensive and short term'.[56] We also heard about the capacity for allied health services to aid older people in reducing social isolation, increasing interaction and improving communication.[57]

In a submission to us, Allied Health Professions Australia stated:

> what is needed is a system that prioritises and funds supports for people to retain and improve function, remain independent, participate in community life, and focus on achieving their own individual goals, regardless of what life stage they are at.[58]

A key theme that emerged from the evidence was the need for the aged care system to support the delivery of allied health care in a way that is person-centred and focuses on the goals of the individual.[59] Speech pathologist and managing director of allied health care provider AvantiCare, Ms Lidia Conci, described older people's need for ongoing allied health care as ultimately being 'about ensuring that individuals who want to continue to be engaged in things that are meaningful for them and have purpose in their life need to have capacity to do so'.[60] She added that allied health service providers' ultimate goal is to facilitate wellbeing.[61]

We heard evidence from representatives of two aged care providers, Churches of Christ Life Care and Southern Cross Care (SA, NT & Vic), about the allied health care programs they deliver. Chief Executive Officer of Life Care, Mr Allen Candy, explained that the

organisation has moved from a 'deficit model' to an outcome model in which 'outcomes have to be linked to resident goals'.[62] Mr Candy told us that Life Care assesses progression against those goals after six months, in both residential and home care. Executive of Services at Southern Cross Care (SA, NT & Vic), Ms Josephine Boylan-Marsland, similarly stated that their allied health program sets goals based on what is important to participants so that those goals are meaningful and also used in reviewing an individual's progress.[63]

Many witnesses emphasised the importance of comprehensive initial assessments and ongoing assessments in the delivery of allied health care.[64] Mr Nicholas Young, a physiotherapist who works with Ms Violi at Concentric Healthcare Services in the role of Chief Executive Officer, told us about the need for 'clearly identified clinical outcome measures' to ensure that the allied health services delivered to older people are achieving the desired improvements.[65]

The importance of a collaborative, multi-disciplinary delivery of allied health and associated services was also highlighted by many witnesses and is considered further later in this chapter. We heard about the role that can be played by a wide range of allied health disciplines in supporting older people and, in particular, by physiotherapists, occupational therapists, exercise physiologists, dietitians, speech pathologists and podiatrists. We also heard about the importance of allied mental health professionals, including psychologists and social workers, and the need to integrate mental health responses with other allied health services.[66]

Barriers to access

The evidence highlights that many people receiving aged care do not receive allied health services that they need. Ms Hewat stated that:

> there are many, many services that could be and should be provided, that are not. And we have many anecdotal examples of where people are left…without intervention not just for a few weeks, for months, even years where allied health could have and should have intervened. And the quality of life of that person would have been greatly enhanced.[67]

Dr Hewitt told us that most of the allied health disciplines are not represented in residential aged care.[68] Mr Candy told us that 'age should not reduce choice'. He described a need for 'greater clarity from government on provider obligations related to balancing dignity of risk in supporting consumers' choices with our obligations to keep everyone safe'.[69]

We heard a great deal of evidence about the inadequacies of the current funding system, particularly in relation to access to allied health services by people living in residential aged care. Ms Violi described the funding system as 'the primary factor behind the limitations placed on current interventions'.[70] Ms Violi, Mr Young and Ms Conci described the ways in which their businesses are required to navigate a range of different sources of funding to provide various allied health care services.[71]

Dr Hewitt explained that, in the current system, allied health practitioners are required 'to make the person in front of us fit into a funding stream or mechanism', rather than assessing the individual's need and matching services to that need.[72] Consultant geriatrician, Dr Stephanie Ward, agreed that funding operates as a constraint on preparing

care management plans involving allied health care for older people.[73] Mr Young criticised the requirement under the Aged Care Funding Instrument to deliver 'one size fits all care' to older people, regardless of their individual diagnoses.[74]

Witnesses told us that the prescriptive nature of the Aged Care Funding Instrument means that allied health practitioners are not funded to deliver interventions that are most appropriate and evidence-based.[75] We also heard evidence that this restriction on the ability of allied health practitioners to use their professional skills and training can adversely affect the composition and retention of the allied health workforce engaged in aged care.[76]

A particular complaint about the operation of the Aged Care Funding Instrument was that it is reactive and does not incentivise or support a preventative care approach.[77] Many witnesses referred to the vital role of allied health care in preventing physical and cognitive decline, in addition to providing restorative short-term care in response to acute events.[78]

A number of witnesses told us that the design of the current aged care system means that access to high quality allied health care is dependent on the values and commitment of individual approved providers of residential aged care.[79] Ms Violi and Ms Conci each described positive experiences of working with providers who encourage allied health input to provide their residents with the care they need.[80] However, they explained that this was at the initiative of the provider and results in a financial burden to the provider. Ms Violi stated that 'if it is a service that residents need, it should come from the funding'.[81]

While much of the evidence we heard related to people living in residential aged care, witnesses described similar considerations affecting people receiving aged care services at home. We heard that the level of use of Home Care Packages to fund allied health care remains low and is affected by a lack of understanding of the availability and benefits of allied health.[82]

A number of witnesses also referred to the use of funding available from the Commonwealth Home Support Programme for the delivery of allied health to people living at home, particularly for wellness and reablement focused services.[83] However, the approved provider witnesses were critical of the limited funding for allied health services.[84] Dr Tim Henwood, Group Manager of Connected Living – Community Wellness & Lifestyle, Southern Cross Care (SA, NT & Vic), explained that to support the style of allied health programs the organisation delivers, 'we need…an extension of both the dollar value of each of those outputs and the number of outputs, so we can service all the people who are coming through our front door'.[85] Ms Hewat described the need for a change of culture in the aged care sector, to view allied health services as valuable rather than a burden on funding. She stated that 'allied health has to be seen as a priority. It has not been'.[86] Ms Conci attributed this to attitudes about the needs of older people:

> They are normally viewed as dependant, frail and sick which creates a perception that when they reach a certain age or functional ability they must be 'nursed' rather than supported with the capacities that still remain, and therefore are perceived as a burden on society and the public dollar. I do not believe that there is enough emphasis on investing in preventative care and the wellbeing of the older person, but rather their frailty and illness.[87]

19.1.5 Preventative care and early intervention

We heard evidence that the current attitude to treatment and care for people receiving aged care is largely reactive, and often focused on treating pre-existing problems rather than preventing future ones. Associate Professor Macfarlane told us that while it is cheaper in the long term to invest in preventative health care strategies, he believes that there is little political appetite to do so, because the 'pay off' will occur well outside the electoral cycle—usually 20 or 30 years later. He said:

> We know from research, for example, that about 20 per cent of cases of dementia can be prevented with appropriate early lifestyle interventions, and if you decrease the number of people who ultimately are going to require services for aged care and dementia-specific behaviour management, that eases the burden on services.[88]

Ms Boylan-Marsland said that there needs to a 'whole system change of the industry' where mind-sets are changed 'from ill-being to a well-being thinking'. She went on to say 'we've had to change all of our systems, all of our structures, from job descriptions to appraisals, to a whole array of systems to create a health living'.[89] Preventative care, delivered by health professionals such as general practitioners, psychologists and dentists, as well as by other allied health professionals such as physiotherapists, occupational therapists and exercise physiologists, can make a substantial difference to the quality of life of older people. It can enhance independence, and it can enable people to live longer in their own homes safely and comfortably.[90] For older people living in the community, early intervention through good preventative care can also provide significant support to their carers, partners and families. Dr Argo told us that early intervention can have long-term positive effects for older people in terms of physical health as well as mental health and overall wellbeing.[91] Early intervention also involves providing emotional, social and recreational support to address loneliness and isolation. As Mr Silver told us, it 'involves addressing isolation and loneliness as well as understanding the importance of maintaining a focus on identity, purpose and meaning'.[92]

Dr McGowan suggested that preventative care could align well with the responsibilities of State and Territory Governments, particularly in relation to mental health. This is because State and Territory Governments would have an interest in preventing hospital admissions.[93]

Over the course of the hearing, witnesses were asked about improving the focus on early intervention and preventative care. Allied health practitioner witnesses strongly supported this approach.[94] Ms Conci said:

> Early intervention is key in preventing the rapid decline that is commonly associated with older individuals who are experiencing health issues or are withdrawing from meaningful and purposeful activities.[95]

Mental health professionals gave evidence about the impact that funding constraints have had on service delivery of mental health support for older people in aged care. A consequence of those constraints is that older people may not access treatment early on, which can lead to much more serious mental health issues later on.

Dr Argo told us that, at public mental health services, funding comes with strict guidelines about who can receive a referral for treatment. According to Dr Argo, unless the older person is 'actively suicidal, or actively psychotic, you've got no chance of getting your referral through'.[96] Dr Corser and Associate Professor Macfarlane shared similar experiences.[97]

Associate Professor Macfarlane described the rationing of funding for mental health services and said that psychiatry service providers must make daily choices about when and where to operate and who to provide services to.[98] He said that if more funding was available to these service providers, 'the availability of services would flow on to patients who would otherwise have been prioritised lower down the tree of need'.[99]

Dr Argo observed that, if mental health services were provided early on and in a proactive way, mental health outcomes could be improved in the long term.[100] She said:

> If I get in with a family and put everything in place and put the education [in], it's very less likely that it all sort of turns into a disaster and explodes at the end. And I think mental health is very similar.[101]

Entry into residential aged care can increase the risk of functional deterioration—for example, a previously independent person could be told that they are not allowed to move without the aid of a staff member.[102] In residential aged care, many residents experience problems with mobility and activities of daily living. According to Dr Ward:

> Many have experienced, or are at high risk, of falls. Weight loss, poor oral intake and difficulties with swallowing are common concerns for both staff and family members.[103]

We heard that services that can assist older people to maintain their mobility and balance, and prevent deconditioning for as long as possible, are an important part of ensuring dignity, independence, and quality of life in residential aged care.[104] Dr Ward told us that a baseline assessment of mobility needs and goals, and the development of a program conducted by a physiotherapist to optimise mobility and balance to prevent deconditioning, can address this. She stressed the need for reassessment of these plans after any change in function and mobility. This could include after a fall or injury, or following an illness.[105]

Dr McGowan told us that as with mental health and physical functioning, early intervention for oral health can prevent significant health concerns in the future, not just for oral health but for general health and wellbeing.[106] He added that the impact of dental care is 'greatly enhanced if it's triggered by a sort of ongoing assessment of the need'.[107] Dr Wallace affirmed the need for good, everyday dental health care for people living in residential aged care.[108]

Ms Nicole Stormon, Vice President, Australian Dental and Oral Health Therapists' Association, suggested that the deterioration of oral health with ageing might warrant only a treatment-based approach to dental care.[109] However, Ms Stormon also told us that a preventative model could limit the potential for deterioration from the outset. A preventative model of care and a treatment-based model offer different, but not mutually exclusive, solutions.[110]

Ms Violi stated:

> an older Australian should be able to proactively access each discipline to assess and manage each area of their health; for example, dentistry, psychology, speech pathology etc. What we normally see is a reactive approach, where an area of their health has hit a point whereby the allied health discipline is alerted to manage it. There should instead be a twofold approach: a proactive, preventative measure and one that deals with episodes of acute needs, e.g. post-stroke.[111]

In its post-hearing submissions, SA Health emphasised the need to implement a preventative care approach and the benefits this could provide:

> There is a need for a shift in the aged care paradigm to investment in preventative care and reablement of older people, to maximise the time that they can remain in their homes, stay connected and vital in their communities and delay the need for 24-hour care. This will not only benefit older people but will also have a positive effect on the acute health care system.[112]

19.1.6 Holistic assessment

We were told that 'a necessary precondition of managing something is an adequate assessment'.[113] Ms Hewat explained that timely and multi-faceted assessments are an important part of a preventative care model. She said that 'the most important thing is that the funding system addresses that holistic approach to care, and it starts right at the beginning from that first assessment, whether you're in community or going into a residential aged care facility, that assessment needs to be comprehensive'.[114]

One example given of assessment models not functioning optimally was the mental health assessments carried out on people on entry into residential aged care. Older people entering residential aged care are assessed for depression within the first 55 days of their entry.[115] However, there is no requirement that mental health assessments must be completed by a mental health professional.[116] There is also no obligation on an approved provider to undertake a mental health assessment for an incoming resident, unless they intend to make a claim for funding for mental health care services under the Aged Care Funding Instrument for that resident.[117] We heard about the challenges with identifying and assessing the mental health needs of older people in aged care and, as a result, that the accuracy of these assessments may be questionable.[118]

Professor Bhar explained that because the level of a person's depression is linked to the financial subsidies payable for the care of that person, there can be inflated reporting. He went on to say that the assessment tool, the Cornell Scale, is not always appropriate in an aged care setting as it is overly complex, requires trained staff to administer the assessment tool and does not measure anxiety.[119] Dr Hewitt told us that care planning is restricted by the 'limited number of prescriptive non-evidence based methods that are driven by the funding mechanism'.[120]

Multiple health practitioners told us that holistic assessments of older people's needs should prioritise their quality of life and wellbeing, as well as restoring or maintaining functionality and sustaining their independence. They further emphasised that plans need to focus on an older person's individual goals and needs, with the understanding that these are likely to change over time.[121] Ms Conci explained Avanticare's approach:

> The philosophy that underpins our model and all the services we deliver is that having purpose and meaningful activity in an individual's life enhances wellbeing and reduces or delays physical and cognitive decline.[122]

Dr Nigel Lyons, Deputy Secretary, Health System Strategy and Planning, New South Wales Ministry of Health, stated that the needs and goals laid out in the initial holistic assessment should be reviewed on an ongoing, periodic basis 'to ensure that there's an appropriate alignment of the supports for the need'.[123] According to Dr Lyons, if an older person experiences an acute health event that results in a change to the person's care needs, this also requires appropriate additional assessment and review. Ms Violi said that Concentric's practitioners review residents every three months to ensure that their needs are being met. She told us that 'Maintaining "wellness" is dynamic, and we need to be flexible with our delivery in respect to what we are delivering and how we are doing so.'[124]

Ms Boylan-Marsland described her organisation's approach to holistic assessment through early identification. She said that Southern Cross Care (SA, NT & Vic) uses an array of assessments to identify risks and set meaningful goals for the resident. These include assessments of function, physical mobility, depression, physical performance, fitness, frailty, vulnerability, activities of daily living, continence, behaviour, skin screening, and hospital presentation.[125] According to Ms Boylan-Marsland, this access to a wide range of information is critical to an older person's ability to remain empowered and in control.

Dr Argo stressed the importance of a holistic mental health assessment involving a thorough assessment of multiple factors, including biological, medical, psychological, cognitive, social and spiritual factors.[126] Professor Bhar stated that the screening for mental health should be broadened for older people entering residential aged care to include anxiety and suicidal ideation, rather than limiting assessment to depression.[127] He added:

> We have observed that residents who score highly on the Cornell Scale [for depression] do not necessarily get referred for mental health treatment or offered counselling. Facilities must have a clear and transparent mental health referral plan for residents that screen positive for mental health problems.[128]

We were told that for services to be delivered within a holistic framework, there should be an interplay between the aged care provider and its staff, general practitioner, and relevant allied health professionals.[129] Allied health professionals are trained to assess the care needs of adults who need aged care services.[130] Ms Conci said that 'Restorative care and rehabilitation are the domain of an allied health professional and a well-trained clinician can facilitate significant positive outcomes for their clients.'[131] In relation to oral health, registered nurses and care staff have an important role to play in ensuring that this is integrated into residents' overall care plans. Dr Dooland acknowledged the complexities of bringing together medical and dental elements of care plans. However, he stressed that oral care should be part of the initial assessment stages of entry into aged care.[132]

Providers can take up a role, beyond the initial assessment, which matches up older people with appropriate services. According to Associate Professor Macfarlane, this is likely to require more upfront work from providers.[133] However, by doing this initial work, a 'shotgun referral' process will be avoided and there will be less ongoing work in accessing services over time.[134] Dr Hewitt described best practice as being 'a single multifactorial assessment that identifies the clinical needs of the resident and their goals and preferences' and maps out possible barriers to achieving the person's health and wellbeing goals. She suggested that a strategy would then be developed, in partnership with the older person, as well as with the registered nurses and allied health professionals who are best suited to address that person's needs.[135]

19.1.7 Multidisciplinary delivery of care

Witnesses highlighted the importance of a multidisciplinary approach to the delivery of care and described the positive experiences of working within multidisciplinary teams.

Allied health care

Ms Conci advocated offering the 'full complement of multi-disciplinary allied health services' because that 'enables a holistic approach to delivering care which maximises the opportunity for optimal wellbeing outcomes'.[136] Her organisation focuses on delivering 'holistic and evidence-based services', including physiotherapy, occupational therapy, speech pathology, dietetics, and podiatry.[137] Ms Conci emphasised that service delivery must remain based on the assessed need of an older person's capability and the programs that can best optimise that person's health and wellbeing.[138]

Ms Violi and Mr Young, whose business also employs practitioners from a range of allied health disciplines, similarly emphasised the need to promote a multidisciplinary approach. Ms Violi told us that funding for allied health should allow for all disciplines of allied health to be involved in care.[139]

Dr Hewitt highlighted the role of assessment as the starting point for multidisciplinary care. She explained that an integrated care approach involves individualised assessment, which leads to referrals to relevant disciplines who 'work together to support the person as a whole, including their physical, emotional, social and cognitive (biopsychosocial) needs'.[140] Dr Hewitt told us that, in this way, a multidisciplinary approach can address multi-morbidities in older people.

Ms Conci also highlighted the need for allied health and other professionals to be 'better informed on each other's specific role and how a team approach can optimise wellbeing'.[141] She told us that, during her many years of experience in the aged care sector, she has observed that different disciplines 'predominantly work in silo'. Ms Conci described how educating allied health professionals about the role of other disciplines gives rise to a more holistic approach to care and benefits clients.[142]

Oral health care

We heard that the delivery of quality oral health care requires different divisions of registered oral health practitioners to work together.[143] Ms Stormon and Dr Matthews each referred to the relationship between dentists and other oral health practitioners, including dental therapists, dental hygienists, oral health therapists and dental prosthetists.

Dr Matthews described her role as a dentist as 'working in partnership' with oral health therapists, who can gather information about patients' needs and provide insights to her.[144] Ms Stormon, an oral health therapist, said that:

> It's embedded within our profession…we love to work that way. We're trained to work that way…I can't do all facets of oral health. Arguably no dental practitioner can do all aspects of dental care. We have to work within teams. And, naturally, when oral health does escalate, you need treatment, you need more complex thinking and that's where dentists are trained.[145]

Dr Matthews told us that the provision of oral health care to people living in residential aged care should involve 'a mix of practitioners from all divisions of registered dental practitioners tailored to each individual patient'.[146]

Witnesses told us that oral health care needs to be included in a holistic view of the wellbeing of older people, particularly in residential aged care. Dr Matthews told us that an 'interdisciplinary approach, involving families, carers and RACF [residential aged care facility], allied health and medical staff has been shown to have the greatest success'.[147] Dr Wallace explained that oral health needs to be considered as part of general holistic health care, involving the interaction of oral health practitioners with existing multidisciplinary teams in residential aged care.[148] She said that without an onsite qualified oral health practitioner who works within a multidisciplinary team, 'oral health will never change for our frail and elderly'.[149] Dr Dooland told us that oral health care must be integrated into the wider health and wellbeing of an individual, particularly in the care planning that takes place at an aged care facility.[150]

A number of witnesses also highlighted the need for an effective referral process as part of multidisciplinary and collaborative delivery of oral health care. Professor Wright outlined screening processes that may be used by oral health therapists, aged care nurses or medical practitioners and can act as the beginning of a referral process, through which public or private dentists can become involved in providing care.[151]

Dr Wallace described the preventative oral health program she has developed, known as Senior Smiles, which provides older people living in residential aged care with oral health care. A core component of this program is the establishment of referral pathways to dentists, dental prosthetists and dental and oral health hygienists.[152] Ms Stormon told us that, as part of her assessment of an individual's oral health, she might identify systemic issues that require referral to another allied health practitioner, such as a dietitian or nutritionist.[153]

Mental health care

We also heard that there is a need for greater involvement of mental health professionals as part of holistic care delivered to older people.

Associate Professor Macfarlane explained that existing State and Territory Government-based older person's mental health services are generally 'multidisciplinary in composition'.[154] Dr Argo outlined her experience working in these multidisciplinary environments in the Queensland public health system, with disciplines including 'medical Doctors—GPs [general practitioners], psychiatrists, neurologists and geriatricians; nurses of all levels, allied health and fellow psychologists'.[155] She described this multidisciplinary team structure as 'the optimal way' to care for people, because 'if the teams truly are multidisciplinary…everybody gets a chance to contribute to the person's care'.[156]

However, we heard that there is limited access to multidisciplinary mental health services, and to broader emotional wellbeing support, through other channels for people receiving aged care. Witnesses told us that there needs to be greater incorporation of mental health practitioners into the delivery of care to older people, alongside other allied health care practitioners and medical professionals. Mr Silver explained that:

> There has been a lack of understanding of the different roles that the different Mental Health professions can take in the delivery of services. There is a need to incorporate Social Work, Counselling, Psychology, with Occupational Therapy and Nursing and other Allied Health services, together in more of a multi-disciplinary team approach. More connections need to also be made with medical and specialist services such as GP's [general practitioners], Psychiatrists, Geriatricians and Psycho-geriatricians. Each has a particular knowledge and skill set that can make a unique contribution to service delivery and this needs to be explored further.[157]

Mr Silver described mental health professionals, including social workers, as a 'fundamental and essential' part of the delivery of an allied health multidisciplinary approach by aged care providers, particularly during a person's transition into residential aged care.[158] Both Mr Silver and Professor Bhar encouraged the expansion of multidisciplinary mental health teams, including the possibility of drawing on the peer workforce.[159]

Dr Argo explained that multidisciplinary care provision is particularly necessary for people with complex care needs such as people with a diagnosis of dementia.[160] She described current limitations of multidisciplinary care for people experiencing cognitive decline, including, for example, that many rehabilitation services will not accept a person with a dementia diagnosis nor include a mental health practitioner as part of their multidisciplinary team. Dr Argo told us that 'true multidisciplinary led teams…are an excellent way to avoid limiting care to focus solely on physical gains' and to encompass 'cognitive, emotional, social and spiritual functioning'.[161]

Supporting collaborative multidisciplinary teams

The evidence indicates that one of the key elements of a multidisciplinary approach is collaboration and the sharing of perspectives by the various people involved in an individual's care. In the context of mental health, Professor Bhar commented that:

> It is important that mental health services within residential aged care are multidisciplinary. We have found that different professional groups—psychologists, social workers and counsellors have provided distinct perspectives that when shared, provide for a more complete conceptualisation of the client.[162]

Mr Lovelock similarly explained that the 'broad perspectives' brought by staff from different disciplines when working together to provide holistic mental health care are 'important for effective consumer care and support'.[163]

We heard that an important part of supporting collaborative service delivery is providing opportunities for those involved in a multidisciplinary team to have discussions about the individuals for whom they care.[164] Dr Ward told us that case conferencing is a standard practice in geriatric care in hospital settings to allow the sharing of expertise of various medical, nursing and allied health professionals.[165] She explained that, in her professional experience, the opportunity to discuss a patient with a colleague, such as an allied health professional, in a setting like a case conference allows 'problem solving in a more holistic way'. Dr Ward described these interactions as 'the beauty about working in an interdisciplinary or multidisciplinary team'.[166] She explained that:

> Perhaps a colleague like [physiotherapist] Dr Hewitt or an occupational therapist may have thought of something I haven't, or perhaps I would have picked up on something that they haven't, or one of us will have an insight that the other won't and we will be able to make a better nuanced and more effective plan.[167]

Dr Ward also told us that she saw a role for telehealth in facilitating discussions with other practitioners, for example an allied health professional based in a residential aged care facility or a private practitioner to whom a resident has been referred.[168]

Dr Henwood described the weekly case conferencing that forms part of the multidisciplinary program delivered by Southern Cross Care (SA, NT & Vic) to people receiving home care services. He explained that new clients and any existing clients who have a change in their health situation are discussed at these meetings to allow the multidisciplinary team to work together to make sure that each individual client's goals are being met.[169] He told us:

> And the aim is for those teams to work together, leverage their expertise so that, as I said before, that client can get on to their best health pathway. And we apply this across a variety of levels for the community sector.
>
> We have high risk meetings for high risk clients who have dementia or who have level 4 packages and higher care needs, and then all the way back down to our CHSP [Commonwealth Home Support Programme] clients who are using that aged care entry-level program to get started. And if they present to us, for example, with lower back pain, then we're looking at the holistic picture. Is it a foot strike issue, is it shoulder issue, is it a spinal issue, our podiatrist, our physiotherapist, occupational therapist, exercise physiologist, dietitians, social work, exercise scientist, registered nurses are all working together to make sure we're ironing out what is the needs for that client.[170]

Dr Corser explained that the use of a multidisciplinary team approach is limited for mental health professionals by a lack of funding within the current system for activities such as case conferencing.[171] She told us that psychologists currently are only funded while seeing their client, which fails to recognise that 'treating mental health issues in older adults often requires sessions with carers, family and/or nursing staff'.[172] Dr Corser said that expanding funding to support case conferencing sessions held with other members of a multidisciplinary team would support the use of such teams in a residential aged care or home care setting.[173] Dr Argo agreed that funding parameters should be expanded to allow the inclusion of care givers—including family, friends and aged care staff—in mental health treatment.[174]

Dr Argo also highlighted the benefit of multidisciplinary teams in educating allied health and medical health professionals, particularly in addressing the holistic needs of older people, not simply their mental or physical health in isolation.[175] She explained that, in her experience, multidisciplinary teams provide 'a really rich training field' and 'on the job training' that will be crucial to growing a larger skilled aged care workforce.

Involvement of medical professionals in multidisciplinary care

Another element of good multidisciplinary care highlighted by witnesses across allied, mental and oral health was engagement with general practitioners and other medical professionals. In a post-hearing submission, the Royal Australian College of General Practitioners supported the inclusion of general practitioners in the assessment of, planning for and review of older people with complex needs. We heard that a person's regular general practitioner has an important role to play in integrating the clinical advice of other specialists into their overall care plan.[176] Ms Violi told us that 'a multidisciplinary approach in which a GP [general practitioner] liaises with the allied health clinicians to build a more complete management plan is, in our opinion, best practice'.[177] Ms Conci considered that general practitioners play a role in overseeing a person's overall medical care and general health:

> There is certainly opportunity to improve the role of a GP [general practitioner] in aged care, particularly through improved referral pathways and collaborative approaches to treatment plans.[178]

Dr Beagley emphasised the strong association between physical health and mental wellbeing, particularly for older people. She told us that 'the role that GPs [general practitioners] can play in an integrated assessment is really important'.[179] Dr Argo described the need for mental health professionals to work with general practitioners in conducting assessments and preparing treatment plans for mental health or cognitive concerns.[180] Dr Corser said that when psychologists collaborate with medical practitioners about medication needed to augment treatment delivered by psychologists, the client seems to gain the most benefit.[181]

Dr Matthews explained that medical practitioners, including those working in a hospital setting, can facilitate opportunities to assess oral health through referrals. She told us that there is a need to raise the profile of oral health and create awareness with medical and health colleagues about the importance of oral health assessments.[182]

A number of witnesses spoke of difficulties with access to general practitioners and specialist medical clinicians.[183] Professor Bhar told us that there is 'a great need…to foster communication between health care professionals' involved in the care of people who live in residential aged care.[184] He referred to general practitioner mental health reviews as one method of reducing fragmentation of mental health care by requiring interaction between psychologists or other mental health practitioners and general practitioners. Multiple witnesses described a need for general practitioners to receive more education about the role and benefits of allied health professionals, to allow general practitioners to be more involved in supporting a wellbeing and reablement approach to care for older people.[185]

Collaboration with aged care staff and families

Witnesses explained that another important element of multidisciplinary care is collaboration with aged care staff and the families of those receiving care.[186] Ms Hewat emphasised the need for the close involvement of aged care staff as part of multidisciplinary delivery of allied health care to older people. She said Allied Health Professions Australia:

> strongly contends that this is not a health model, this is an aged care model. And whilst there are health services that are required, the key thing is that this is embedded within the aged care system and it is integrated, because just having people fly in and fly out, so to speak, does not embed a systemic approach to the care and re-ablement of older people. It's not just about going in one to one, talking to the person and leaving. It is about dealing with the other staff, the care staff who are there every day. The people who are serving them meals, the people who are getting people out of bed, the people who are assisting with showering. They all need to be part of the team. They all need to understand what's going on. And having a dedicated aged care multidisciplinary allied health team is the key to that success.[187]

Ms UX detailed her mother's experience of receiving acute mental health services from her local Older Person's Mental Health Unit while living in residential aged care. Ms UX described a lack of collaboration between different people involved in her mother's care, and said:

> I think that there needs to be better communication between the various stakeholders involved in Mum's care and better care coordination. Mum's Care Coordinator within the OPMHU [Older Person's Mental Health Unit] is a position that is reassigned to a different person every six months, which I believe disrupts continuity of care. Mum feels as if she's being passed around, and we feel like we're always playing catch-up.[188]

Multiple witnesses described the central role of aged care nurses in undertaking assessment, referral and collaboration with allied, mental or oral health professionals following referral.[189] Ms Conci explained that registered nurses and nurse practitioners can play a beneficial role within a multidisciplinary team in 'early identification of issues and referral to the appropriate allied health professional'.[190] Ms Conci also told us that personal care workers are well placed to identify issues early, due to their frequent contact with residents, and to raise these issue with a care manager for referral to relevant allied health professionals.[191]

The requirement for ongoing interaction and support between relevant professionals and aged care staff was highlighted, particularly in relation to oral health care. Dr Matthews told us that:

> In the RACF [residential aged care facility] setting, by mandating the inclusion of routine daily oral hygiene measures and any other regular preventive strategies into the medical health plan rather than the personal care plan and with the active involvement of a registered dental practitioner in each RACF who provides ongoing training and feedback to RACF staff, it will ensure services are provided which will translate into positive patient outcomes.[192]

Ms Stormon told us that oral health practitioners had a role to ensure that personal care workers and nurses working in aged care are 'skilled, but also confident' to employ skills they have learned, to enable them to be part of the broader care team.[193] Dr Wallace described how, as part of her embedded oral health program:

> practitioners become part of the RACF [residential aged care facility] staff, they interact with the…multidisciplinary team and establish oral health as part of general health care. This is… a change that will ensure oral health is considered as part of holistic care for the residents of the future.[194]

A number of witnesses told us that telehealth could aid in collaborative assessment and treatment planning for the oral health care needs of people in residential aged care facilities. Dr Dooland, Dr Matthews and Ms Stormon all agreed that telehealth could be used by registered nurses or personal care workers to seek assistance from dental professionals in the use of assessment or screening tools.[195]

We heard about the role of allied health assistants working in residential aged care facilities within a broader multidisciplinary team and the scope to expand their involvement. Ms Hewat told us that allied health assistants, properly trained and working under the supervision of allied health practitioners, are 'a key part of the model'.[196]

Professor May described allied health assistants as having 'a valuable role to play in providing sustainable and frequent allied health interventions in aged care under a supervised and delegated model'.[197] Allied health assistants can implement and support allied health programs, monitor progress and report to remote allied health practitioners. Both Professor May and Ms Hewat emphasised the particular benefit of having allied health assistants 'on the ground' on a daily basis when access to allied health practitioners is limited by geography or supply.[198]

Ms Violi and Ms Conci each explained that, if allied health assistants are employed at facilities where their businesses provide allied health services, they and their allied health practitioners work closely with the assistants. They both told us that they encourage the allied health assistants to participate in the continuing professional development programs provided by their businesses to ensure the assistants have a shared approach and philosophy in delivering care.[199]

Dr Hewitt described a successful program that she had run remotely and which, with the support of an allied health assistant, had involved the delivery of mobility assistance programs to people living in residential aged care. As a practitioner based in regional Australia, Dr Hewitt told us that she saw particular potential for a model of care delivery involving allied health assistants, employed by aged care providers, in regional or rural locations where access to allied health practitioners is more limited.[200]

19.1.8 Embedded care in residential aged care

The issue of limited access to services for those living in residential aged care was highlighted by a number of witnesses. Several witnesses said that it is desirable for people to receive services at the place where they live, particularly if they have reduced mobility.[201] Some evidence considered possible models for embedding allied, mental and oral health service delivery within residential aged care facilities. We heard that, at present, the embedded approach is not common.[202] However, a number of witnesses told us that embedded delivery of these services is the best way of providing this care.

Embedded delivery models allow for a preventative approach to care, which supports early identification and intervention.[203] Witnesses also observed that an embedded approach is supportive of multidisciplinary delivery of care. Professor Bhar described it as allowing different professionals to 'work hand in hand in a team environment'.[204]

Dr Ward gave evidence about the benefits that an embedded approach provides for her work as a geriatrician attending residential aged care facilities. She told us:

> I still love the opportunity, when that opportunity presents itself, to engage with allied health staff when I see residents in residential aged care...Some facilities I visit actually do employ, say, a social worker or an occupational therapist. And I'm able to connect with those when I'm assessing a resident and making a plan. And it's fantastic. I will get their perspective and I can get their input into making a management plan for a patient I see. But that's the exception.[205]

The models described by witnesses for the provision of embedded care varied between allied, mental and oral health care, particularly in relation to the extent of interventions offered by the embedded practitioner. However, the evidence we heard in relation to each type of care was generally supportive of a model where practitioners are employed by an aged care provider to deliver services at a residential care facility on an ongoing basis.

The evidence about embedded delivery of oral health care primarily considered a model through which oral health professionals are placed in a residential aged care facility to provide preventative care and assessments for residents. A number of witnesses referred to the Senior Smiles program which operates in this manner. Dr Wallace explained this model:

> it places a qualified oral health practitioner, an oral health therapist or a dental hygienist, into aged care facilities to provide education for the residents and for the staff to conduct or value health risk assessments, to develop oral health care plans for the residents, and also to establish referral pathways to local dentists or prosthetists for the residents' oral health needs.[206]

The Senior Smiles model involves the facility paying the oral health practitioner directly.[207] Dr Wallace explained that she preferred embedding practitioners, rather than using an outreach model, because 'the facilities need to take responsibility for holistic care for the residents and oral health is part of holistic care'.[208] She said that:

> If they're [aged care providers] not made to pay the practitioner and then those oral health services are directly attached to their accreditation processes, then it won't happen. We've had research in aged care facilities for decades. We've had train the trainer programs. We've had people going in once every six months to provide dental care such as restorations, relief of pain, etcetera, and that's all very necessary and we need those things in place, but without a practitioner within the facility embedded within the multidisciplinary team, then oral health is forgotten, and it becomes a luxury rather than a necessity.[209]

Ms Stormon outlined the benefits she sees for a multidisciplinary approach involving aged care staff in an embedded model:

> You start to understand what their profession is, you start to understand what their role is and what your role is to do with their role. So I think just the natural camaraderie and the working relationships that you get with other professionals working in a multidisciplinary team, which we stress is just so important across all facets of health—that's what makes it work. And then choosing to go in the non-embedded route, I just fear that we would miss out on all that, as we have done before.[210]

The mental health professionals who gave evidence each described very low rates of embedded mental health services in residential aged care facilities.[211] Professor Bhar cited research which showed that, in a survey of 90 residential aged care facilities in Australia, only 11 employed psychologists and only 12 employed social workers.[212] Mr Silver said that:

> There are unfortunately very few examples of social workers, psychologists or counsellors employed directly by facilities. The few that have them on staff are able to embed mental health services into the culture of facility as an integral member of the team. Their value and effectiveness lies in early intervention with residents, especially as they enter the facility; assisting in their transition; being involved in staff training, support and consultation; and in offering support to residents' families.[213]

Dr Corser described her experience working as an embedded psychologist employed at a residential aged care facility. She told us that her role included 'assessing and delivering psychological intervention to older adults, supporting family members of people residing in the centre, supporting and providing training in mental health to staff, and training post-graduate students in working with older adults'.[214]

Dr Corser explained that having a psychologist in an embedded role ensured that mental health issues were identified and treated more effectively.[215] She implemented staff training to increase knowledge of symptoms of mental health issues, as well as training in basic skills to improve the emotional wellbeing of both staff and residents.[216] The funding for Dr Corser's embedded role was provided by the aged care provider, who 'saw the benefit of having a psychologist there' to support the mental health of residents, families and staff.[217] She described the benefits she experienced working as a practitioner embedded in the facility:

> Working as an employee of the aged care centre meant I was working within the system and could have more influence as I developed relationship[s] with the staff working in the aged care centre. It also meant I could work with a variety of people toward the care of the person. I was available to speak to staff on different shifts, be included in case conferences and/or clinical meetings, engage in ad hoc discussions with medical practitioners, staff or family as needed. Clinical staff were reassured that they could seek professional advice about psychological issues of people in their care in a timely way. Overall, it encouraged the use of an interdisciplinary approach to people's care in an environment that historically had a medical focus.[218]

Mr Silver told us that 'wherever possible, the preference is for services and practitioners to be embedded as part of the facility / agency and the team rather than taking an external approach by simply visiting individuals'.[219] Professor Bhar agreed, stating that this approach allows treatment to be 'multi-disciplinary and systemic' and affords mental health professionals the opportunity to 'work collaboratively with aged care staff to design and implement treatment strategies tailored for residents'.[220]

Allied health witnesses described the benefits of having multidisciplinary teams, consisting of a range of allied health professionals, employed as part of the staff at residential aged care facilities. Professor May told us that:

> I consider it important that allied health be embedded within aged care with a sustainable funding model that allows for a service model where there is consistency and relevance to client therapy plans and goals. Consistency and relevance come with good knowledge of clients' issues and motivators and this can only occur if time is spent with clients. Episodic care models are often time bound and financial viability comes through volume of clients seen, rather than time spent with clients.[221]

Similarly, Ms Conci told us that in her experience, it is more difficult for allied health workers who attend facilities with less regularity on a 'consultative call out basis' to have the same impact on an individual's overall care and care plan, than for those who are 'on the ground' more often, such as physiotherapists and occupational therapists.[222]

Representatives of Life Care and Southern Cross Care (SA, NT & Vic) described to us the allied health programs they deliver. Each organisation provides a program that encompasses home care and residential care clients and is delivered by a broad multidisciplinary team.[223] Both programs are coordinated by a clinical staff member. Both providers highlighted the ability of their embedded models to support a multidisciplinary and holistic approach to care.

Dr Henwood from Southern Cross Care (SA, NT & Vic) told us that one of the benefits of his organisation's embedded model is the ability to conduct internal referrals between different allied health professionals.[224] He said that the model also allows for regular reassessment of an individual's needs to ensure that their allied health treatment 'pathway' continues to meet their changing requirements.

Mr Candy told us that 'the multidisciplinary approach is absolutely critical'.[225] He explained that Life Care had brought psychologists into its multidisciplinary team to provide a mental health perspective, in addition to nursing, lifestyle and allied health staff. He told us that 'we've got a slightly broader approach, looking more holistically at the individual'.[226]

Another benefit that the providers described as a result of embedding their programs was the capacity to involve and upskill their own nursing and care worker staff. Mr Candy explained that Life Care chooses to employ a core team of allied health professionals. He said that considerations of level of need and regionality may affect which disciplines are employed, or engaged as specialist contractors, but that 'where possible, [they] should be employed directly by the provider'.[227] Mr Candy described the approach at Life Care as follows:

> We want people to work for us who get what we're about, the experience we're trying to create for our people. We want to partner with them on their journey as they age. We don't want someone coming in as a contractor. …I think there's a strong correlation…You need to own and develop and train these people in your expectations about what you're trying to deliver. Maybe when you've just got specialty things, such as speech pathologists, that you might want to actually just bring them in as needed but, wherever possible, I think you've got to try and have them employed, develop them, train them in actually working with aged care. A lot of people come out of university, they've got great qualifications, they've got no experience of working with the elderly.[228]

Dr Henwood explained that Southern Cross Care (SA, NT & Vic) conducts training with the personal care workforce as part of its program, in particular home care workers. He said that:

> It expands their knowledge about health and wellness. It gives them some ideas about home-based exercise…engaging the client when they are there with the client to not only support them to be more physically active but to socially engage them as well.[229]

A number of witnesses highlighted the need for greater training opportunities specific to services for older people in relation to embedded mental health services.[230]

Some witnesses raised a number of considerations regarding the workforce in the implementation of embedded models. Ms Conci described the need for allied health practitioners employed by aged care providers to have sufficient professional development opportunities and clinical guidance from more senior practitioners.[231] Others highlighted the possible limitations of insufficient numbers of particular practitioners with aged care specific training and experience.[232] Ms Hewat acknowledged that it might not be feasible for providers in rural or remote areas to have embedded allied health services.[233] She stated that in such areas, a model of contracting multidisciplinary allied health providers into those facilities, as well as community care delivery, would be preferable. She told us that the model for the delivery of services 'really does need to be tailored to the needs of the area and the facilities and what is available'.[234]

The residential aged care providers who gave evidence explained that their provision of embedded allied health services uses the funding they receive through the Aged Care Funding Instrument.[235] Ms Boylan-Marsland described how Southern Cross Care (SA, NT & Vic) has had to make significant efforts to increase and change its Aged Care Funding Instrument resourcing to build its allied health model.[236] She told us that she thought many aged care organisations, particularly small ones, would struggle to do the same.[237]

Representatives of the Australian Department of Health were asked whether the Australian Government had considered funding an embedded care scheme such as the Senior Smiles oral health care program. Acting Deputy Secretary for Health System Policy and Primary Care, Ms Rishniw and Deputy Secretary of the Health Financing Group, Ms Shakespeare, responded that, to their knowledge, the Australian Government had not considered such a program.[238]

19.1.9 Funding allied, mental and oral health care

In this section, we set out an overview of some of the evidence we heard about the existing funding models for delivery of allied, mental and oral health care services in aged care.

Aged Care Funding Instrument

Aside from funding through the Medicare Benefits Schedule, discussed further below, the Aged Care Funding Instrument is the primary way that provision of allied and mental health care services is funded in residential aged care. There is no funding allocation available for oral health care under this funding instrument.

Allied health professionals spoke about the Commonwealth Home Support Programme and the Short-Term Restorative Care Programme as positive examples of how allied health is funded in aged care.[239] Witnesses also described the benefits of how other systems, such as the Australian Department of Veterans' Affairs and the National Disability Insurance Scheme, fund provision of allied health care services.[240]

Mr Candy told us that appropriate and sustainable funding is required to implement best practice models. He was critical of the Aged Care Funding Instrument and said that:

> Simplifying the funding model away from ACFI [Aged Care Funding Instrument] with its 900 combinations, to a simpler format, is required. Currently a large number of highly skilled aged care nurses and allied health practitioners from both providers and government are engaged in administrative tasks rather than care provision.[241]

Aged care providers and health professionals also told us that the constraints of the Aged Care Funding Instrument are a substantial barrier to accessing appropriate allied health services in residential care. We also heard that many aged care providers only provide allied health care if they get additional funding for a particular kind of care, such as massage therapy for pain management under the complex health care domain in the Aged Care Funding Instrument.[242]

Ms Boylan-Marsland explained that the Aged Care Funding Instrument does not adequately cover the costs for Southern Cross Care (SA, NT & Vic) to deliver health promoting services to the residents in its aged care facilities. She told us that it costs the organisation an extra $13.36 per resident a day to deliver its interdisciplinary health promoting approach in residential care.[243] Mr Candy also described similar service delivery programs run by Life Care which are not covered by the Aged Care Funding Instrument, and so rely on funding from the provider and client contributions.[244] Ms Boylan-Marsland explained that:

> The allied health services provided to residents in SCC [Southern Cross Care] residential homes are not directly or adequately funded. The current funding tool (ACFI – aged care funding instrument) does not support proactive holistic allied health engagement. Allied health funding through ACFI is only directly linked through the complex pain management component. This means that our allied health professionals are only funded to provide massage for pain management. Not only is this not always best practice, it is also deskilling our allied health workforce.[245]

Other health professionals emphasised the beneficial effects of allied health-led rehabilitation.[246] Ms Conci stated:

> Allied Health Professionals are restorative care and rehabilitation specialists who are best skilled for conducting assessment of an older person's functional capability and difficulties, and for developing programs and recommendations aimed at optimising health and wellbeing.[247]

Witnesses expressed strong support for a funding model that can ensure provision of a comprehensive range of allied health services to older people with complex care needs, in residential care and home care.[248] They were clear in their evidence that the Aged Care Funding Instrument is not such a model.[249]

Medicare Benefits Schedule

The Medicare Benefits Schedule pays benefits for allied health services in some limited circumstances. We heard that these arrangements are inadequate to meet the needs for allied health services of people receiving aged care, particularly as a person may only receive a total of five services under these Medicare Benefits Schedule items in a calendar year.[250]

We heard that it can be difficult for aged care residents to travel for mental health services.[251] Dr Lyons agreed that reform was needed in this area and there should be equity across all groups no matter where people reside.[252]

Other allied health services are available for aged care residents under the Chronic Disease Management Scheme. However, as Ms Conci explained, the Chronic Disease Management Scheme is not meeting the needs of people living in residential aged care. She said:

> The current MBS [Medicare Benefits Schedule] scheme has potential as a funding model but in its current form offers limited benefit to all the allied health disciplines. It is widely utilised for Podiatry in residential care but underutilised for the other disciplines. The current structure only funds a set fee of $53.80 per session for every discipline, irrespective of the length of consultation, discipline specific fee and cost of each service.[253]

As noted above, the Medicare-funded allied health services are limited to five sessions per year, which Ms Conci described as 'extremely restrictive and does not allow any opportunity for ongoing management to maintain wellbeing'.[254] She said the five session annual limit:

> discourages a holistic approach by restricting the ability to use multiple disciplines which is required most of the time, particularly when managing chronic comorbidities. Each MBS [Medicare Benefits Schedule] requires a full care plan to be generated by the GP [general practitioner] and therefore is reliant on the medical practitioner agreeing to commit the time that is required to do this. Allied health services are typically requested by the care staff of the facility, however in order to access the scheme they must generate and prepare all of the documentation for the GP to give authority and generate the care plan. This is an extremely inefficient process and with services such as Podiatry where almost every resident requires the service, then this process is unnecessary.[255]

Allied Health Professions Australia told us that the nature of the Medicare items 'massively limits the extent to which aged care residents are likely to access funded services'.[256] The organisation explained that the current Medicare funding ignores the many extra (unpaid) hours that allied health providers are required to spend either in preparation for sessions or follow up activities. Allied Health Professions Australia went further to say the drawbacks of this funding are that it:

- is only available for five 20-minute consultations per year
- does not cover extended consultations, home visits or group sessions
- does not cover non-face-to-face work outside of consultations
- provides no additional funding for travel and other costs associated with providing onsite care.[257]

Dr Corser also highlighted that treating the mental health of older people living in residential aged care often looks different to treating those people in the community. She said:

> MBS [Medicare Benefits Schedule] items need to recognise that treating mental health issues in older adults often requires sessions with carers, family, and/or nursing staff. Medicare rebates should also be available for these sessions under the resident's mental health treatment plan.[258]

Ms Violi told us that, even where Medicare funding is available for services, the funding is still inadequate. She explained that:

> The ongoing freezes of both the Medicare Benefits Schedule allied health items and the Department of Veterans Affairs allied health funding is significantly impacting the viability of providing many allied health services, particularly to those client groups most reliant on funding through these programs. In our company, we have actively chosen to move the focus of our preferred service delivery away from the delivery of services for those client groups as the funding from those programs does not allow our businesses to operate sustainably.[259]

There is no funding for oral health services under the Medicare Benefits Schedule. Funding for adult public dental services is provided by both the Australian and State and Territory Governments, with Australian Government funding allocated through the National Partnership Agreement on Public Dental Services.[260] Access to public dental services is means tested for people in the community. Older people in Australia are in the age bracket with the highest proportion of eligibility for public oral health services. However, Ms Stormon told us that wait times for treatment and transporting residents to dental services can be difficult.[261]

The National Partnership Agreement uses a dental weighted activity unit, which is based on a fee for service model. Much like in other allied health professions, we heard evidence that this fee for service model does not always capture the time needed to provide care for older people. Professor Wright said that for 'really high risk and vulnerable older patients we should have a more embracive funding arrangement, that it's not on items of service, but it's on care itself'.[262]

Several witnesses told us that they would like to see funding provided for dental outreach services for older people in a similar way to the Child Dental Benefits Scheme or the previous Chronic Disease Dental Scheme.[263] In a post-hearing submission, the Australian Dental Association said that the Australian Government funding a Senior Dental Benefits Schedule would be 'a far superior mechanism to a new National Partnership Agreement for funding dental outreach services for the frail aged'.[264]

Impact of funding models on care

Witnesses highlighted how funding models can shape decisions about the provision of health care services in the aged care sector.

We heard from representatives of Southern Cross Care (SA, NT & Vic) and Life Care who told us that current aged care funding does not support a wellness and rehabilitation focus.[265] Both providers said that they bear the additional costs of providing holistic wellbeing services for the benefit of their residents.[266] Their evidence indicates that these beneficial models of care can be provided despite limitations of funding models. However, we also heard evidence of other instances in which inadequate funding models contributed to inadequate service delivery for older people.[267] Ms Conci observed that in her experience, 'decisions to employ or engage allied health providers are often based on cost of service over quality to maximise the profit margins from these funds'.[268]

Several witnesses provided examples of how aged care funding limited their ability to offer comprehensive health care services.[269] Dr Hewitt told us that she had seen many instances of Aged Care Funding Instrument funding permitting an assessment of a person, but not providing for the services to address their needs arising out of it. Some examples given were balance impairment, cognitive decline and mobility impairment.[270]

A particular complaint about the operation of the Aged Care Funding Instrument was that it is reactive and does not incentivise or support a preventative care approach.[271] Ms Violi told us that, as an allied health service provider, Concentric is often 'limited to deliver reactive responses at the bare minimum' if it has to rely only on funding under the Aged Care Funding Instrument.[272] She went on to say that this places pressure on her business because she and her staff 'do not want to reduce our clinical standards' and want to 'ensure our team has the adequate and necessary experience'.[273] Dr Hewitt described the current funding approach as 'one size fits all' and said:

> at best, this results in allied health practitioners being frustrated by not being able to help the person with a best practice program, and at worst, being directed by the person's residential care facility to provide interventions that will maximise their funding, without any consideration for the needs and goals identified in the assessment. I have witnessed (but cannot quantify) a trend towards experienced therapists leaving the sector, and early career therapists turning over rapidly because of these issues.[274]

Professor Bhar also reflected on workforce issues arising from his experience in geriatric mental health. He told us that in 2018 the Australian Government funded a stepped care model to introduce psychological services to residents through Primary Health Networks, which was applauded by the mental health sector.[275] We were told that the program is yet to be evaluated but that initial funding appears to be inadequate.[276] However, the new program highlighted that there were very few practitioners with the experience and training to deliver such services.[277] Dr Corser agreed that there are not enough geriatric psychiatrists to do the work.[278]

Professor Bhar and Mr Silver established the Swinburne University Wellbeing Clinic for Older Adults in 2011. They told us that the clinic was developed to provide a service for older adults living in residential aged care facilities.[279] It is funded by small contributions from Swinburne University and research grants, and is largely run on the basis of a huge volunteer workforce.[280] It is an accessible program to address the emotional, psychosocial and mental wellbeing needs of older adults, especially those living in residential care, while also providing a practical training program for mental health professionals and students who are entering the workforce.[281] They said that their clinic is the only one of its kind in Australia. Professor Bhar told us that the model is 'absolutely scaleable' and 'offers two things at the same time: a service right now, but also a workforce for the future'.[282]

Dr Wallace gave an example from her Senior Smiles program about the consequences of the withdrawal of funding. She told us that in 2014, her program funded a dental hygienist to be placed at a particular residential aged care facility for 12 months. In that 12 months, the practitioner set up a number of oral health care policies, procedures and protocols. When the pilot program ended, the facility decided not to continue the service at their own expense. In 2017, Dr Wallace received further funding and was able to place a practitioner back into the facility. She told us that, in the two years Senior Smiles was not on site, all of the oral health care protocols and procedures had become non-operational.[283]

Ms Boylan-Marsland stated that providers want to see more thoughtful funding that goes beyond just addressing pain management. She said:

> we learnt that the ACFI [Aged Care Funding Instrument] needs to change. The AN-ACC [Australian National Aged Care Classification] that is being proposed is also not a good funding tool as well, because it's again deficit funding. …We don't want to just do assessments and we don't want to be…doing a lot of paperwork. We really want to focus on outcomes…[284]

A theme of the evidence was that funding is a key driver for service delivery. Professor May said that, at present, funding models are driving the types of services that are delivered, rather than the needs of the individuals driving what services are provided to them.[285] As Ms Violi explained:

> Aged care providers will change their provision of allied health as long as they receive funding to do so. It is not that they do not want to implement best practice, it is that the funding is limited and it does not support an improved program.[286]

Accountability

During the hearing, Counsel Assisting tested several proposed funding reforms for the delivery of allied, mental and oral health care services to people receiving aged care. One consistent theme of the evidence was the need for accountability to be closely linked to any future funding.[287]

Associate Professor Macfarlane spoke about the importance of transparency in the context of funding for mental health care services. He told us that there is limited accountably around how Health Networks allocate funding ostensibly provided for public aged psychiatry services.[288] He said that 'Aged psychiatry is not a high-profile medical specialty' and:

> Its challenges are rarely considered newsworthy, its patients are often rendered voiceless by illness. As such, aged psychiatry budgets risk being seen as the low-hanging fruit to be harvested when other areas of the Health Networks' budgets come under strain.[289]

Associate Professor Macfarlane explained that the resources of State-funded aged psychiatric services could be enhanced quickly in the short term at very little cost, however this requires the 'will of State and Territory governments to enforce accountability and transparency mechanisms on that funding'.[290]

Some witnesses were open to the proposition that funding for preventative oral health and allied health services could be provided to the aged care provider.[291] However, they emphasised that this must come with increased accountability. As Ms Stormon said, 'it's not just, "Give them money." Make them accountable for it as well'.[292] Ms Violi stated that while proposed funding held by aged care providers for ongoing care needs may be a good idea in theory, close scrutiny is needed to ensure that the best allied health care is provided.[293] Ms Hewatt explained that there would need to be oversight of the funding and an assurance that the majority goes to the actual service delivery, and that some is used for systems that support a wellness and restorative approach.[294]

Ms Conci told us that an advantage of funding going directly to the aged care provider is that the allied health provider is accountable to the residential care provider, and must demonstrate that positive outcome measures are being delivered, as the aged care provider is responsible for the overall care of the resident. However, she also outlined some disadvantages with this model:

> Allied health service delivery is not the core business of residential aged care operations, therefore the services are less likely to be given the investment of time and resources that are required for residents to get value from them, and more likely to be considered a supporting service. If allied health service delivery is the responsibility of the residential care provider and there is no value alignment with the allied health provider, then limits can be placed on innovative and progressive approaches, disadvantaging the resident.[295]

Ms Violi voiced a concern that if aged care providers are funded to deliver allied health services, they will make profit-driven decisions to seek out cheap allied health service provision. She called for allied health service fees to be gazetted and transparent to avoid this issue. She also called for the funding to be based on residents' needs and goals, similar to the National Disability Insurance Scheme. She said that there should be 'incentives for the providers to access the appropriate allied health in a timely manner and to provide preventative care (rather than solely reactive care)'.[296]

Ms Boylan-Marsland told us how Southern Cross Care (SA, NT & Vic) ensures accountability at their facilities, saying that:

> Each month, SCC [Southern Cross Care] actively monitors resident and client function and quality of life. These outcomes are reported to the Board each month with individual sites and service programs being held accountable for the continued wellbeing of SCC residents and clients.[297]

Several witnesses called for greater specificity in the Aged Care Quality Standards as a mechanism to increase aged care provider accountability for the provision of allied health care.[298] Ms Hewat told us that auditing processes would need to be adjusted to take into account the needs of allied health multidisciplinary care.[299] Ms Conci said:

> If the Aged Care Quality Standards were to emphasise the necessity for allied health services to meet several of the standards with a focus on wellbeing, then the Aged Care Quality and Safety Commission would be in a better position to hold providers to account on the delivery of these services and to enforce the provision of wellbeing models of care.[300]

Dr Wallace gave evidence that preventative oral health care, such as daily hygiene and care planning, should be linked to an approved provider's accreditation in the same way that nutrition is. She said that she wants facilities to 'take responsibility for providing holistic oral health care to their residents'.[301]

We were told that an important feature of accountability is an ability for outcomes to be measured.[302] Professor Bhar suggested that one measurable outcome might be an aged care provider conducting a mental health assessment within a specified time after an older person's entry into residential aged care.[303] Ms Stormon recommended that the Oral Health Assessment Tool be used to measure residents' oral health and service level performance indicators.[304] Ms Violi told us that selecting measures for allied health is challenging but they need to include simple physical measures, such as mobility, as well as broad measures about residents' quality of life.[305] Dr Hewitt's words echoed Ms Violi's views and said:

> To keep organisations, or practices accountable, a requirement should be made to measure and report on outcomes, including, but not limited to, consumer experience, health and wellness outcomes, ambulance call outs, avoidable hospitalisations, reduced lengths of stay, QALYs [quality adjusted life years].[306]

19.1.10 Conclusion

In Volume 3, in chapters on better access to health care, funding and program design, we make recommendations about the funding of, and access to, allied, mental and oral health services for people receiving aged care.

Endnotes

1 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0002 [11].
2 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0002.
3 Exhibit 17-8, Melbourne Hearing 4, Statement of Harry Lovelock, RCD.9999.0309.0001 at 0004 [14].
4 Exhibit 17-8, Melbourne Hearing 4, Statement of Harry Lovelock, RCD.9999.0309.0001 at 0006–0007 [28].
5 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0002 [16].
6 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0002.
7 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser RCD.9999.0342.0001 at 0003.
8 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0003.
9 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0003.
10 Exhibit 17-8, Melbourne Hearing 4, Statement of Leanne Beagley, RCD.9999.0363.0001 at 0002 [11].
11 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0002.
12 Exhibit 17-12, Melbourne Hearing 3, Statement of Beryl Hawkins, WIT.0742.0001.0001 at 0002 [12].
13 Exhibit 17-12, Melbourne Hearing 3, Statement of Beryl Hawkins, WIT.0742.0001.0001 at 0003 [14].
14 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0003.
15 Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8114.42–46.
16 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0003 [21].
17 Transcript, Melbourne Hearing 4, Ms UX, 15 July 2020 at T8102.40–43.
18 Exhibit 17-7, Melbourne Hearing 4, Statement of Mark Silver, RCD.9999.0307.0001 at 0004.
19 Exhibit 17-8, Melbourne Hearing 4, Statement of Harry Lovelock, RCD.9999.0309.0001 at 0008 [36].
20 Transcript, Melbourne Hearing 4, Christopher McGowan, 17 July 2020 at T8317.25–30.
21 Exhibit 17-12, Melbourne Hearing 4, Statement of Beryl Hawkins, WIT.0742.0001.0001 at 0003.
22 Transcript, Melbourne Hearing 4, Beryl Hawkins, 16 July 2020 at T8206.36–86.
23 Transcript, Melbourne Hearing 4, Kathleen Matthews, 16 July 2020 at T8187.26–28.
24 Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon, RCD.9999.0299.0001 at 0002 [8].
25 Transcript, Melbourne Hearing 4, Martin Dooland, 16 July 2020 at T8224.25–27.
26 Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon, RCD.9999.0299.0001 at 0002 [8].
27 Exhibit 17-14, Melbourne Hearing 4, Statement of Martin Dooland, RCD.9999.0313.0001 at 0004.
28 Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon, RCD.9999.0299.0001 at 0004 [13].
29 Transcript, Melbourne Hearing 4, Martin Dooland, 16 July 2020 at T8229.4–16.
30 Transcript, Melbourne Hearing 4, Kathleen Matthews, 16 July 2020 at T8185.21–22.
31 Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 28, RCD.9999.0343.0002 at 0011 [41].
32 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8195.14–15.
33 *Quality of Care Principles 2014* (Cth), sch 1 pt 2 s 2.7.
34 Exhibit 17-11, Melbourne Hearing 4, Statement of Kathleen Matthews, RCD.9999.0302.0001 at 0008.
35 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8171.20–28.
36 Exhibit 17-9, Melbourne Hearing 4, Statement of Janet Wallace, RCD.9999.0303.0001 at 0008.
37 Transcript, Melbourne Hearing 4, Martin Dooland, 16 July 2020 at T8227.16–23.
38 Transcript, Melbourne Hearing 4, Clive Wright, 16 July 2020 at T8217.27–34.
39 Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon, RCD.9999.0299.0001 at 0008 [20].
40 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8173.11–22.
41 Transcript, Melbourne Hearing 4, Kathleen Matthews, 16 July 2020 at T8185.11–23; T8189.16–37.
42 Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon, RCD.9999.0299.0001 at 0004 [16].
43 Transcript, Melbourne Hearing 4, Penny Shakespeare, 17 July 2020 at T8348.5–30.
44 Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon, RCD.9999.0299.0001 at 0004 [16].
45 Transcript, Melbourne Hearing 4, Kathleen Matthews, 16 July 2020 at T8183.29–35.
46 Transcript, Melbourne Hearing 4, Clive Wright, 16 July 2020 at T8222.42–44.
47 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8175.5–11.
48 See, for example, Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0003; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0005; 0007; 0010; Exhibit 17-20, Melbourne Hearing 4, Statement of Esther May, RCD.9999.0358.0001 at 0003 [15]; Transcript, Melbourne Hearing 4, Jennifer Hewitt, 16 July 2020 at T8237.14–16; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8256.25–27; Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8281.29–44.
49 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0005.
50 Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8256.18–22; Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0003; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0005 [28].
51 Transcript, Melbourne Hearing 4, Jennifer Hewitt, 16 July 2020 at T8235.37–38.
52 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.999.0345.0001 at 0004 [9a]; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0005–0006; Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8286.1–5.
53 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8287.34–40.
54 Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8282.28–30.

55 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD. 9999.0345.0001.0001 at 0003 [8a]; 0011 [15b]; Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0007 [7]; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0006 [30a]; Exhibit 17-21, Melbourne Hearing 4, Life Care – Response to draft propositions, undated, RCD.9999.0334.0001 at 0003; Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8279.4–9; Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8287.30–33.

56 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0009.

57 Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0004; 0006 [6]; Transcript, Melbourne Hearing 4, Beryl Hawkins, 16 July 2020 at T8205.25–28; Exhibit 17-19, Melbourne Hearing 4, Allied Health Professions Australia – Response to draft propositions, RCD.9999.0325.0001 at 0005.

58 Exhibit 17-19, Melbourne Hearing 4, Allied Health Professions Australia – Response to draft propositions, RCD.9999.0325.0001 at 0002.

59 Transcript, Melbourne Hearing 4, Angeline Violi, 16 July 2020 at T8257.16–18; Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8279.7–10; Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8300.23–25; Transcript, Melbourne Hearing 4, Christopher McGowan, 17 July 2020 at T8323.23–28.

60 Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8256.30–33.

61 Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8261.25–28.

62 Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8296.41–8297.36.

63 Transcript, Melbourne Hearing 4, Josephine Boylan-Marsland, 17 July 2020 at T8298.37–8299.7.

64 Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0005; Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001.0001 at 0009; Transcript, Melbourne Hearing 4, Stephanie Ward, 16 July 2020 at T8244.15–18; Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8282.35–38; Transcript, Melbourne Hearing 4, Nigel Lyons, 17 July 2020 at T8322.40–47.

65 Transcript, Melbourne Hearing 4, Nicholas Young, 16 July 2020 at T8255.29–38.

66 Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0004; Exhibit 17-19, Melbourne Hearing 4, Allied Health Professions Australia – Response to draft propositions, RCD.9999.0325.0001 at 0011; Transcript, Melbourne Hearing 4, Stephanie Ward, T8235.22–23.

67 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8281.35–39.

68 Transcript, Melbourne Hearing 4, Jennifer Hewitt, 16 July 2020 at T8237.12–14.

69 Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0009 [7d].

70 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0010.

71 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0006–0008 [11]; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0008.

72 Transcript, Melbourne Hearing 4, Jennifer Hewitt, 16 July 2020 at T8234.32–37.

73 Transcript, Melbourne Hearing 4, Stephanie Ward, 16 July 2020 at T8235.5–8.

74 Transcript, Melbourne Hearing 4, Nicholas Young, 16 July 2020 at T8259.29–37.

75 Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0002; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0012, 0014; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8258.33–39.

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77 Exhibit 17-22, Melbourne Hearing 4, Southern Cross Care (SA, NT & Vic) – Response to propositions, RCD.9999.0357.0020 at 0021; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0011.

78 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0004; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0007 [32b]; 0009 [40b]; Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0003 [6]; Transcript, Melbourne Hearing 4, Nicholas Young, 16 July 2020 at T8255.29–30; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8256.24–32; Transcript, Melbourne Hearing 4, Nigel Lyons, 17 July 2020 at T8322.22–25.

79 Transcript, Melbourne Hearing 4, Jennifer Hewitt, 16 July 2020 at T8237.7–14; Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8277.3–5; Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8304.5–10.

80 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0010; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 202 at T8254.25–29.

81 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0010.

82 Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 22, CTH.1000.0004.1012 at 1015; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.999.0345.0001 at 0004 [9c]; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0009.

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84 Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0007 [30g]; Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8302.33–38.

85 Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8310.41–47.

86 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8288.1–3.

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88 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8141.13–16.

89 Transcript, Melbourne Hearing 4, Josephine Boylan-Marsland, 17 July 2020 at T8296.31–34.

90 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0016–0017.

91 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0005.

92 Exhibit 17-6, Melbourne Hearing 4, Statement of Mark Silver, RCD.9999.0307.0001 at 0002.
93 Transcript, Melbourne Hearing 4, Christopher McGowan, 17 July 2020 at T8316.7–17.
94 Exhibit 17-16, Melbourne Hearing 4, Jennifer Hewitt – Response to propositions, RCD.9999.0327.0001 at 0001; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0004 [9b].
95 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0004 [9b].
96 Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8120.33–43.
97 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8133.33–8134.2; Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8121.23–29.
98 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8133.33–8134.2.
99 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8133.47–8134.2.
100 Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8122.1–16.
101 Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8122.5–7.
102 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0003.
103 Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0001.
104 See, for example, Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8286.16–19; Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8296.6–13.
105 Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0002.
106 Transcript, Melbourne Hearing 4, Christopher McGowan, 17 July 2020 at T8317.32–38.
107 Transcript, Melbourne Hearing 4, Christopher McGowan, 17 July 2020 at T8319.36–3.
108 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8175.7–11.
109 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8184.41–8185.3.
110 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8185.1–4.
111 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0007.
112 Submissions of SA Health, Melbourne Hearing 4, RCD.0012.0065.0001 at 0002.
113 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8142.1–2.
114 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8288.3–7.
115 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0307.0001 at 0007 [9].
116 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0005 [37].
117 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0005 [37].
118 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0005 [34]–[37].
119 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0008 [a–d].
120 Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0009.
121 Exhibit 17-16, Melbourne Hearing 4, Jennifer Hewitt – Response to propositions, RCD.9999.0327.0001 at 0002; Transcript, Melbourne Hearing 4, Nigel Lyons, 17 July 2020 at T8322.4047; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0002 [6b]; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0012; Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0002 [5].
122 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0002 [6b].
123 Transcript, Melbourne Hearing 4, Nigel Lyons, 17 July 2020 at T8322.40–43.
124 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0012.
125 Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0003 [11]–[13].
126 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0002.
127 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0008.
128 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0008.
129 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0004 [8k].
130 Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0005.
131 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0003 [7].
132 Transcript, Melbourne Hearing 4, Martin Dooland, 16 July 2020 at T8223.20–39.
133 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8140.13–21.
134 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8140.21–24.
135 Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0009.
136 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0002.
137 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0001 [4].
138 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0009 [12e].
139 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0002; 0019.
140 Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0009.
141 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0009 [12e]; [13d].
142 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0009 [12e].
143 Exhibit 17-9, Melbourne Hearing 4, Statement of Janet Wallace, RCD.9999.0303.0001 at 0005 [5b].
144 Transcript, Melbourne Hearing 4, Kathleen Matthews, 16 July 2020 at T8196.41–8197.2.
145 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8197.4–18.
146 Exhibit 17-11, Melbourne Hearing 4, Statement of Kathleen Matthews, RCD.9999.0302.0001 at 0006.
147 Exhibit 17-11, Melbourne Hearing 4, Statement of Kathleen Matthews, RCD.9999.0302.0001 at 0011.
148 Exhibit 17-9, Melbourne Hearing 4, Statement of Janet Wallace, RCD.9999.0303.0001 at 0007.
149 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8171.31–32.

150 Transcript, Melbourne Hearing 4, Martin Dooland, 16 July 2020 at T8223.20–26.
151 Transcript, Melbourne Hearing 4, Clive Wright, 16 July 2020 at T8222.28–38.
152 Exhibit 17-9, Melbourne Hearing 4, Statement of Janet Wallace, RCD.9999.0303.0001 at 0002.
153 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8184.23–25; T8184.30–31.
154 Exhibit 17-5, Melbourne Hearing 4, Stephen Macfarlane – Response to draft propositions, RCD.9999.0339.0002 at 0008 [5.1]; Transcript, Melbourne Hearing 4, Stephen MacFarlane, 15 July 2020 at T8130.24–29.
155 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0001.
156 Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8107.38–42.
157 Exhibit 17-7, Melbourne Hearing 4, Statement of Mark Silver, RCD.9999.0307.0001 at 0006.
158 Transcript, Melbourne Hearing 4, Mark Silver, 15 July 2020 at T8159.26–32.
159 Exhibit 17-6, Melbourne Hearing 4, Sunil Bhar – Response to draft propositions, RCD.9999.0336.0001 at 0004; Exhibit 17-7, Melbourne Hearing 4, Mark Silver – Response to draft propositions, RCD.9999.0336.0005 at 0007.
160 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0005.
161 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0005.
162 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0014.
163 Exhibit 17-8, Melbourne Hearing 4, Statement of Harry Lovelock, RCD.9999.0309.0001 at 0009 [44].
164 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0019.
165 Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0005–0006.
166 Transcript, Melbourne Hearing 4, Stephanie Ward, 16 July 2020 at T8242.15–22.
167 Transcript, Melbourne Hearing 4, Stephanie Ward, 16 July 2020 at T8234.45–8235.4.
168 Transcript, Melbourne Hearing 4, Stephanie Ward, 16 July 2020 at T8242.15–22.
169 Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8299.9–15.
170 Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8299.15–26.
171 Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8110.2–8111.9.
172 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0007.
173 Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8110.4–8111.9.
174 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0003.
175 Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8109.38–43; T8110.5–8.
176 Submissions of Royal Australian College of General Practitioners, Melbourne Hearing 4, 13 August 2020, RCD.0012.0064.0001 at 0005.
177 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0019.
178 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0008 [12b, c].
179 Transcript, Melbourne Hearing 4, Leanne Beagley, 15 July 2020 at T8155.5–9.
180 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0002; Exhibit 17-7, Melbourne Hearing 4, Mark Silver – Response to draft propositions, RCD.9999.0336.0005 at 0006.
181 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0005.
182 Transcript, Melbourne Hearing 4, Kathleen Matthews, 16 July 2020 at T8187.31–41.
183 Exhibit 17-3, Melbourne Hearing 4, Statement of Alison Argo, RCD.9999.0362.0001 at 0006; Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0007; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0008 [12d].
184 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0007.
185 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0018; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0019, 0023; Exhibit 17-19, Melbourne Hearing 4, Allied Health Professions Australia – Response to draft propositions, RCD.9999.0325.0001 at 0011; Exhibit 17-22, Melbourne Hearing 4, Southern Cross Care (SA, NT & Vic) – Response to propositions, RCD.999.0357.0020 at 0020–0021; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0007–0008.
186 See, for example, Transcript, Melbourne Hearing 4, Leanne Beagley, 15 July 2020 at T8158.12–25; Transcript, Melbourne Hearing 4, Mark Silver, 15 July 2020 at T8158.27–37; Transcript, Melbourne Hearing 4, Sunil Bhar, 15 July 2020 at T8159.4–14.
187 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8277.24–33.
188 Exhibit 17-2, Melbourne Hearing 4, Statement of UX, WIT.0747.0001.0001 at 0011 [76].
189 See, for example, Transcript, Melbourne Hearing 4, Jennifer Hewitt, 16 July 2020 at T8236.7–11; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8262.28–36.
190 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0008 at [12b].
191 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0008 [12a].
192 Exhibit 17-11, Melbourne Hearing 4, Statement of Kathleen Matthews, RCD.9999.0302.0001 at 0009.
193 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8195.1–12.
194 Exhibit 17-9, Melbourne Hearing 4, Statement of Janet Wallace, RCD.9999.0303.0001 at 0007.
195 Transcript, Melbourne Hearing 4, Kathleen Matthews, 16 July 2020 at T8196.15–20; Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8196.26–35; Transcript, Melbourne Hearing 4, Martin Dooland, 16 July 2020 at T8220.21–33.
196 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8278.8–15.
197 Exhibit 17-20, Melbourne Hearing 4, Statement of Esther May, RCD.9999.0358.0001 at 0005.
198 Exhibit 17-20, Melbourne Hearing 4, Statement of Esther May, RCD.9999.0358.0001 at 0005; Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8278.8–15.

199 Transcript, Melbourne Hearing 4, Angeline Violi, 16 July 2020 at T8253.40–44; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8254.1–8.
200 Transcript, Melbourne Hearing 4, Jennifer Hewitt, 16 July 2020 at T8244.38–8245.14.
201 Transcript, Melbourne Hearing 4, Stephan Macfarlane, 15 July 2020 at T8230.5–6; Transcript, Melbourne Hearing 4, Martin Dooland, 16 July 2020 at T8219.41–45; Exhibit 17-6, Melbourne Hearing 4, Sunil Bhar – Response to draft propositions, RCD.9999.0336.0001 at 0002; Exhibit 17-7, Melbourne Hearing 4, Mark Silver – Response to draft propositions, RCD.9999.0336.0005 at 0007.
202 See, for example, Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8117.30–33; Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8117.30–40; T8118.5–15.
203 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8170.2–5; Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0005; Exhibit 17-19, Melbourne Hearing 4, Allied Health Professions Australia - Response to draft propositions, RCD.9999.0325.0001 at 0014.
204 Transcript, Melbourne Hearing 4, Sunil Bhar, 15 July 2020 at T8160.37–40.
205 Transcript, Melbourne Hearing 4, Stephanie Ward, 16 July 2020 at T8234.7–15.
206 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8168.31–35.
207 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8170.30–-33.
208 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8171.20–21.
209 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8171.21–28.
210 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8195.33–38.
211 Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8117.30–33; Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8117.30–40.
212 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0003.
213 Exhibit 17-7, Melbourne Hearing 4, Statement of Mark Silver, RCD.9999.0307.0001 at 0002.
214 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0001.
215 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0005.
216 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0003.
217 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0002; Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8117.23–28.
218 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0004.
219 Exhibit 17-7, Melbourne Hearing 4, Statement of Mark Silver, RCD.9999.0307.0001 at 0006.
220 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0017.
221 Exhibit 17-20, Melbourne Hearing 4, Statement of Esther May, RCD.9999.0358.0001 at 0006.
222 Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8252.33–39.
223 Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0002–0003; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0002 [7].
224 Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8300.28–35.
225 Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8299.45.
226 Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8299.46–8300.4.
227 Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8303.5–10.
228 Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8304.10–22.
229 Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8303.10–22.
230 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0006; Exhibit 17-7, Melbourne Hearing 4, Statement of Mark Silver, RCD.9999.0307.0001 at 0004; Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0004–0005 [b].
231 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0014 [20a].
232 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8129.1–12; Exhibit 17-8, Melbourne Hearing 4, Statement of Harry Lovelock, RCD.9999.0309.0001 at 0009 at 0012 [58]; Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0004.
233 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8277.39–8278.2.
234 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8278.1–2.
235 Transcript, Melbourne Hearing 4, Josephine Boylan-Marsland, 17 July 2020 at T8296.22–34; Exhibit 17-21, Melbourne Hearing 4, Life Care – Response to draft propositions, RCD.9999.0334.0001 at 0003.
236 Transcript, Melbourne Hearing 4, Josephine Boylan-Marsland, 17 July 2020 at T8296.22–39.
237 Transcript, Melbourne Hearing 4, Josephine Boylan-Marsland, 17 July 2020 at T8296.37–39.
238 Transcript, Melbourne Hearing 4, Tania Rishniw and Penny Shakespeare, 17 July 2020 at T8348.5–35.
239 Exhibit 17-19, Melbourne Hearing 4, Supplementary response of Allied Health Professionals Australia, RCD.9999.0360.0001 at 0001, 0003, 0004; Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8301.41–8302.10; Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8278.41–8279.14.
240 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8277.15–22; Transcript, Melbourne Hearing 4, Nigel Lyons, 17 July 2020 at T8322.8–32; Transcript, Melbourne Hearing 4, Angeline Violi, 16 July 2020 at T8261.4–18; T8264.20–26; Exhibit 17-18, Adelaide Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0007 [6c].
241 Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0007 [7].
242 Transcript, Melbourne Hearing 4, Nicholas Young, 16 July 2020 at T8259.29–37; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8258.33–39; Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8302.21–29.
243 Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0006 [28].
244 Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0007.
245 Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0005 [24].

246 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0003.
247 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0009 [12e].
248 Exhibit 17-19, Melbourne Hearing 4, Allied Health Professions Australia – Response to draft propositions, RCD.9999.0325.0001 at 0014; Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 20, RCD.9999.0324.0001 at 007; Exhibit 17-21, Melbourne Hearing 4, Life Care – Response to draft propositions, RCD.9999.0334.0001 at 0003; Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 21, NTH.0007.0002.0001 at 0006–0007 [22].
249 Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0004–0008; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0011; Exhibit 17-17, Melbourne Hearing 4, Supplementary statement of Lidia Conci, RCD.9999.0365.0001 at 0002.
250 Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0003.
251 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0010 [56].
252 Transcript, Melbourne Hearing 4, Nigel Lyons, 17 July 2020 at T8315.20–24.
253 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0010 [15a].
254 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0011 [15a].
255 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0011 [15a].
256 Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 7, AWF.001.04299.01 at 0007–0008
257 Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 7, AWF.001.04299.01 at 0007–0008.
258 Exhibit 17-4, Melbourne Hearing 4, Statement of Diane Corser, RCD.9999.0342.0001 at 0007.
259 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0008.
260 Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 23, NDH.0001.0016.0001.
261 Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon RCD.9999.029.0001 at 0007.
262 Transcript, Melbourne Hearing 4, Clive Wright, 16 July 2020 at T8219.4–16.
263 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8174.31–34; Exhibit 17-11, Melbourne Hearing 4, Statement of Kathleen Matthews, RCD.9999.0302.0001 at 0006.
264 Submissions of Australian Dental Association, Melbourne Hearing 4, 31 July 2020, RCD.0012.0065.0024 at 0024.
265 Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0007; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan, WIT.1348.0001.0001 at 0005 [24].
266 Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0003; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0006 [28].
267 Exhibit 17-17, Melbourne Hearing 4, Supplementary statement of Lidia Conci, RCD.9999.0365.0001 at 0002.
268 Exhibit 17-17, Melbourne Hearing 4, Supplementary statement of Lidia Conci, RCD.9999.0365.0001 at 0002.
269 Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0004; Exhibit 17-17, Melbourne Hearing 4, Supplementary statement of Lidia Conci, RCD.9999.0365.0001 at 0002.
270 Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0004–0008.
271 Exhibit 17-22, Melbourne Hearing 4, Southern Cross Care (SA, NT & Vic) – Response to propositions, RCD.9999.0357.0020 at 0021; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0011.
272 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0011.
273 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0011.
274 Exhibit 17-16, Melbourne Hearing 4, Jennifer Hewitt – Response to propositions, RCD.9999.0327.0001 at 0002.
275 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0005.
276 Transcript, Melbourne Hearing 4, Leanne Beagley, 15 July 2020 at T8156.12–17; Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8108.35–40.
277 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0004.
278 Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8111.18–20.
279 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0013.
280 Transcript, Melbourne Hearing 4, Sunil Bhar, 15 July 2020 at T8151.15–18.
281 Exhibit 17-7, Melbourne Hearing 4, Statement of Mark Silver, RCD.9999.0307.0001 at 0001.
282 Transcript, Melbourne Hearing 4, Sunil Bhar, 15 July 2020 at T8151.25–41.
283 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8170.30–45.
284 Transcript, Melbourne Hearing 4, Josephine Boylan-Marsland at T8301.14–25.
285 Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8288.42–8289.3.
286 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0022.
287 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8190.2–43; Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8139.35–47; Exhibit 17-16, Melbourne Hearing 4, Jennifer Hewitt – Response to propositions, RCD.9999.0327.0001 at 0002.
288 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0006 [48].
289 Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0006 [48].
290 Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8139.35–47.
291 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0019 [c]; Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8190.28–43; Exhibit 17-16, Melbourne Hearing 4, Jennifer Hewitt – Response to propositions, RCD.9999.0327.0001 at 0002 [4vii].
292 Transcript, Melbourne Hearing 4, Nicole Stormon, 16 July 2020 at T8190.28–43.
293 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0019 [13c].
294 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8287.27–32.
295 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0012 [15c].

296 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0019.
297 Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0005 [23].
298 Exhibit 17-11, Melbourne Hearing 4, Statement of Kathleen Matthews, RCD.0000.0302.0001 at 0008; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0015 [22d].
299 Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8279.46–8280.5.
300 Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0015 [22d].
301 Transcript, Melbourne Hearing 4, Janet Wallace, 15 July 2020 at T8171.39–8172.1.
302 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0021–0022.
303 Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0012.
304 Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon RCD.9999.029.0001 at 0010 [21].
305 Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0021–0022.
306 Exhibit 17-16, Melbourne Hearing 4, Jennifer Hewitt – Response to propositions, RCD.9999.0327.0001 at 0002.

20. Sydney Hearing 2: The Response to COVID-19 in Aged Care

20.1 Hearing overview

20.1.1 Introduction

We examined the aged care sector's response to the COVID-19 pandemic at a public hearing held in Sydney, New South Wales, from 10 to 13 August 2020. This hearing explored what could be learned to enable the aged care sector to better prepare for and respond to future outbreaks of COVID-19, future pandemics, infectious disease outbreaks and other emergencies. The two principal areas of focus were preparedness and balancing infection control with quality of life.

During the four-day public hearing, we heard oral evidence from 27 witnesses and received a total of 273 documents into evidence. The witnesses included direct experience witnesses, infectious disease experts, and representatives of approved providers, unions and the Australian and State Governments. This was conducted as a virtual hearing with all witnesses giving evidence remotely by video link.

Between the announcement of our inquiry into COVID-19 on 14 May 2020 and the hearing, the number of positive COVID-19 cases in Victoria increased exponentially. Between 8 July 2020 and 10 August 2020, there were 1221 new cases among residents of Victorian aged care facilities. By 10 August, 189 residents in Victoria were reported as having died.[1] We did not have the resources or time to conduct a full inquiry into the impact of COVID-19 on aged care in Victoria, but some witnesses in the hearing were able to give evidence about the unfolding situation there. These included Ms Diana Asmar on behalf of the Health Workers Union, and Ms Julie Kelly, a psychologist offering psychological services to residents in Victorian facilities.

Counsel Assisting prepared written submissions at the conclusion of the hearing.[2] There was an opportunity to provide submissions in response. Post-hearing submissions were received, and parties with leave to appear were given an opportunity to respond to these. On 30 September 2020, following this hearing, we published *Aged care and COVID-19: a special report*. In that report, we identified four areas where immediate action ought to be taken to support the aged care sector.

In this chapter, we outline the evidence we heard about the impact of COVID-19 on those receiving aged care, the preparedness of the aged care sector, and the lessons from the outbreaks in NSW facilities in early 2020.

20.1.2 The impact of COVID-19 on older people

COVID-19 is a public health crisis that has disproportionately affected aged care in Australia. COVID-19 is caused by the virus SARS-CoV-2, and is a highly contagious respiratory virus.[3] As Professor Mary-Louise McLaws, Professor of Epidemiology, University of New South Wales explained:

> It is an envelope virus meaning it is relatively easy to inactivate from contaminated hard surfaces with detergent and water, alcohol based hand rub (ABHR) (at least 75% isopropanol or 80% ethanol) or a bleach solution. The difficulty is when a patient is shedding the virus the high-touch surfaces, hands and uniforms of carers continue to become contaminated. The virus is predominantly spread by 'direct' spread (i.e. person-to-person) via droplet size particles expelled from the airways of an infected person in saliva, coughing, sneezing, singing, possibly breathing and speaking. After exposure to SAR-CoV-2 on average 15% (range 12%–18%) will not develop symptoms (asymptomatic). Therefore, 85% will develop symptoms by days 3-5 after exposure. Droplets from a positive person can remain suspended in the air for many seconds.[4]

Older Australians are considered to be a high risk group for contracting COVID-19, with the highest risk of death following contraction of the disease.[5] Residential aged care facilities have certain features that can make it difficult to prevent and respond to an outbreak of COVID-19. Many older people living in residential aged care facilities live in close proximity.[6] Residents can frequent communal dining and lounge areas.[7] Some facilities have shared bathrooms.[8] Residents are cared for by workers who provide services for multiple residents and sometimes at multiple facilities.[9] Facilities are often understaffed and under resourced.[10] Many aged care workers are only trained to deliver care needs, and are not trained to deliver the clinical care required for a pandemic.[11]

Ms Kathy Dempsey, Clinical Excellence Commission, NSW Health, told us that health care is 'very regimented' and strategic with infection control, whereas aged care is a 'balance between infection control and providing a homely and inviting environment and often the two don't match when things are going wrong'.[12] She pointed to things like design, soft furnishings, books, flowers and personal belongings which are present in aged care, and which all 'add to the microbial footprint when you are trying to manage and reduce the spread of infections'.[13]

By the first day of the hearing, 168 people living in residential aged care in Australia had died due to COVID-19.[14] As at 13 September 2020, there had been 593 deaths of people living in residential aged care due to COVID-19.[15] This represented approximately 73% of all of Australia's COVID-19 related deaths to that date.[16]

The pandemic resulted in a number of measures imposed to protect older people, particularly those living in residential facilities. These measures have gone beyond those imposed on the rest of the population and very often have been the cause of human tragedy. Residents across Australia have been subject to restrictions on visitation for much of 2020.[17] The States and Territories have issued public health directions which have impacted on visitors to aged care homes. Aged care providers have imposed restrictions in line with these directions. Some providers have elected to impose stricter restrictions on visitation rights in an attempt to halt the spread of COVID-19.

Ms Virginia Clarke told of her experience when her father, a resident of Newmarch House, tested positive to COVID-19. After an outbreak on Easter Sunday, Ms Clarke received a phone call to say all residents, including her father, would be tested for COVID-19. Despite calling multiple times the following week, Ms Clarke only found out by accident that her father had tested positive on Friday 17 April 2020. On Sunday 19 April 2020, he died in the facility. Ms Clarke had not seen her father for more than a month before he died due to the visitation restrictions at the facility.[18]

Ms Clarke described the shock she felt when she discovered her father had tested positive.[19] She told us that she could not get answers to her questions, and that there was a lack of communication and support from the facility during and after her father's death.[20] Ms Clarke described the turmoil she felt when she realised that her father did not seem to have been told by staff that he had tested positive to COVID-19, and that she did not want to upset him by telling him herself over the phone because he was isolated by himself, alone in his room.[21] In its submissions, Anglicare Sydney acknowledged communication failures during the outbreak, including those experienced by Ms Clarke and endorsed the apology of Mr Grant Millard, Chief Executive Officer of Anglicare Sydney, for those failures that 'amplified the distress and trauma suffered by the residents and their families and friends'.[22]

While imposed to keep residents safe, such restrictions inevitably have consequences for the physical, mental and emotional health and wellbeing of residents. For the families of residents, the inability to see, touch and hug their loved ones has often been devastating, particularly given it comes at a time when fear for the health and safety of older people is widespread.[23]

Ms Merle Mitchell AM told us about her experience as a resident of an aged care facility in Victoria which had been locked down since February. Ms Mitchell said of the lockdown, 'from the time I wake up to the time I go to sleep, I'm sitting in my own room in my one chair', with her only view that of a brick wall.[24] Social activities in her facility such as bingo and crosswords were continuing, but meals were now delivered to residents in their rooms.[25] Ms Mitchell told us that at the time of the hearing, she had seen her daughter twice during lockdown; once in a room with a glass partition, and more recently for Ms Mitchell's birthday through a window opened a crack to speak through.[26]

Ms Mitchell gave evidence about how the lockdown meant she could no longer visit friends, or receive the massages which were part of her care plan.[27] Ms Mitchell described the decline she witnessed in residents living with dementia, who she believed do not understand why their families are no longer visiting them. She acknowledged the success of her facility in keeping the virus out, but asked 'at what cost?'[28]

Visitor restrictions

A witness given the pseudonym 'UY' described the effect of visitation restrictions on her father, who died in residential aged care during a lockdown. UY was an informal carer for her father, who had become non-verbal with motor neurone disease and dementia.[29] UY described her father as an Italian man for whom family connection was everything,

who had come to rely on physical touch to communicate.[30] We heard that before lockdown she visited almost every day to take him outside for the walks he loved, and played games with him to keep his brain active.[31]

UY told us that the restrictions imposed at her father's facility from the end of March allowed for window visits where family members had to wear masks. Eventually, the facility allowed visits in a converted hairdressing salon where family would be separated by a glass partition.[32] UY said that with the ability to hug and shake hands with his family taken away, she thought her father looked very confused during their visits in the salon.[33] UY said that she did not want him living like that.

By mid-May 2020, UY believed her father had deteriorated significantly.[34] On 6 June 2020, UY's father went to sleep and did not wake up. He died six days later. UY told us that she believed 'Dad gave up wanting to live because his family support and connection was disconnected'.[35] UY has called for aged care facilities to allow key family members to continue to visit and care for their loved ones during lockdowns. She told us that an aged care facility 'will never replace the love and connection a family can give'.[36]

BaptistCare described isolation from loved ones, other residents and other key supports as 'the most significant issue experienced by residents' during the outbreak at Dorothy Henderson Lodge.[37] Opal Aged Care acknowledged the impact of visitor restrictions on relatives and representatives of residents in its facilities, particularly for those relatives who usually provided daily care support for residents with specific needs.[38] The South Australian Department of Health said that restrictions on visitors had reduced the ability of family and other advocates to have regular oversight of the quality of care that residents were receiving, most significantly at facilities which had been placed into complete lockdown.[39]

Since COVID-19 cases first occurred in Australia early in 2020, the ability of people to visit residents of aged care facilities has been a contested issue. We heard of inconsistencies and a lack of clarity regarding visitation guidelines between State and Territory Governments and the Australian Government.[40] Ms Janet Anderson PSM, Commissioner, Aged Care Quality and Safety Commission, said that restrictions on visitation have had 'both a positive and negative impact on residents' quality and safety of care', and have caused distress to families.[41] Between January and 30 June 2020, the Commission received 4691 complaints, with a significant number of these attributed to the pandemic.[42] One of the most common issues raised was visitation.[43]

Mr Jonathan Anderson, Opal Aged Care's NSW South Regional General Manager, described the 'overwhelming' feedback from residents and their families that all they wanted was to 'keep their loved one safe'.[44] On the other hand, Dr Stephen Judd, Chief Executive Officer, HammondCare, reported that a HammondCare survey of residents and families confirmed that most preferred to stay open to visitation, even if it presented a risk.[45] Ms Angela Raguz, Registered Nurse, General Manager of HammondCare, told us that 'underestimating the *physical* impact on people of not seeing people who they love, that's a mistake'.[46] She spoke of the need to balance and manage the risk.[47] Mr Michael Lye, Deputy Secretary for Ageing and Aged Care at the Australian Department of Health,

similarly described the 'delicate balance' that needed to be achieved, and noted that he was not aware of any cases where visitation had resulted in a case of COVID-19 within a facility.[48]

Some provider witnesses described the measures they implemented to strike a balance between COVID-19 precautions and other parts of life that contributed to the health and happiness of residents. Dr Judd told us that HammondCare made the decision to continue allowing visitors into their facilities to see residents because 'we thought it [the pandemic] was going to be a marathon, not a sprint', and that the approved provider believed restricting visitation would have a very 'bad impact' on its residents.[49] HammondCare set up a concierge service early on to coordinate and screen visitors. This service was staffed by corporate staff and volunteers, which relieved the pressure on front line workers.[50] HammondCare intended to continue this service unless directed to stop by a public health order.[51]

As the pandemic progressed, a code regarding visitation arrangements was developed by the aged care sector.[52] The Industry Code for Visiting Residential Aged Care Homes during COVID-19 (the Code) was published on 11 May 2020.[53] The Code was voluntary and therefore not binding on approved providers.

Witnesses told us that the successful implementation of initiatives to support visitation, including the measures set out in the Code, required resources and was dependent upon adequate staffing.[54] Ms Annie Butler, Federal Secretary, Australian Nursing and Midwifery Federation, and Ms Carolyn Smith, Aged Care Director, United Workers Union, each described a lack of acknowledgement of the increased staffing numbers required to support the measures in the Code.[55]

Ms Butler explained that the staffing needed to support the Code's approach 'just comes off the floor, increasing the workload and burden…for the existing staff'.[56] This extra pressure on the workforce was in addition to what Ms Smith described as the 'heavy burden' felt by care workers to provide the care that residents have been lacking due to missing out on regular family visits.[57] Some providers had increased staff numbers to meet these additional needs. But according to the evidence of union surveys, many providers had reduced staff numbers.[58]

However, the evidence indicated that there are some measures that can be taken to facilitate visitation, such as running a concierge service, as mentioned above, and running training programs for family members on infection control and the use of personal protective equipment.[59]

Professor McLaws stated that a:

> 'lock-down' can only be made humane if visitors are given a roster, routinely screened and wear a face shield (so the elderly residents can see their families and assist with hearing them), and perform hand hygiene then are placed behind a Perspex screen for visitations in a well ventilated room or outside (weather permitting). An alternative given to residents is the choice of moving into their family's household.[60]

Mental and allied health care

Two allied health professionals gave evidence about the impact of COVID-19 related measures on the health and wellbeing of residents in many aged care facilities, not just those in facilities managing a COVID-19 outbreak. Ms Julie Kelly is a registered psychologist and art psychotherapist who delivers services to people in residential aged care facilities in south-east Melbourne. Mr Rik Dawson is a gerontological physiotherapist and a director of the Australian Physiotherapy Association, members of which provide services across Australia.

Ms Kelly said she had seen increased levels of depression, anxiety, confusion, loneliness and suicide risk in aged care residents.[61] She told us that the cause of these increased rates of mental health concerns depends on the individual, but included factors such as missing their family, changed routines, concern about catching the virus and fear of being isolated in their rooms.[62]

Mr Dawson expressed concern about reduced mobility as a result of COVID-19 restrictions, and the long-term consequences of this. He said that particularly in Melbourne, people living in residential aged care were not doing the common incidental exercise that occurs when they undertake the usual activities of daily living.[63] He explained that this reduced activity means that older frail people 'deteriorate very quickly', losing their muscle strength which rapidly leads to a loss of balance and increased falls.[64] In its submission, the Australian Physiotherapy Association highlighted concerning early data from Western Australia which suggested a marked increase in hip fractures among elderly people during the three months to 30 June 2020.[65]

There is a risk that these health impacts will have long-term ramifications for residents. As Mr Dawson said, once frail older people lose their mobility, it may never return. He stated that once an older person loses their ability to walk, it is highly likely 'they won't walk again, because older people don't have the bounce back that a lot of us younger people have'.[66] Mr Dawson described the challenges that COVID-19 measures have posed for maintaining the mobility of aged care residents:

> 50 per cent of people in a nursing home need physical assistance, staff assistance, to get out of bed, to get out of a chair and walk. And what we are seeing is the response to managing infection in facilities that have had outbreaks. It's just the care staff don't have the time to devote to help these people move and walk. And unfortunately, we as physios are not there generally to help them do that; we're there to deliver massage, essentially. So it's a missed opportunity in some ways that we're a workforce there that could be enabling people to reduce the harm of this physical inactivity that's a response to COVID.[67]

In its submission, Opal Aged Care recognised the effect of COVID-19 measures on residents' mobility. Opal highlighted that individual care plans should be in place to 'manage conditioning throughout the lockdown and to support reconditioning when isolation is lifted'.[68] It referred to this as 'one of the most important considerations in resolving outbreak situations promptly and effectively'.[69]

Mr Dawson and Ms Kelly also told us that the restrictions have had an impact on the ability of allied health professionals to provide services at a time when there was increased need. The Australian Physiotherapy Association described the effect of visitation restrictions on the delivery of physiotherapy services:

> Residential aged care facilities (RACFs) locked external (privately funded) physiotherapists and other allied health practitioners out. Large healthcare providers (who provide almost 100% of residential aged care physiotherapists and many other allied health staff) and their employees scrambled to adapt to new rules restricting physiotherapists and other allied health practitioners to working at one site only in a bid to reduce transmission.[70]

Mr Dawson said that while the Code had helped, at the time of the hearing there were still a number of residents who were not getting access to services because of the perceived risk of infection.[71] In addition, physiotherapists are often only paid by providers through the Aged Care Funding Instrument to provide a limited range of pain relief services, and not the mobility work that Mr Dawson explained was urgently needed.[72] The Australian Physiotherapy Association also highlighted the impact of COVID-19 on delivery of allied health to those receiving home care services, as a result of high rates of cancellation of physiotherapy appointments due to clients' fear about COVID-19 transmission.[73]

Ms Kelly told us that her team could no longer work across multiple sites due to the risk of cross-contamination, which meant they needed to use telehealth at a number of facilities.[74] She explained that she experienced variability in the way residential aged care facilities responded to the first phase of COVID-19 lockdowns, with some seeing psychologists as essential workers and others requesting that they return once the restrictions were lifted.[75] Ms Kelly said that, with Stage 4 restrictions in place in Victoria, her business was considering increasing the use of telehealth and only providing services on site to those who were clinically high risk.[76]

In reflecting on its experience of a COVID-19 outbreak, BaptistCare described access to mental and allied health as 'difficult' during the outbreak.[77] BaptistCare encouraged a review of the provision of these essential services in such circumstances to improve ongoing access.[78]

20.1.3 The impact on the aged care workforce

The COVID-19 pandemic has also affected aged care workers. We heard that nurses and personal care workers must work in close proximity to residents who are, or may be, COVID-19 positive. They perform intimate tasks which place them at risk of catching the virus.[79] During the Dorothy Henderson Lodge and Newmarch House outbreaks, it was recognised that some of these tasks involved risks of transmission of COVID-19 to workers.[80] Mr Millard acknowledged that those working at Newmarch House made 'personal sacrifices to put themselves into harm's way'.[81]

Union surveys and accounts provided to the Royal Commission detail multiple examples of insufficient supplies of personal protective equipment and a lack of relevant training for the workforce.[82] Almost half of all Australian Nursing and Midwifery Federation members surveyed between 15 April and 6 May 2020 reported a lack of access to adequate supplies

of personal protective equipment.[83] Ms Diana Asmar, Secretary of the Health Workers Union, referred to a guideline in place at a residential aged care facility that only permitted the use of two masks per shift.[84]

In addition to shortages of supply, witnesses also described challenges associated with insufficient training and experience in the use of personal protective equipment.[85] Ms Asmar told us that personal care workers receive no training on the use of personal protective equipment as part of their certification.[86] Ms Butler, of the Australian Nursing and Midwifery Federation, agreed that personal care workers would have 'incredibly varied' and in many instances 'way too little' understanding of infection prevention and control principles.[87] She told us that, in comparison, the training that graduate nurses receive provides them with a working knowledge of infection prevention principles and universal precautions, including the use of personal protective equipment.[88]

Ms Smith, Western Australia State Secretary of the United Workers Union, described the extent of training in the use of personal protective equipment across the sector in response to COVID-19 as 'completely inadequate' and 'neglectful'.[89] Mr Lye, of the Australian Department of Health, told us that there was an expectation that aged care workers had a proficiency in the use of personal protective equipment. However, he agreed that training about the use of personal protective equipment should be compulsory and of a much higher standard.[90]

We heard that many aged care workers are employed on a casual basis and work in multiple facilities. Ms Asmar explained that it is common for Health Workers Union members to be working three or four low paid jobs across multiple facilities 'to make ends meet'.[91] Professor McLaws emphasised how this practice increases the risk of spreading the virus.[92] We were told that some aged care workers have been restricted from working across multiple facilities by providers instigating a 'no secondary employment' policy or a blanket restriction on workers having more than one job.[93] Ms Asmar explained that the impact on workers has been reduced work hours. She said that those with leave have had their entitlements depleted and experienced 'a significant loss of income'.[94]

We heard that the pandemic has increased the workload for staff of residential aged care services, even for those that have not experienced an outbreak. A number of witnesses described the increased time taken to deliver daily care due to the use of personal protective equipment, in particular appropriate donning and doffing procedures.[95] Witnesses also spoke of the workload arising for staff in conducting screening and other measures associated with visitors attending services.[96] In addition, workers have been picking up the role of informal care and support that visiting family and friends usually provide to residents.[97]

We heard that the increased workload was particularly apparent in services experiencing an outbreak, due to increased care needs, resident isolation requirements and staff shortages.[98] In its written submissions, Anglicare Sydney explained that, particularly in the early stages of the outbreak at Newmarch House, 'even simple care tasks took five times as long' in personal protective equipment. This exacerbated the acute staffing shortage.[99]

Witnesses told us that the collective effect of these factors is a workforce, particularly in Victoria, that is overworked and traumatised.[100] In addition, many aged care workers are grieving for residents who have died after contracting COVID-19, and others are worried about potentially taking the virus into their work place or home to their loved ones.[101] The panel of union representatives were asked about recent initiatives introduced in Victoria in response to the COVID-19 outbreaks to provide funding for enhanced mental health support for nurses and personal care workers in the aged care sector, particularly access to counselling services. While Ms Butler and Ms Asmar each welcomed these recent initiatives, Ms Asmar pointed out that cleaners of aged care facilities and other workers who have relationships with residents were ineligible for this support.[102]

In their evidence, the union representative witnesses were asked about the introduction of the Pandemic Leave Disaster Payment by the Australian Government. Ms Butler and Ms Asmar explained that the majority of members of their respective unions working in aged care were covered by enterprise bargaining agreements and are not eligible for the leave payment.[103] Other workers have been required to exhaust all annual leave, sick leave and long service leave before being eligible for paid pandemic leave.[104]

Ms Smith told us that aged care workers are suffering significant economic hardship and described these workers as 'overworked and bearing the economic brunt of this pandemic'.[105] Ms Butler told us that to prevent and contain this outbreak:

> we need full paid pandemic leave for everybody so that people are stopped from going to work when they have even the slightest of symptoms, that they're supported and that they don't have to make a choice between food on the table and…the loss of money.[106]

20.1.4 The Australian Government's preparedness

A central issue explored was the preparedness of the aged care sector to respond to COVID-19. COVID-19 is a novel virus about which experts' understanding continues to evolve.[107] The risk of an outbreak of COVID-19 in an aged care home is extremely high even with very low rates of community transmission.[108] People aged 80 years and over who contract COVID-19 have the highest risk of death, followed by those aged between 60 and 70 years.[109]

We heard from the Australian Nursing and Midwifery Federation and from Professor Joseph Ibrahim, Head of Health Law and Ageing Research Unit at Monash University, that they had raised concerns about the sector's lack of preparedness for COVID-19 and offered solutions.[110] One aspect that was explored in this context was whether there was a COVID-19 plan for aged care, whether there should be such a plan, and what it should address.

The Australian Government is responsible for system governance, policy, funding and regulation of aged care, while the State and Territory Governments have frontline responsibility for public health, and have command responsibility in a health emergency.[111] The Australian Government addressed the 'planning and readiness work' carried out by the Australian Department of Health and the Aged Care Quality and Safety Commission to prepare for the COVID-19 pandemic at length in its submissions.[112]

The Health Sector Plan

There was a national COVID-19 plan that the Australian Government sought to adapt and apply to the aged care sector. That plan, the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* (Health Sector Plan), was developed in January 2020 and published on 18 February 2020. On 27 February 2020, it was activated by the Prime Minister in anticipation of a pandemic.[113] The Health Sector Plan was developed against the background of the National Health Emergency Response Arrangements which had been in place since 2011 and provided a 'whole-of-government response to significant national health emergencies, including pandemics'.[114]

The Health Sector Plan was a 56 page document that set out different scenarios that required responses; governance arrangements; decision making and consultative arrangements; and communication and coordination arrangements.[115] It adapted an existing document, the Australian Health Management Plan for Pandemic Influenza, to set out an 'Operational Plan' which provides additional detail to support the implementation of activities under the COVID-19 health sector plan at an operational level.[116]

The health sector plan noted that 'The Australian Government will also be responsible for residential aged care facilities; working with other healthcare providers to set standards to promote the safety and security of people in aged care and other institutional settings; and establishing and maintaining infection control guidelines, healthcare safety and quality standards.'[117] It also set out the role of State and Territory Governments in establishing 'systems to promote the safety and security of people in aged care and other institutional settings' in the context of their responsibility for the 'operational aspects of public health responses'.[118]

There were a number of other references to the aged care sector in the health sector plan, but there was no detail. Indeed, the plan noted that 'additional strategies' may be required to support aged care.[119] The health sector plan stated that aged care is a high-risk area, but it did not deal with known gaps in the aged care system and did not address what needed to happen in aged care.

The Communicable Diseases Network Australia Guidelines

On 13 March 2020, two days after the World Health Organization had declared the pandemic, the Communicable Diseases Network Australia (CDNA) released its *National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia* (CDNA Guidelines).[120] The CDNA Guidelines were updated on 30 April 2020 and on 14 July 2020.[121] Dr Brendan Murphy, who was Australia's Chief Medical Officer until he left this role on 26 June 2020 to become Secretary of the Australian Department of Health, described these guidelines as 'the fundamental foundational plan'.[122]

The CDNA Guidelines, like the health sector plan, were based on 'previous work on Influenza Outbreaks in Residential Care Facilities in Australia'.[123] Professor Ibrahim gave evidence that the CDNA Guidelines are not a plan for the sector.[124] He said 'I can't overemphasise that the CDNA plan is a plan for an individual facility. It is not a plan for the country.'[125] The Australian Nursing and Midwifery Federation submitted that a COVID-19 response plan for aged care should address:

> (a) gaps in workforce numbers and training, including the likelihood that more staff would be necessary to deliver care during the pandemic;
>
> (b) access to personal protective equipment and training in its proper use;
>
> (c) a lack of clinical skills, especially in infection control;
>
> (d) deficits flowing from the absence of skills related to infection control in the case of personal care workers that are taken for granted in the health sector;
>
> (e) the challenges of achieving high level infection control in a homelike setting;
>
> (f) deficiencies in governance and managerial ability;
>
> (g) the significant operational differences between aged care facilities and hospitals;
>
> (h) the challenges associated with the interface with the State health sector.[126]

The first and second versions of the CDNA Guidelines did not identify the Australian Government as having a role in the aged care system that it funds and oversees. Mr Lye explained that it was unnecessary to make any reference to the role of the Australian Government in the document because it was a Commonwealth document, but accepted that the Commonwealth's role 'probably needed to be made explicit'.[127] It was not until the third version of the CDNA Guidelines was published in July that the role of the Australian Government was set out.[128] The role was described at a very high level.[129]

In its submissions, the Australian Government stated that the role of the Australian Department of Health was added to the third version to 'provide greater clarification on each entities' role, including clarifying the primary role of States and Territories'.[130] The Australian Government further explained that while the role of the Australian Department of Health could have been more expressly identified in the previous versions, the description included in the third version reflected the work it had performed since 11 March 2020.[131] It pointed out that its absence from the previous versions did not mean that it was not working actively to respond to an outbreak. These services included:

> (a) allocation of a State-based 24/7 case manager who will connect the service provider to all available Commonwealth support;
>
> (b) access to, if requested, a nurse first responder (through Aspen Medical) who can assess infection prevention and control and ensure this is robust, provide ongoing oversight and training;
>
> (c) surge workforce support including clinical and non-clinical staff; and
>
> (d) access to primary health care including GPs [general practitioners] and allied health services via Primary Health Networks.[132]

The advisory role of State and Territory governments to residential care facilities is summarised in the CDNA Guidelines. The CDNA Guidelines also state that the primary responsibility for managing COVID-19 outbreaks lies with the residential aged care facility.[133] However, the guidelines did not contain a description of how the various levels of government would interact or who would be responsible for making decisions, for example about residents who test positive to COVID-19.

The aged care regulator

The Australian Government's submissions set out in detail the activities of the Aged Care Quality and Safety Commission in relation to the COVID-19 pandemic.[134] The evidence we heard in relation to Newmarch House and Dorothy Henderson Lodge suggested that the Aged Care Quality and Safety Commission was involved in responding to those outbreaks. It was also apparent that it has published a volume of material over the course of the pandemic.[135]

The Australian Government noted that the Aged Care Quality and Safety Commission contacted 878 aged care providers by telephone in March and 'asked them to explain what their response had been to the CDNA Guidelines and the Australian Health Protection Principal Committee guidance on visits to residential aged care services'. It stated that these responses were 'risk rated' and informed further monitoring and other regulatory activities including site visits.[136] On 20 March 2020, the Aged Care Quality and Safety Commission asked residential care providers to complete an online self-assessment survey on their preparedness.

In relation to the self-assessment survey, Professor Ibrahim commented:

> I do not know how many completed the self-assessment and what information was received by the Commission. My observation of human behaviour is that providers would have been unlikely to provide a full and frank response, due to a fear of receiving a sanction. The questions asked are relatively broad and do not provide any guidance to assist with problem identification or suggested solutions.[137]

According to the Aged Care Quality and Safety Commission's summary of this self-assessment, 42.7% of facilities rated themselves best practice, 56.8% rated themselves satisfactory, and 0.5% rated themselves as in need of improvement.[138] Newmarch House assessed its readiness in the event of a COVID-19 outbreak at the service as best practice.[139]

Ms Erica Roy, General Manager of Service Development and Practice Governance at Anglicare Sydney told us that, in hindsight, this assessment was not accurate because it was based around the CDNA Guidelines, which treated 'COVID-19 as a flu-like illness'.[140] Ms Roy said that COVID-19 is a much more virulent virus than the flu and the contingencies in the self-assessment around preparing for loss of staff did not anticipate the true number of staff that could be lost in the event of an outbreak.[141]

The Aged Care Quality and Safety Commission did not conduct risk profiling from available government data. The risk profiling could have addressed resident vulnerability based on information about age, persons with dementia and care classification; the

facility's vulnerability based on information about performance, complaints and physical environment; and the organisation's response capability factoring in matters such as proximity to public hospitals and staffing levels.[142]

In response to Professor Ibrahim's comments about the need for a national audit of residential aged care facilities, the Australian Government submitted:

> During April 2020, the ACQSC [Aged Care Quality and Safety Commission] analysed the results of the residential services survey responses, together with information received through the telephone contacts, complaints information and other intelligence to determine the appropriate regulatory responses. This analysis resulted in a revised risk rating for all residential services and informed the ACQSC of required monitoring and regulatory activities. As a result of the revised risk ratings, the ACQSC has conducted 31 additional site visits and undertook additional telephone monitoring assessment contacts to follow up on risks identified.[143]

We heard that if in monitoring a residential aged care facility, an employee of the Aged Care Quality and Safety Commission found out about a COVID-19 outbreak, that information should routinely be conveyed to the Australian Department of Health immediately to ensure the approved provider met its responsibilities to report under the 'First 24 hours' document.[144] When questioned by Senior Counsel Assisting, Ms Anderson could not explain why such information was not conveyed when it came to the attention of one her employees in a particular case in Melbourne in July.[145] She explained that the Commission has 'now put in place an arrangement to ensure that happens routinely'.[146]

20.1.5 The first two outbreaks in NSW

Dorothy Henderson Lodge, operated by BaptistCare NSW/ACT, was the first Australian residential aged care facility to experience a COVID-19 outbreak. It is an 80-bed facility which employed 78 staff (60 permanent and 18 casual).[147] BaptistCare told us that on 3 March 2020, a personal care worker employed by BaptistCare and working at Dorothy Henderson Lodge was diagnosed as COVID-19 positive.[148] By 6 March 2020, four residents and two more staff members had tested positive.[149] On 7 May 2020, nine weeks later, the outbreak was declared over.[150] By this time, of the 16 residents who had tested positive, six had died.[151] Five staff members had tested COVID-19 positive and all had recovered.[152]

In its submission, BaptistCare noted:

> We were the first Australian aged care provider to experience an outbreak of COVID-19. The death of our first resident was the second Australian death from COVID-19. Together with the Australian community we were witnessing a rapidly escalating international pandemic. The news cycle was increasingly dominated by reports highlighting how vulnerable older people and people living in aged care were to contracting and developing serious complications from COVID-19. This created uncertainty and fear of the virus, and significantly impacted our residents, our staff and their respective families.[153]

A month before the Dorothy Henderson Lodge outbreak was declared over, on 11 April 2020, a staff member employed by Anglicare Sydney at Newmarch House was diagnosed as COVID-19 positive.[154] Newmarch House is a residential aged care facility licensed for 102 beds and at the time of the outbreak, had 97 residents.[155] Newmarch House contained three connected buildings with each building representing a wing of residence,

known as Lawson, Wentworth and Blaxland.[156] The Wentworth wing contained a 16-bed dementia-specific wing known as Wentworth Heights.[157] The outbreak at Newmarch House was declared over on 15 June 2020.[158] At this time, a total of 71 individuals had tested COVID-19 positive. Thirty-seven of these people were residents who had tested COVID-19 positive, of whom 19 had died. Seventeen deaths were attributed directly to COVID-19.[159] A total of 34 staff had tested COVID-19 positive, all of whom recovered.[160]

On 6 May 2020, the Aged Care Quality and Safety Commission issued a statutory notice to Anglicare Sydney requiring it to agree in writing to four conditions within 24 hours, failing which Anglicare Sydney faced revocation of its approved provider status (Notice to Agree).[161] The Commission had taken earlier regulatory action against Anglicare Sydney from 23 April 2020, including issuing a non-compliance notice on 3 May 2020.[162] In the Notice to Agree, the Commissioner's delegate stated that because of Anglicare Sydney's non-compliance, he was satisfied that there was an 'immediate and severe risk to the safety, health and wellbeing of care recipients at the Service'.[163] The Notice to Agree referred to concerns about whether the provider had 'suitable processes and systems in order to control transmission of the virus at the service'.[164] In its most recent accreditation audit in September 2018, Newmarch House passed all 44 expected outcomes, including Standard 4.7 for infection control.[165] Newmarch House had rated its readiness in the event of a COVID-19 outbreak as 'best practice' when responding to the survey by the Commission in March 2020.[166]

Learning from outbreaks

As Dr Murphy said, 'There is no rule book for this pandemic. There is no rule for this virus. We are learning more about it all the time.'[167] As Opal Aged Care observed:

> Learning from COVID-19 outbreaks should be shared widely to ensure that person-centred care, rapid response, decision making, collaboration and shared accountability is informed by lived experience, and sector capability is strengthened for the benefit and protection of people living in aged care and the community.[168]

BaptistCare, Opal Aged Care, Anglicare Sydney and HammondCare all provided submissions that outlined the lessons from their experiences. BaptistCare held a live streamed training and education session for BaptistCare workers with Dr James Branley, Head of Diseases, Nepean Hospital and Ms Kathy Dempsey, Senior Manager, Healthcare Associated Infections, Clinical Excellence Commission, on or around 9 March 2020 which provided practical guidance to staff.[169] They published those resources on YouTube and Facebook and communicated their availability widely. They also shared their experiences in a number of online seminars.[170] BaptistCare wanted to assist other providers in preparing for an outbreak by sharing its learnings with the sector.[171]

We examined what the Australian Government did to ensure that the lessons of the first two aged care outbreaks in Sydney in March and April 2020 were conveyed to the aged care sector.

The Australian Government commissioned Professor Lyn Gilbert AO, Honorary Professor and Senior Researcher, Marie Bashir Institute for Infectious Diseases and Biosecurity and Sydney Health Ethics, University of Sydney, to undertake a review of the Dorothy

Henderson Lodge outbreak. Her report is dated 14 April 2020.[172] BaptistCare was provided with a copy of the review on 14 April 2020 and submitted, 'The review and the interaction with Professor Gilbert provided us with invaluable information, feedback and expert information about the virus.'[173]

The Australian Government informed us that Professor Gilbert's report was provided directly to the Communicable Diseases Network Australia and Australian Health Protection Principal Committee on 15 April 2020. It was publicly released by the Department on 25 August 2020.[174] The Department also published Professor Gilbert's report on Newmarch House after the hearing.[175]

Beyond these reports, some of the learnings from these outbreaks were incorporated in the third version of the CDNA Guidelines, including:

- the allocation of a case manager to connect the facility to support from the Australian Government
- access to a surge workforce which is no longer limited to Mable Technologies Pty Ltd and Aspen Medical.[176]

In its submission, the Australian Government identified seven key lessons from the Dorothy Henderson Lodge and Newmarch House outbreaks, and outlined in some detail how they had been funded and implemented.[177]

We focus in the following sections on four areas that were exposed by the NSW outbreaks: the clarity of roles and responsibilities, and the need for infection control expertise, realistic workforce planning and the impact on a facility of losing most or all of its workforce. Other lessons that were identified in evidence included:

- Services must have clear, detailed and well-drilled outbreak management plans before an outbreak commences and must provide effective leadership in responding.[178]
- Services must have a communication plan, and dedicated staff to support it, to enable communications with residents, families and staff.[179]
- Residents should have as much contact as they need with friends and families, including by electronic means, and as much access to care and support services including allied health services, as they safely can.[180]
- More should be done to ensure that residents can engage in as many stimulating and meaningful activities as they wish and safely can.[181]
- Residents and approved providers, or their legal representatives, should have access to advocacy services during an outbreak to resolve issues expeditiously.[182]
- Consideration should be given to the size, design and layout of future residential aged care facilities with a view to supporting infection control practices.[183]

Clarity of roles and responsibilities

On 6 May 2020, Mr Millard told the Anglicare Board that 'over the course of the outbreak there has been a frustrating level of dysfunction in the collaboration between Newmarch House / Anglicare management and the numerous government departments, agencies and hospital employees at both Federal and State level…with an interest in management of the outbreak'.[184] He also stated:

> Anglicare has looked to these authorities for their expert advice in dealing with the outbreak, but this advice has often been conflicting. Further, there is a lack of clarity regarding which of these authorities has responsibility for decisions and how this authority intersects with Anglicare's responsibilities under the Aged Care Act to manage the home.[185]

In their report about the outbreak at Newmarch House, Professor Gilbert and Adjunct Professor Alan Lilly similarly concluded:

> Emergency response and interagency operations were characterised by a lack of clarity in the relationships and hierarchy among government health agencies, including Nepean Blue Mountains Local Health District, NSW Health, the Commonwealth Department of Health and the Aged Care Quality and Safety Commission. This created confusion for Anglicare Board and managers, who were unfamiliar with the state agencies and the hierarchy of decision-making in the context of a COVID-19 outbreak.[186]

Anglicare Sydney agreed that there was evidence of confusion between the aged care and health care systems in the response to the outbreak at Newmarch House, 'particularly during the first two weeks of the outbreak'.[187] Anglicare Sydney submitted that there was 'evidence to the same effect in relation to the HammondCare response in Melbourne in mid-May 2020, which indicates that the problem is a systemic one rather than being unique to Newmarch House (or indeed, unique to New South Wales)'.[188]

Dr Nigel Lyons, Deputy Secretary Health System Strategy and Planning, NSW Ministry of Health, gave evidence that the respective roles of approved providers and the Australian and NSW governments were clarified in April 2020.[189] These arrangements were not formalised until 'on or about 23 June 2020', when they were reflected in a joint protocol between NSW and the Australian Government.[190] The purpose of this protocol was to formalise the coordination of government support to an aged care provider in their management of a COVID-19 outbreak in an Australian Government-funded residential aged care facility in NSW.[191] It set out the roles and responsibilities of the Australian Government, aged care providers and various NSW government agencies. It also included governance arrangements and identified 'trigger events'.[192]

Mr Lye agreed that the NSW protocol was helpful in guiding the roles of the Australian and NSW governments in relation to any future outbreaks, but said that the roles and responsibilities in relation to other States and Territories were defined in the CDNA Guidelines, which he described as 'our guiding principle…our touchstone'.[193] On the other hand, Dr Lyons gave evidence that the NSW protocol had been shared with the Australian Health Ministers Advisory Council 'as good practice in how to facilitate fast mobilisation of required government support to an RACF [residential aged care facility] in the event of a COVID-19 outbreak'.[194]

At the time of the hearing, comparable protocols, having regard to jurisdictional differences, had not been entered into between the Australian Government and other States and Territories. Professor Nicola Spurrier, Chief Public Health Officer, South Australian Department of Health and Wellbeing, explained at the hearing that she was not sure if there was a framework document that governed the relationship between the Australian and South Australian governments in relation to aged care.[195] She subsequently confirmed that there was no such protocol.[196] On 7 August 2020, the Prime Minister announced that National Cabinet would work to develop further joint Australian Government and State plans for the aged care response to COVID-19.[197] As the health sector plan noted, 'a clear understanding of the roles and responsibilities between parties responding to a novel coronavirus outbreak will support quick decision making and efficient, coordinated use of resources'.[198]

In its post-hearing submission, the Australian Government outlined the allocation of responsibility during the Newmarch House outbreak. It described the service provider as having day-to-day responsibility for managing the outbreak.[199] NSW Health also said that 'the primary responsibility for the care and wellbeing of residents in RACFs [residential aged care facilities] is that of the provider'.[200]

The Australian Government described the role of the State-based department of health, in this instance NSW Health, during the Newmarch House outbreak as having:

> broad overall responsibility for leading the public health response and supporting Anglicare in executing its role, and had ultimate responsibility for making decisions about how to respond to the outbreak from a public health perspective.[201]

The Australian Government Department of Health was 'responsible for supporting Anglicare's capacity to manage the outbreak, and providing services and assistance including funding for surge staffing'.[202] The aged care regulator was responsible for 'providing regulatory oversight to ensure that the provider remained focused on its responsibilities for ensuring the ongoing quality of care and the safety of residents'.[203]

Mr Millard described the difficulty which Anglicare Sydney had experienced in managing the response during the Newmarch House outbreak, 'given the large number of agencies involved and the early challenges about roles and responsibilities'.[204] We also heard evidence about the lack of control Anglicare Sydney felt they had over the situation, despite the significant responsibility allocated to them.

At Newmarch House, residents were treated according to a policy known as 'Hospital in the Home'.[205] Hospital in the Home involves providing acute or subacute care in the patient's home or in the community as a substitute for in-hospital care.[206] Reflecting on the experience of the Hospital in the Home program at Newmarch House, Mr Millard told the Anglicare Sydney Board on 27 May 2020 that:

> In the event of infection at another home, Anglicare would be far more assertive regarding the most appropriate management of COVID-19 positive residents and would strongly push for these residents to be immediately transferred to hospital.[207]

In its submissions, Anglicare Sydney emphasised the role of government in responding to outbreaks of COVID-19 in aged care, in the context of infection control expertise being available to residential aged care providers. Anglicare Sydney submitted that:

> the pandemic is a public health emergency. Responsibility for public health lies with government, not approved providers of residential aged care. This is particularly so given the highly complex nature of COVID-19 and the continually evolving state of knowledge about the virus and how best to handle outbreaks. Outbreaks of COVID-19 in residential aged care homes, where the residents are far more vulnerable to the virus than the general community, are as much public health emergencies as outbreaks in the community (if not more).[208]

On 25 July 2020, the Australian Government announced the establishment of the Victorian Aged Care Response Centre.[209] The Australian Government submitted that the role of the Centre is to provide additional resources and expertise to assist the Victorian public health units to address the impact on residential aged care in Victoria, in addition to the assistance provided through the Department of Health's Aged Care COVID-19 Taskforce.[210] It submitted:

> Taking this additional step was necessary because of the unprecedented scale of community transmission in Victoria, and the fact that the public health response at the State level was unable to effectively control or respond to the level of transmission without additional assistance. The scale of the community transmission had resulted in multiple outbreaks in aged care facilities, which again, were not being effectively responded to by the State public health system.[211]

The Australian Government has noted in its submission to us that 'work has been done to plan for the establishment of response centres in other jurisdictions'.[212]

Putting local arrangements to one side, Professor Ibrahim gave evidence that there should be a national coordinating body that feeds in to the established structures of the Australian Health Protection Principal Committee and National Cabinet.[213] He said:

> You have a pandemic, therefore you need public health experts. You need an emergency response, you need emergency responders. And it's in an aged care setting where most people die, therefore you need people who know aged care. And so you need to put those four elements together and now you have a taskforce and a group that can do something. Having only half of that will fail.[214]

The Australian Government, on 21 August 2020, announced the establishment of a 'time-limited AHPPC [Australian Health Protection Principal Committee] Aged Care Advisory Group'.[215]

The need for infection control expertise

Ms Melanie Dicks, Regional Operations Manager, Southern BaptistCare NSW/ACT, told us that 'The presentation of COVID-19 and the immediate crisis, particularly in relation to the contact assessment and loss of staff, challenged our infection prevention and control management in a way that we hadn't seen prior.'[216] BaptistCare submitted that the outbreak showed that their infection prevention and control practices need to be modified so that staff are sufficiently prepared for a pandemic situation.[217]

BaptistCare was advised that a staff member had tested positive late on 3 March 2020. On 4 March 2020, infection prevention control specialists from the NSW Clinical Excellence Commission and an infectious disease specialist visited the service and provided specific training on using personal protective equipment to staff before their shift.[218] Professor Gilbert's report, dated 14 April 2020, into the Dorothy Henderson Lodge outbreak stated that BaptistCare was a well-managed organisation, but observed that access to an experienced infection prevention and control specialist was critical in this outbreak.[219]

This approach to the Dorothy Henderson Lodge outbreak may be contrasted with the Newmarch House outbreak. Ms Roy, an experienced registered nurse who held a management role at Anglicare Sydney and provided onsite clinical guidance at Newmarch House during the outbreak, told us that she was unaware of the need for this level of infection control expertise until Ms Dicks from BaptistCare arrived to assist.[220] Ms Dicks stated that she went in to assist Newmarch House on 24 April, after the outbreak had started on 11 April. She said there had been infection control support before she arrived, but she identified a need for more infection control expertise and contacted Ms Dempsey.[221]

In its submission, Anglicare Sydney stated that, in light of the experience at Dorothy Henderson Lodge and with the benefit of hindsight, it 'stood to benefit from having an expert infection control practitioner on site at Newmarch House immediately after the outbreak started'.[222]

Anglicare Sydney described controlling and mitigating the risk of infection at Newmarch House as 'one of the greatest challenges that Anglicare Sydney faced' in its management of the outbreak.[223] Their submission stated:

- personal care workers in the aged care sector generally lack the level of clinical skills, especially in infection control, that are taken for granted in the health sector
- achieving high level infection control in a home-like setting presents challenges
- 'nothing could be more important to help an aged care provider prepare for and respond to a COVID-19 outbreak' than to provide high level infection control expertise early in any outbreak response, to assist with outbreak management plans, to provide training to staff and to provide help on the first day of any outbreak.[224]

Ms Dicks of BaptistCare supported a suggestion that residential aged care services have contact with infection prevention and control experts before and during an outbreak. She said:

> Some sort of documentation and communication of a panel of experts of infection control practitioners that could be accessed to participate in development of emergency plans and then also in the participation of an outbreak, because what you need from that specialist is somebody who will oversee the infection control plan as it commences in the outbreak management documents and planning and then monitoring the implementation of the plan itself. So a panel is a good solution, given that there are so many organisations that may be smaller or regional and access to specialist services are limited.[225]

Professor Gilbert was asked about the difference between the Dorothy Henderson Lodge and Newmarch House outbreaks in terms of the timing when infection control expertise was sought. She described this as an 'important difference'.[226] However, she said:

> The problem is that there aren't an unlimited number of infection control professionals able to provide this advice at short notice…whether there are really enough infection control professionals at the moment to actually do that for every aged care facilities is a little bit difficult to tell.[227]

Professor Gilbert said this was 'something that needs planning in the future'.[228] She observed that it would not be cost effective to have such a professional full-time in every aged care facility, but that there could be a consultant to a facility who trains 'a small number of relatively senior staff, one would hope, and permanent, not a transient workforce, but people who are likely to stay in the facility', and who could then be a resource when they need help or to refresh training.[229]

The Australian Department of Health published the third version of the CDNA Guidelines on 14 July 2020, and prepared a document entitled 'First 24 Hours – Managing COVID-19 in a Residential Aged Care Facility' dated 29 June 2020.[230] The third version of the CDNA Guidelines noted that the Department of Health could facilitate 'access to, if requested, a First Nurse Responder who can assess infection prevention and control and ensure this is robust, provide ongoing oversight and training'. It also noted that a service should establish an outbreak management team in the first 24 hours, which should include an infection prevention and control practitioner, who could be 'an employee skilled in IPC [infection protection and control], an IPC Practitioner organised by the PHU [public health unit] / local health district or a First Nurse Responder'.[231] The 'First 24 Hours' document similarly referred to the role of the Clinical First Responder from Aspen, and otherwise referred to the need to appoint an infection control lead for the service.[232]

The Australian Government noted in its submission that:

> During the COVID-19 pandemic, infection control specialists are organised and engaged by the public health units of each State and Territory. In the case of Victoria, the Department assisted with the provision of such experts given the circumstances…[233]

The need for realistic workforce planning

Evidence at the hearing pointed to workforce challenges when responding to an outbreak of COVID-19 and the need for realistic workforce planning. In the sections that follow we set out the evidence about some of these challenges including the loss of an existing workforce, accessing a surge workforce, and managing the impacts of loss of staff, including the effects on care delivered to residents.

Loss of existing workforce

One of the most significant challenges in managing the NSW outbreaks was the effect of large numbers of staff being unable to attend the service from the outset due to having potentially been infected with COVID-19.[234] In addition, Opal Aged Care noted that some of its team 'understandably, were reluctant to work due to anxieties about COVID-19'.[235]

Dorothy Henderson Lodge lost almost its entire workforce within the first 48 hours.[236] BaptistCare noted:

> On commencement of the outbreak and following contract tracing, MoH [Ministry of Health] directed 11 staff to self-isolate. Within a further 48 hours and following additional contact tracing, MoH directed that a further 64 staff self-isolate. This was almost the entire workforce of DHL [Dorothy Henderson Lodge]. Other staff who were on leave at the time were not required to self-isolate but were unavailable to assist. The loss of the majority of the home's workforce was not contemplated in our crisis and emergency management plans.[237]

BaptistCare also raised the likelihood of increased staffing requirements during an outbreak:

> The outbreak also required a significant increase in staff above levels usually employed at the home. This was due to the separation and isolation of residents avoiding the deployment of staff across more than one accommodation wing to minimise cross infection risks, the additional time needed to change PPE [personal protective equipment] between interactions with residents and managing our medication management system.[238]

Within two days of the outbreak at Newmarch House, the facility had lost 40 staff members (34%) who had to be stood down due to close contact with positive COVID-19 cases.[239] Within a week, Newmarch House had lost 87% of its workforce 'who were the carers known to and trusted by the residents'.[240] Mr Millard gave evidence that Newmarch House's outbreak management plan had assumed a 30 to 40% loss of staff based on 'what we understood to be conservative provisioning'.[241] He said:

> As part of its COVID-19 preparedness, Anglicare Sydney had established a surge workforce. But it quickly proved simply not to have enough people in it, once many of those workers themselves were required to be removed from the site due to infection or exposure to COVID-19.[242]

Mr Millard gave evidence that planning on the basis of 30 to 40% of staff loss in an outbreak was commonly accepted in the industry, but turned out to be 'totally unrealistic'.[243]

The Australian Government submitted that it 'recognised from the earliest stages of its planning for the COVID-19 pandemic that an outbreak in an aged care setting would give rise to a significant workforce impact because it was likely that the close contacts of an infected staff member (including other staff) would have to isolate'.[244] A survey sent by the Aged Care Quality and Safety Commission in March 2020 asked residential services whether they had a staffing contingency plan 'in case up to 20% to 30% of staff are unable to present for work'.[245] That same range appeared in the first three versions of the CDNA Guidelines.[246]

The CDNA Guidelines did not advise providers that they should expect to lose the majority, if not the entirety, of their workforce within the first few days of an outbreak. Mr Lye gave evidence that services need to plan 'for what the service is capable of managing alone' and it should 'not be asked to plan for something that is not within their capability'.[247] Dr Murphy also said that providers could not be expected to have a plan to surge up to more than 20 to 30%. He explained, 'We advised them that in the unlikely event, as in a big outbreak, that if it was worse than that we would provide the extra surge' support.[248]

The Australian Government submitted that the figure of 20 to 30% was sourced from known percentage rates of staffing shortages from influenza outbreaks within residential aged care.[249] It submitted that this remains an appropriate figure for the anticipated loss of workforce in most affected facilities, on the basis that in general most facilities with an outbreak have only lost a small percentage of their workforce due to COVID-19.[250] The Australian Government also set out the steps it had taken to ensure providers could access adequate staffing, including through a surge workforce, if required.[251]

Access to a surge workforce

At the time of the outbreak at Dorothy Henderson Lodge, there was no surge workforce support from the Australian Government Department of Health in place. BaptistCare drew its replacement workforce from a variety of sources including staff from its other facilities, NSW Health and Healthcare Australia.[252] It also recruited from some unorthodox sources such as people who ran camps and restaurants, and chefs who were out of work as a result of the pandemic.[253] Those individuals were trained and buddied with existing BaptistCare staff in facilities other than Dorothy Henderson Lodge, in anticipation of filling future workforce gaps.[254] At the time of the hearing, BaptistCare was keeping those individuals on the books in case of a second wave in NSW.[255] BaptistCare told us that several of these people had enquired about future job opportunities with the organisation, having seen the value they could add to the aged care environment.[256]

On 12 April 2020, the Australian Government announced measures to fill staffing gaps in the aged care workforce, including:

- new emergency teams from Aspen Medical, to be on standby if there was a significant outbreak in a residential aged care facility
- access to a surge workforce through Mable Technologies Pty Ltd to help providers who are unable to fill critical skills because of infection or staff having to isolate.[257]

Mr Millard said the support provided by Aspen Medical was 'invaluable'.[258] However, he explained that initially the services provided to Newmarch House by Mable were problematic. Mr Millard told us that the:

> types of people who were being provided, I think there were very few people who had any residential aged care experience, some had home care experience. None of them had any practical experience in the use of PPE [personal protective equipment]. Now, this was changed over a number of weeks and we were supplied by very capable people but early on they just weren't up to the task. It was dangerous for them.[259]

Mable outlined in its submission that it operates a technology platform that allows independent workers to connect with people seeking care.[260] The submission noted that Mable is not an agency or labour hire organisation. It does not play any role in selecting workers for particular jobs and does not supervise care workers in the performance of jobs.[261]

In its submission, Mable further advised that it was engaged by the Australian Government 'to assist in meeting demand for care workers as a consequence of the COVID-19 pandemic'.[262] In April 2020, the majority of its 8000 registered workers were experienced in home care and providing services under the National Disability Insurance Scheme rather than residential care or hospital services. Mable acknowledged there were initial teething problems for Anglicare Sydney in identifying personal care workers with residential experience.[263]

Mable explained that 'It was Anglicare's responsibility to use Mable's platform to select and engage appropriately qualified and experienced care workers for their requirements from the many workers capable of being sourced via the Mable platform.'[264] It advised that 'every personal care worker engaged by Anglicare Sydney via the Mable platform had completed a COVID-19 infection control training program provided by the Commonwealth', and explained that Anglicare Sydney was required to provide those workers with sufficient personal protective equipment and training in its use.[265] During the hearing, Mr Lye told us that the Australian Government had broadened its surge workforce support beyond Aspen and Mable.[266]

Effect on residents of staffing changes

Ms Butler described the effect of significant staffing changes on residents. She said that, with new staff 'brought in…and without visitors, then the residents just have no connection to familiarity and the usual sort of support mechanisms they rely on'.[267] She described it as 'an incredibly stressful situation for everybody right now'.[268] We set out above the evidence about the various ways in which the quality of life of older people can be compromised during a pandemic. This lack of familiarity, coupled with a lack of visitation, can contribute to the distress and anxiety experienced by older people during a pandemic.[269]

BaptistCare referred to the replacement of their workforce at Dorothy Henderson Lodge as 'one of the most significant challenges during the outbreak'.[270] In its submission, BapstistCare outlined the effect of the loss of staff on their model of care, which aims to 'embed person-centred care and a relational approach' through 'consistent assignment partnerships [which] promote continuity of care for residents who are partnered with staff who get to know them, their routines and their choices'.[271] The familiarity of staff with residents was also intended to support family members to be enabled as 'partners in care'.[272] The effect on this model of care was described in BaptistCare's submission as follows:

> The arrival of significant numbers of replacement staff meant it was not possible to maintain our model of care. This was partly because many agency staff…were experienced in acute services and unfamiliar with the aged care operating environment. It was also due to agency staff being unfamiliar with the needs and preferences of our residents, many of whom have cognitive issues which limit their ability to communicate what they need or prefer directly to staff. This challenge highlighted the unique role of staff in an aged care environment where relational aspects of care are more important than in the acute sector.[273]

In an effort to address this challenge, BaptistCare said it 'gradually increased the consistency of staff in particular wings to enable staff to become more familiar with the needs and preferences of residents'.[274] The concern about continuity of care by familiar staff was also recognised by Opal Aged Care. Opal explained that a key goal of the organisation was to 'reduce the amount of agency team in the home to ensure continuity of care for our residents by team they knew and trusted'.[275]

Mr Millard acknowledged that the use of different staff compromised the quality of care at Newmarch House, due to their lack of familiarity with residents and, at times, limited clinical expertise.[276] He described the loss of 87% of the Newmarch House workforce as:

> distressing for the residents, distressing for their families and friends and distressing for our regular staff, because they were not able to care for the residents with whom they had established relationships at a time when the residents were anxious, confused and at times frightened.[277]

In its submission, Anglicare Sydney recognised that the large number of agency staff working at Newmarch House, who were unfamiliar with the residents, affected the ability of staff to provide specific information to families about their loved ones. Anglicare Sydney acknowledged that this 'undermined the families' trust in Anglicare Sydney, at a time when the families of the residents at Newmarch House needed to be able to trust that their loved ones were being cared for'.[278] While these communication problems were largely resolved from the start of May, Anglicare Sydney recognised that 'the early failures in… communication had added additional trauma to the families, at a time when they were already distressed'.[279]

Challenges in managing a surge workforce

Ms Roy explained that to manage the agency staff brought into Newmarch House, additional onsite managers had to be made available and additional procedures put in place.[280] A number of these managers were themselves brought in from other Anglicare Sydney facilities or contracted from Aspen.[281] Ms Dempsey explained the governance challenges that arose in relation to managing infection control with staff from many different sources, who were unfamiliar with the facility:

> There are key strategies and principles that you need to apply [with infection prevention and control] but you also need to understand how to apply those, and when you are faced with a difficult environment that's where the challenges actually arise. When you've got a lot of different agencies and there were a lot of resources from what I could tell…but it seemed to kind of lack…a policing and command post that…if there's any issues then you go to one source.
>
> They had a lot of resources. They had certainly a lot of PPE [personal protective equipment]. And were practising infection control but it was just trying to streamline that and bring that into a degree of…organised system.[282]

Dr Branley similarly described the coordination of care between different groups of staff, sourced from various agencies, as 'problematic'.[283] While Dr Branley told us that he did not think technical variations in infection control approaches were significant at Newmarch House, nor that breaches of infection control were significant in transmission to residents, he explained that 'there was not a uniform approach to infection control because training was not identical between staff from different places'.[284] Dr Branley also attributed some decision making issues that arose at Newmarch House, particularly early in the course of the outbreak, to the mix of staff from different sources. He said:

> it was unclear to me who was making some non-clinical decisions and who was ultimately responsible…For example, various nursing staff from various agencies had been designated to make decisions regarding various issues such as infection control, palliative care, whether the residents should be showered and decisions regarding PPE [personal protective equipment].[285]

We also heard evidence that care at Newmarch House was further compromised by the need to revert to paper-based information systems due to new staff being unfamiliar with the electronic systems operated by Anglicare Sydney.[286] Mr Millard explained that the reversion to a paper system had a flow-on effect on the review of notes as part of comprehensive handovers. He said that, while the paper notes were ultimately scanned into the electronic system, the lack of a local management review process resulted in there being 'no timely oversight of this information to inform care plans and interventions'.[287]

BaptistCare experienced a similar problem during the outbreak at Dorothy Henderson Lodge. Mr Ross Low, Chief Executive Officer of BaptistCare NSW/ACT, told us that they had not envisaged that 'when you completely lose your workforce and you have agency staff come in…they do not understand your electronic clinical system'.[288] Mr Low explained that the system had to be downloaded into a paper-based system which also removed the feature of the electronic system which prompts staff to attend to specific care needs of particular residents, such as the need for regular insulin. He urged the aged care sector to 'contemplate how they will operate if they do not have anybody that understands their system working for them at that particular point in time'.[289]

The inability to use electronic systems also affected the ability of external health agencies engaged at Newmarch House to access the clinical records of residents. Dr Branley explained that the Virtual Aged Care Service, which provided specialist geriatric medical care to Newmarch House residents during the outbreak, was able to access the electronic system used at the facility. However, once the decision was made by one of the emergency nursing teams to record notes on paper instead, the Virtual Aged Care Service team 'did not have easy access to the notes made by nursing staff' at Newmarch House.[290]

Dr Branley recommended that residential aged care facilities need to have 'a consistent clinical note and pharmacy system which can be integrated with the State health IT system and laboratory data' and that 'further efforts should be made to have an information sharing platform' between the hospital and residential aged care sectors.[291] This issue is not raised in the third version of the CDNA Guidelines or the 'First 24 Hours' document, both of which are key documents to guide providers on preparing for and responding to outbreaks of COVID-19 in residential aged care.[292]

20.1.6 Hospitalisation

An important question in the response to COVID-19 in aged care is the timing and circumstances in which a resident who tests positive to COVID-19, and whose condition may not warrant hospitalisation or who may not consent to hospitalisation, should nevertheless be transferred to hospital.

Evidence of approved providers

A policy of transferring COVID-19 positive patients to hospital was initially followed at Dorothy Henderson Lodge. Thirteen of the 16 residents who tested positive were sent to hospital.[293] Of the remaining three, one did not want to go to hospital and received palliation services at the home. The remaining two recovered.[294] As concern grew about the pandemic and the capacity of the hospital network to cope with the expected number of cases, decisions about hospital transfer were made by the Ministry of Health on a case by case basis.[295] Residents who would not benefit from hospitalisation were required to be cared for at the home.[296]

At Newmarch House, as noted above, residents were treated pursuant to a policy known as Hospital in the Home.[297] The Australian Government submitted that it initially took the view that COVID-19 positive residents at Newmarch House should be externally separated and hospitalised as necessary, but that responsibility for that decision lay with the public health officials from NSW Health.[298] The prevailing view was that residents at Newmarch House would be separated within the facility on the basis of their COVID-19 status where possible, and this would be preferred over hospitalisation unless clinically necessary.[299]

According to Anglicare Sydney, of the 37 residents who tested positive to COVID-19 at Newmarch House, only two were transferred to hospital.[300] One of those died.[301] The other 16 residents who died of COVID-19 were all treated at Newmarch House.[302] Dr Lyons gave slightly different evidence, that 'six out of 37 residents who had tested positive for COVID-19 were transferred to hospital. Two of the six were no longer positive at the time of transfer'.[303]

In oral evidence, Ms Dicks was clear that the transfer to hospital of COVID-19 positive residents in the early stages of the outbreak at Dorothy Henderson Lodge assisted them in controlling the outbreak.[304] She explained that this provided an opportunity 'to actually stabilise our outbreak plan and ensure that our resources were working'.[305] Ms Dicks also said that hospitalisation of COVID-19 residents, even those with mild symptoms for whom hospitalisation may not have been medically required:

> allowed us to say that the service had no active cases at that point, and it certainly supported encouraging staff to come as well because at that time staff were fearful to come on site so we had to work strongly and support our staff to ensure their safety, and not having COVID positives helped that in the initial phase.[306]

Ms Dicks reflected on the challenges of transporting frail cognitively impaired residents to hospital, noting that rapid changes to their environments or unknown environments are highly distressing for them.[307] She explained that this needed to be managed supportively on a case by case basis through discussion with the resident, their family and the health service to which they were transported.[308]

Mr Millard told the Anglicare Board on 27 May 2020, 'In the event of infection at another [Anglicare Sydney] home, Anglicare Sydney would be far more assertive regarding the most appropriate management of COVID-19 positive residents and would strongly push for these residents to be immediately transferred to hospital.'[309] He explained that this was based on his concern for the wellbeing of the other residents and protecting the staff.[310] He commented that:

> because you had the ongoing presence of COVID-positive residents in the home, it really had another impact on the—all the residents who were still confined to their rooms. I believe that if we would have been able to transfer out COVID-positive residents earlier, we might have had an earlier liberalisation of what was, really, extremely difficult for our residents to go through being isolated in their rooms with the doors closed.[311]

Reflecting on the Newmarch House experience of COVID-19 positive residents being treated in place, Ms Roy said:

> The implication of having the COVID-positive residents along with the COVID-negative residents, the acute clinical status of those residents that were COVID-positive meant that resources were being pulled towards the focus on that acute care.[312]

She explained that having all of the residents (negative and positive) in the home 'put a greater burden on an already stressed workforce' and made it difficult to replace staff who were being isolated as part of contact tracing.[313] At the time she gave evidence, Ms Roy said she believed that moving COVID-19 positive residents to hospital would have resulted in less trauma to family members and may have caused less distress to the Newmarch House residents because families were unable to visit their loved ones at the facility.[314]

In its submission, Anglicare Sydney acknowledged the 'clear divide' in the expert evidence regarding automatic hospitalisation of aged care residents who test positive to COVID-19.[315] However, Anglicare Sydney submitted that, with the benefit of hindsight, it considered there are strong benefits of hospital transfer for aged care residents who test positive to COVID-19.[316]

Expert evidence

Professor McLaws was a strong advocate of the 'automatic transfer' approach. She told us that 'All COVID-19 positive residents must be admitted to hospital while complying with their Advance Care Plan during admission.'[317] Her reasons for this approach were:

- The built environment in a hospital is designed to contain the spread of infection.
- Hospital staff have been trained in infection prevention and control.[318]

Professor McLaws stated that hospital transfer is 'the only logical way to prevent the transmission of COVID-19 to other residents, staff and visiting clinicians'.[319] Professor Spurrier said the more sophisticated use of personal protective equipment in a hospital setting would provide a 'better ability for the family to spend some quality time with their loved one'.[320]

Professor McLaws explained that even in a facility with single rooms and individual bathrooms, separating positive and negative residents 'would be very difficult'.[321] She added that 'in a hospital with best practice, what you would find is that staff do not share their care between positive and negative patients…Best practice is you do not have negatives anywhere near positives'.[322] Professor McLaws considered that it may be possible to avoid transfers if 'you could put them [positive residents] totally in a different building'. However, even in such a situation Professor McLaws was concerned that, because many residents are allocated a room for life, this sort of uprooting could 'cause a lot of distress and disharmony'.[323]

Dr Melanie Wroth, Chief Clinical Adviser at the Aged Care Quality and Safety Commission, told us that she strongly recommended that COVID-19 positive residents should be separated from residents who had tested negative at Newmarch House.[324] She said that the best way to protect people is to 'completely limit the exposure of people who may still be negative from having any contact with people who are known to be positive'.[325]

Dr Branley was involved in responding to the COVID-19 outbreaks at both Dorothy Henderson Lodge and Newmarch House.[326] He believed that 'admitting patients to hospital just because they are positive is not in accordance with best practice and with large numbers would create further opportunities for transmission of the virus'.[327] He also considered that such an approach was at odds with the approach taken to COVID-19 positive people in the general community. Further, it is contrary to 'the Interim Guidelines for the management of COVID-19 in adults' published by the Australian Society for Infectious Diseases.[328]

Dr Branley's view was consistent with the advice in the second version of the CDNA Guidelines dated 30 April 2020, which stated 'Transfer residents to hospital ***only if their condition warrants***.'[329] This advice appears to have been deleted in the more recent version of the CDNA Guidelines dated 14 July 2020.[330] The Australian Government submitted the removal of the advice was not reflective of a particular policy that approved providers should separate residents within a facility in any COVID-19 outbreak or that all COVID-19 affected residents should automatically be transferred to hospital. The Australian Government stated that:

> Ultimately, the decision of whether to transfer the positive residents of an aged care facility experiencing an outbreak to hospital is the responsibility of the State and Territory health authorities who have responsibility for managing the public health aspects of an outbreak, in conjunction with the residents themselves, and their families. This is notwithstanding the responsibility of the aged care provider to continue to manage their service and their capacity to manage such cases.[331]

The policy in South Australia

Unlike NSW, South Australia has a policy of automatically transferring COVID-19 positive residents to hospital. The policy is explained in the submission of the South Australian Department of Health:

> The policy outlines that all residents testing positive to COVID-19 would be transferred to a public hospital to reduce the risk of transmission to other residents and that the SA Health rapid response plan will be triggered if there is one COVID-19 case in a residential aged care facility or other congregated living environment. The policy will also consider issues uniquely associated with regional and remote RACF [residential aged care facilities] and ensure that it is relevant to and feasible for those services.[332]

Professor Spurrier explained that the policy was based on the advice of the World Health Organization which in turn drew on 'an investigation into China and their dealing with the pandemic'.[333] One of the lessons from that investigation was 'that it is best to treat all your COVID-19 patients in the one hospital or in a limited number of hospitals' where there is focused expertise.[334] Professor Spurrier said that South Australia decided 'very early on… that the Royal Adelaide would be our COVID-19 hospital'.[335] She said that because it is a new hospital, it is 'very well set up with individual rooms, negative pressure rooms and the like and also an extensive intensive care'.[336]

Professor Spurrier described the considerations South Australia took into account when formulating its policy including:

- All South Australian aged care facilities are different and while some might have the infrastructure to isolate a positive resident, they could not be confident that all had that ability.[337]
- The workforce in residential facilities does not necessarily have the training in the use of personal protective equipment. Even where they have received training, their lack of knowledge of microbiology and how infections are passed from one person to another means that they are not always going to be able to prevent the spread of the infection.[338]

These considerations led Professor Spurrier to conclude that 'if we have a resident in an aged care facility, that it would be very quickly that that would spread to not only other residents but also other workers in that facility'.[339]

Professor Spurrier accepted that the South Australian approach may not necessarily work in other jurisdictions due to differences between them. In her view, because South Australia has a 'networked health system', it is easier to implement this policy.[340] She also agreed that implementation would be dependent on available hospital beds.[341]

The implementation of the South Australian policy in a particular case has the potential to override a resident's advance care directive. A South Australian 'fact sheet' dated 2 June 2020 explained what happens when a resident is transferred to hospital under the policy:

> The resident's family/substitute decision maker will be notified immediately. If a resident has an Advance Care Directive, and they are unable to make their own decisions, their health care wishes will be respected in the hospital setting. This should be discussed with the treating team.[342]

Professor Spurrier was asked how, in circumstances where a resident's directive is that he or she does not want to be transferred to hospital, their wishes could be respected. Her answer was that the policy was an example of the population focused principle in practice.[343] The individual rights of the resident in such a case are subservient to the broader public health need to take the resident to the 'safest place in terms of not spreading the disease any further to other vulnerable residents in that home'.[344] However, Professor Spurrier explained that under the South Australian policy, while the *setting* may be different from that specified in the Advance Care Directive, the *treatment* requests of the resident will still be respected.

Hospital in the home

As noted above, the majority of COVID-19 positive residents at Newmarch House were treated under the Hospital in the Home Policy of NSW Health, published on 9 August 2018.[345] Hospital in the Home involves providing acute or subacute care in the patient's home or in the community as a substitute for in-hospital care.[346] The NSW guidelines set out certain pre-conditions that should be met before Hospital in the Home can be implemented in a residential aged care facility.

Mrs Virginia Clarke, whose father died at Newmarch House, told us she was not advised of the decision to implement the hospital in place protocol rather than transferring any of the residents out of Newmarch House.[347] She said that when she was subsequently advised of this after the death of her father, while she understood that Anglicare and NSW Health wanted to confine positive residents to the facility, she expected that her father would have had access to the same nurses and facilities as if he had gone to hospital.[348]

In its submission, Anglicare Sydney stated that 'the critical staff shortage' it experienced at Newmarch House was a shortage of registered nurses and care workers and that, to run the Hospital in the Home service, 'a greater number of registered nurses was needed'.[349] A review commissioned by the Australian Department of Health and undertaken by Professor Gilbert and Adjunct Professor Lilly to examine the COVID-19 outbreak at Newmarch House agreed:

> there was no additional nursing support for Hospital in the Home patients or general medical support for COVID-19 negative residents, until later. These shortfalls in nursing and medical support and the increased burden on carers of unfamiliar PPE [personal protective equipment], led to shortfalls in hospital-standard care for some residents with COVID-19 and neglect of or delays in, routine care of many others.[350]

The report also said that successful adoption of Hospital in the Home as a model of care for a large number of residents with COVID-19 in an aged care facility is very challenging.[351] It concluded:

> Decisions about the management of COVID-19 cases should be made by an expert panel. The panel should at minimum include membership from experts in infectious diseases, infection control, geriatric medicine, clinical leadership from the approved provider and a local general practitioner. This panel should consult with the relevant Commonwealth and jurisdictional health agencies, the Aged Care Quality and Safety Commission and the designated representative of the Approved Provider. As…soon as an outbreak is declared: (i) the expert panel should be convened and (ii) residents should be transferred to hospital until the residential aged care facility is deemed safe and appropriate for residents to return. NB: Implications of such decisions will need to be considered in light of individual resident's personal preferences.[352]

NSW Health raised concerns about the Newmarch House report. These concerns include that the report is not independent, as it does not acknowledge or discuss Professor Gilbert's role as part of the senior oversight group which provided advice regarding the outbreak at Newmarch House, and that it is unclear what evidence the reviewers had access to, which evidence was used to draw conclusions, or how that evidence was evaluated.[353] Further, NSW Health said it did not accept the conclusion of the report's authors that a Hospital in the Home model is only suitable if an outbreak is limited to a small number of cases.[354] On this, NSW Health submitted that 'The review on its face has not considered sufficient evidence to reach that conclusion.'[355]

20.2 Conclusion

We decided to hold this hearing to identify what lessons could be learned from the experience of the aged care sector's response to COVID-19 up to August 2020. The evidence we heard about the outbreaks in NSW facilities revealed a number of lessons. This was supplemented by evidence we heard from others including a resident and family members, union representatives, experts and approved providers. The events that unfolded in the aged care sector in Victoria before and during this hearing illustrate just how important these matters are. Given the importance of these issues we presented the Governor-General with a special report on 30 September 2020.

Endnotes

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112 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0010 [38]–0050 [251].
113 Exhibit 18-23, Sydney Hearing 2, Statement of Brendan Murphy, RCD.9999.0447.0001 at 0001 [7]; the Hon Scott Morrison MP, press conference, Australian Parliament House, 27 February 2020, https://www.pm.gov.au/media/press-conference-australian-parliament-house-4, viewed 19 August 2020.
114 Submissions of Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0011 [42]–[44].
115 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 53, NDH.0017.0001.0001 at 0016–0017; 0028–0032; 0020–0023; 0024–0027; 0033–00340.
116 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 53, NDH.0017.0001.0001 at 0041.
117 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 53, NDH.0017.0001.0001 at 0021.
118 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 53, NDH.0017.0001.0001 at 0021.
119 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 53, NDH.0017.0001.0001 at 0017.
120 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 72, RCD.9999.0437.0001.
121 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 7, RCD.9999.0366.0023; tab 71, RCD.9999.0442.0001.
122 Transcript, Sydney Hearing, Brendan Murphy, 12 August 2020 at T8679.20–21.
123 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 7, RCD.9999.0366.0023 at 0023.
124 Transcript, Sydney Hearing 2, Joseph Ibrahim, 12 August 2020 at T8583.14.
125 Transcript, Sydney Hearing 2, Joseph Ibrahim, 12 August 2020 at T8583.42–43.
126 Submissions of the Australian Nursing and Midwifery Federation, Sydney Hearing 2, undated, ANM.0025.0001.0001 at 0003-0004 [14].
127 Transcript, Sydney Hearing 2, Michael Lye, 12 August 2020 at T8646.24–25.
128 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 79, RCD.9999.0442.0001 at 0002–0003.
129 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 79, RCD.9999.0442.0001 at 0002–0003.
130 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0052 [258].
131 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0052 [259].
132 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0052 [258].
133 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 7, RCD.9999.0366.0023 at 0027.
134 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0013 [52]–0050 [251].
135 Aged Care Quality and Safety Commission, *Resource Library,* 2020, https://www.agedcarequality.gov.au/resource-library?query=&resources%5B0%5D=year%*3A7939,* viewed 11 September 2020; See also Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0029 [126]; 0032 [145]; 0033 [147]; 0035 [161], [163], [167]; 0036 [169]–[172].
136 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0021 [82].
137 Exhibit 18-17, Sydney Hearing 2, Precis of evidence – Joseph Ibrahim, RCD.9999.0411.0001 at 0008 [36].
138 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 9, CTH.4026.1004.0007 at 0009.
139 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 12, CTH.4026.1002.0008.
140 Transcript, Sydney Hearing 2, Erica Roy, 11 August 2020 at T8482.21–22.
141 Transcript, Sydney Hearing 2, Erica Roy, 11 August 2020 at T8482.26–32.
142 Exhibit 18-17, Sydney Hearing 2, Precis of evidence – Joseph Ibrahim, RCD.9999.0411.0001 at 0008 [38]; 0014 [64]–0015 [69].
143 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0024 [98].
144 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 31, RCD.9999.0382.0001.
145 Transcript, Sydney Hearing 2, Janet Anderson, 12 August 2020 at T8658.1–9.
146 Transcript, Sydney Hearing 2, Janet Anderson, 12 August 2020 at T8658.14–15.
147 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0002.
148 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0003.
149 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0041.

150 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0003.
151 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0003.
152 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0003.
153 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0004 [4.2].
154 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 104, CTH.1000.0005.7777 at 7777.
155 Transcript, Sydney Hearing 2, Grant Millard 11 August 2020 at T8478.36–37.
156 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 89, NDH.0012.0002.0001 at 0001.
157 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 89, NDH.0012.0002.0001 at 0001.
158 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 104, CTH.1000.0005.7777 at 7777.
159 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 104, CTH.1000.0005.7777 at 7777; tab 120, NDH.0020.0002.0001 at 0008.
160 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 104, CTH.1000.0005.7777 at 7777.
161 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 107, CTH.4026.1001.0460.
162 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0031 [159]; Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 74, CTH.4026.1001.0450.
163 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 107, CTH.4026.1001.0460 at 0460.
164 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 107, CTH.4026.1001.0460 at 0461.
165 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 106, RCD.9999.0390.0001 at 0001; 0029.
166 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 12, CTH.4026.1002.0008 at 0009.
167 Transcript, Sydney Hearing 2, Brendan Murphy, 12 August 2020, T8675.19–20.
168 Exhibit 18-16, Sydney Hearing 2, Opal tender bundle, tab 15, AWF.600.01703.0001 at 0017.
169 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0034 at [9.2.6].
170 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0034 at [9.2.6].
171 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0034 at [9.2.6].
172 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 10, CTH.1000.0004.7114.
173 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0394.0001 at 0012 [6.3.8].
174 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0066 [314]–[315].
175 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0067 [321].
176 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 79, RCD.9999.0442.0001; tab 71, RCD.9999.0437.0001.
177 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0056 [271]–0070 [334].
178 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0057 [273d]. See also Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 121, CTH.1000.0005.8876 at 8907 [1], [3], [4]; Exhibit 18-2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0034 [9.2.2]; 0035 [9.3.1].
179 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0057 [273d]. See also Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 121, CTH.1000.0005.8876 at 8907 [7], [17]; tab 71, ANG.500.007.3067 at 0368 [12]; Exhibit 18-12, Sydney Hearing 2, Statement of Erica Roy, WIT.0793.0001.0001 at 0016 [82]–[84]; 0017 [85]; Exhibit 18-2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0034 [9.2.3]; Exhibit 18-16, Sydney Hearing 2, Opal tender bundle, tab 15, AWF.600.01703.0001 at 0012; 0017; Exhibit 18-15, Sydney Hearing 2, Statement of Stephen Judd, WIT.1367.0001.0001 at 0020 [139]–[142].
180 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0057 [273f]; Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 121, CTH.1000.0005.8876 at 8907 [10], [19]; Exhibit 18-2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0034 [9.2.5]; Exhibit 18-16, Sydney Hearing 2, Opal tender bundle, tab 15, AWF.600.01703.0001 at 0012 [e]; Exhibit 18-15, Sydney Hearing 2, Statement of Stephen Judd, WIT.1367.0001.0001 at 0020 [137]–[138].
181 Exhibit 18-16, Sydney Hearing 2, Opal tender bundle, tab 15, AWF.600.01703.0001 at 0011 [c]; Exhibit 18-2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0034 [9.2.5];
182 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 121, CTH.1000.0005.8876 at 8907 [5].
183 Exhibit 18-15, Sydney Hearing 2, Statement of Stephen Judd, WIT.1367.0001.0001 at 0019 [129]–[132]; 0026 [171]–[172]; Exhibit 18-12, Sydney Hearing 2, Statement of Erica Roy, WIT.0793.0001.0001 at 0015 [80]–[81]; Exhibit 18-16, Sydney Hearing 2, Opal tender bundle, tab 15, AWF.600.01703.0001 at 0016 [vi]; Exhibit 18-2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0024 [6.11.1].
184 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 79, ANG.503.005.8254 at 8256.
185 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 79, ANG.503.005.8254 at 8256.
186 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 121, CTH.1000.0005.8876 at 8879.
187 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0010 [19].
188 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0010 [19]. See also Exhibit 18-15, Sydney Hearing 2, Statement of Stephen Judd, WIT.1367.0001.0001 at 0023 [152].
189 Exhibit 18-18, Sydney Hearing 2, Statement of Nigel Lyons, WIT.0782.0001.0001 at 0005 [19]–0007 [35].
190 Exhibit 18-18, Sydney Hearing 2, Statement of Nigel Lyons, WIT.0782.0001.0001 at 0015 [79].
191 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 26, RCD.9999.0366.0238 at 0238.
192 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 26, RCD.9999.0366.0238 at 0244–0247.
193 Transcript, Sydney Hearing, Michael Lye, 12 August 2020 at T8666.27–41; T8667.1–22.
194 Exhibit 18-18, Sydney Hearing 2, Statement of Nigel Lyons, WIT.0782.0001.0001 at 0015 [82].

195 Transcript, Sydney Hearing 2, Nicola Spurrier, 10 August 2020 at T8394.10–11.
196 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 82, RCD.9999.0448.0001 at 0003.
197 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0042 [214].
198 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 53, NDH.0017.0001.0001 at 0020 [4.1].
199 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0057–0058 [275].
200 Submissions of the State of New South Wales, Sydney Hearing 2, 4 September 2020, RCD.9999.0505.0001 at 0001 [3].
201 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0057–0058 [275].
202 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.999.0509.0001R CD.9999.0509.0001 at 0057–0058 [275].
203 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.999.0509.0001R CD.9999.0509.0001 at 0057–0058 [275].
204 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0034 [176].
205 Exhibit 18-18, Sydney Hearing 2, Statement of Nigel Lyons, WIT.0782.0001.0001 at 0009 [47]–[48].
206 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 1, RCD.9999.0366.0181 at 0187 [1.1].
207 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 90, ANG.514.001.00012 at 0017.
208 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0014 [32].
209 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0039 [195].
210 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0004 [15].
211 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0052–0053 [260].
212 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0059–0060 [284].
213 Exhibit 18-17, Sydney Hearing 2, Precis of evidence – Joseph Ibrahim, RCD.9999.0411.0001 at 0011 [48]–0012 [57].
214 Transcript, Sydney Hearing 2, Joseph Ibrahim, 12 August 2020 at T8580.38–46.
215 The Hon Scott Morrison, MP, Prime Minister of Australia and Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians, Media release, *Reinforcement of Australia's Aged Care Sector*, 2020, https://www.pm.gov.au/media/reinforcement-australias-aged-care-sector, viewed 25 August 2020.
216 Transcript, Sydney Hearing 2, Melanie Dicks, 10 August 2020 at T8416.41–44.
217 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0394.0001 at 0035 [9.3.3].
218 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0394.0001 at 0010 [6.3.3].
219 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 10, CTH.1000.0004.7114 at 7120–7121.
220 Transcript, Sydney Hearing 2, Erica Roy, 11 August 2020 at T8497.43–8497.5.
221 Transcript, Sydney Hearing 2, Melanie Dicks, 10 August 2020 at T8420.45–8421.2.
222 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0014 [31].
223 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0013 [28].
224 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0012–0013 [26].
225 Transcript, Sydney Hearing 2, Melanie Dicks, 10 August 2020 at T8421.39–8422.15.
226 Transcript, Sydney Hearing 2, Gwendolyn Gilbert, 10 August 2020 at T8440.11.
227 Transcript, Sydney Hearing 2, Gwendolyn Gilbert, 10 August 2020 at T8440.13–20.
228 Transcript, Sydney Hearing 2, Gwendolyn Gilbert, 10 August 2020 at T8440.30.
229 Transcript, Sydney Hearing 2, Gwendolyn Gilbert, 10 August 2020 at T8441.38–8442.2.
230 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 79, RCD.9999.0442.0001; tab 31, RCD.9999.0382.0001.
231 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 79, RCD.9999.0442.0001 at 0020.
232 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 31, RCD.9999.0382.0001 at 0008.
233 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0060 [285].
234 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0013 [6.4.1]; Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0019 [106].
235 Exhibit 18-16, Sydney Hearing 2, Opal tender bundle, tab 15, AWF.600.01703.0001 at 0008.
236 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0004 [4.4].
237 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0004 [4.4].
238 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0014–0015 [6.4.10].
239 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0019 [106].
240 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0019 [107].
241 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0019 [107].
242 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0020 [108].
243 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0007 [28].
244 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0060 [286].
245 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 12, CTH.4026.1002.0008.
246 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 71, RCD.9999.0437.0001 at 0011; 0028; tab 7, RCD.9999.0366.0023 at 0033; 0051; tab 79, RCD.9999.0442.0001 at 0012; 0029.
247 Transcript, Sydney Hearing 2, Michael Lye, 12 August 2020 at T8652.28–44.
248 Transcript, Sydney Hearing 2, Brendan Murphy, 12 August 2020 at T8653.37–46.

249 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0060 [288].
250 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0061 [288].
251 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0061 [289]–0062 [293].
252 Transcript, Sydney Hearing 2, Ross Low, 10 August 2020 at T8418.14–19.
253 Transcript, Sydney Hearing 2, Ross Low, 10 August 2020 at T8425.28–30.
254 Transcript, Sydney Hearing 2, Ross Low, 10 August 2020 at T8425.31–36.
255 Transcript, Sydney Hearing 2, Ross Low, 10 August 2020 at T8425.36–39.
256 Transcript, Sydney Hearing 2, Ross Low, 10 August 2020 at T8426.27–30.
257 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0027 [114a], [114d].
258 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0020 [112].
259 Transcript, Sydney Hearing 2, Roy Millard, 11 August 2020 at T8502.36–41.
260 Submissions of Mable Technologies Pty Ltd, Sydney Hearing 2, undated, RCD.0012.0066.0001 at 0001 [1].
261 Submissions of Mable Technologies Pty Ltd, Sydney Hearing 2, undated, RCD.0012.0066.0001 at 0001 [1].
262 Submissions of Mable Technologies Pty Ltd, Sydney Hearing 2, undated, RCD.0012.0066.0001 at 0001 [2].
263 Submissions of Mable Technologies Pty Ltd, Sydney Hearing 2, undated, RCD.0012.0066.0001 at 0001 [2].
264 Submissions of Mable Technologies Pty Ltd, Sydney Hearing 2, undated, RCD.0012.0066.0001 at 0002 [7].
265 Submissions of Mable Technologies Pty Ltd, Sydney Hearing 2, undated, RCD.0012.0066.0001 at 0002 [7].
266 Transcript, Sydney Hearing 2, Michael Lye, 12 August 2020 at T8671.27–35.
267 Transcript, Sydney Hearing 2, Annie Butler, 12 August 2020 at T8617.44–8618.1.
268 Transcript, Sydney Hearing 2, Annie Butler, 12 August 2020 at T8618.1–2.
269 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0019 [107].
270 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0013 [6.4.1].
271 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0013 [6.4.1]–[6.4.2].
272 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0013 [6.4.2].
273 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0014 [6.4.6].
274 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0014 [6.4.6].
275 Exhibit 18-1, Sydney Hearing 2, Opal Care tender bundle, tab 15, AWF.600.01703.0001 at 0001–0009.
276 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0021 [114].
277 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0019 [107].
278 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0023 [56].
279 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0023 [56].
280 Exhibit 18-12, Sydney Hearing 2, Statement of Erica Roy, WIT.0793.0001.0001 at 0007 [30].
281 Exhibit 18-12, Sydney Hearing 2, Statement of Erica Roy, WIT.0793.0001.0001 at 0007 [30].
282 Transcript, Sydney Hearing 2, Kathleen Dempsey, 11 August 2020 at T8521.18–31.
283 Exhibit 18-14, Sydney Hearing 2, Statement of James Branley, WIT.0769.0001.0001 at 0015 [135].
284 Exhibit 18-14, Sydney Hearing 2, Statement of James Branley, WIT.0769.0001.0001 at 0015 [135]–0016 [136]; 0017 [155].
285 Exhibit 18-14, Sydney Hearing 2, Statement of James Branley, WIT.0769.0001.0001 at 0018 [163]–[164].
286 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0021 [114].
287 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0021 [114].
288 Transcript, Sydney Hearing 2, Ross Low, 10 August 2020 at T8429.25–27.
289 Transcript, Sydney Hearing 2, Ross Low, 10 August 2020 at T8429.35–37.
290 Exhibit 18-14, Sydney Hearing 2, Statement of Dr James Branley, WIT.0769.0001.0001 at 0018–0019 [165].
291 Exhibit 18-14, Sydney Hearing 2, Statement of Dr James Branley, WIT.0769.0001.0001 at 0024 [214]–[215].
292 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 79, RCD.9999.0442.0001; Exhibit 18-1, Sydney Hearing, general tender bundle, tab 31, RCD.9999.0382.0001.
293 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0046.
294 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0046.
295 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0021 [6.9.3].
296 Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 14, RCD.9999.0379.0001 at 0021 [6.9.3].
297 Exhibit 18-18, Sydney Hearing 2, Statement of Nigel Lyons, WIT.0782.0001.0001 at 0009 [47]–[48].
298 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0068 [325].
299 Submissions of the Commonwealth of Australia, Sydney Hearing 2, 7 September 2020, RCD.9999.0509.0001 at 0068 [35].
300 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0011 [54]; Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0019 [46c].
301 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0011 [54].
302 Exhibit 18-10, Sydney Hearing 2, Statement of Grant Millard, WIT.0787.0001.0001 at 0011 [53]–[54].
303 Exhibit 18-18, Sydney Hearing 2, Statement of Nigel Lyons, WIT.0782.0001.0001 at 0010 [51].
304 Transcript, Sydney Hearing 2, Melanie Dicks, 10 August 2020 at T8422.36–46.
305 Transcript, Sydney Hearing 2, Melanie Dicks, 10 August 2020 at T8422.45–46.

306 Transcript, Sydney Hearing 2, Melanie Dicks, 10 August 2020 at T8423.31–34.
307 Transcript, Sydney Hearing 2, Melanie Dicks, 10 August 2020 at T8423.46–47.
308 Transcript, Sydney Hearing 2, Melanie Dicks, 10 August 2020 at T8423.47–8424.7
309 Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 90, ANG.514.001.0012 at 0017.
310 Transcript, Sydney Hearing 2, Grant Millard, 11 August 2020 at T8490.17–36.
311 Transcript, Sydney Hearing 2, Grant Millard, 11 August 2020 at T8490.30–36.
312 Transcript, Sydney Hearing 2, Erica Roy, 11 August 2020 at T8496.12–15.
313 Transcript, Sydney Hearing 2, Erica Roy, 11 August 2020 at T8496.19–22.
314 Exhibit 18-12, Sydney Hearing 2, Statement of Erica Roy, WIT.0793.0001.0001 at 0007 [36].
315 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0019 [47].
316 Submissions of Anglican Community Services, Sydney Hearing 2, 4 September 2020, RCD.9999.0503.0002 at 0019 [47].
317 Exhibit 18-4, Sydney Hearing 2, Precis of evidence – Mary-Louise McLaws, RCD.9999.0384.0001 at 0002 [9].
318 Exhibit 18-4, Sydney Hearing 2, Precis of evidence – Mary-Louise McLaws, RCD.9999.0384.0001 at 0002 [9].
319 Exhibit 18-4, Sydney Hearing 2, Precis of evidence – Mary-Louise McLaws, RCD.9999.0384.0001 at 0002 [9].
320 Transcript, Sydney Hearing 2, Nicola Spurrier, 10 August 2020, T8403.12–15.
321 Transcript, Sydney Hearing 2, Mary-Louise McLaws, 10 August 2020, T8398.22.
322 Transcript, Sydney Hearing 2, Mary-Louise McLaws, 10 August 2020, T8398.23–26.
323 Transcript, Sydney Hearing 2, Mary-Louise McLaws, 10 August 2020, T8398.26–30.
324 Transcript, Sydney Hearing 2, Melanie Wroth, 12 August 2020 at T8664.8–14.
325 Transcript, Sydney Hearing 2, Melanie Wroth, 12 August 2020 at T8664.22–34.
326 Exhibit 18-14, Sydney Hearing 2, Statement of James Branley, WIT.0769.0001.0001 at 0003 [19]–0007 [48]; 0007 [49]–0022 [190].
327 Exhibit 18-14, Sydney Hearing 2, Statement of James Branley, WIT.0769.0001.0001 at 0020 [181].
328 Exhibit 18-14, Sydney Hearing 2, Statement of James Branley, WIT.0769.0001.0001 at 0020 [182].
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337 Transcript, Sydney Hearing 2, Nicola Spurrier, 10 August 2020 at T8395.34–38.
338 Transcript, Sydney Hearing 2, Nicola Spurrier, 10 August 2020 at T8395.22–33.
339 Transcript, Sydney Hearing 2, Nicola Spurrier, 10 August 2020 at T8395.30–32.
340 Transcript, Sydney Hearing 2, Nicola Spurrier, 10 August 2020 at T8396.13–15.
341 Transcript, Sydney Hearing 2, Nicola Spurrier, 10 August 2020 at T8396.17–24.
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343 Transcript, Sydney Hearing 2, Nicola Spurrier, 10 August 2020 at T8390.31–47.
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346 Exhibit 18-1, Sydney Hearing 2, general tender bundle, tab 1, RCD.9999.0366.0181 at 0187 [1.1].
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348 Transcript, Sydney Hearing 2, Virginia Clarke, 11 August 2020 at T8473.10–17.
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21. Sydney Hearing 3: Accommodation

21.1 Hearing overview

21.1.1 Introduction

At a public hearing held in Sydney, New South Wales, on 13 and 14 August 2020, we heard and received evidence relating to accommodation suitable for older people to age in place and to receive aged care services there.

We heard oral testimony from 11 witnesses, all of whom gave evidence by video link. This included two direct experience witnesses who gave evidence from the United Kingdom. The remaining nine witnesses gave evidence in three panels. The panels were separated into three themes:

- accommodation suitable for ageing in place and aged care services
- social and affordable housing suitable for ageing in place and aged care services
- physical design of residential aged care in the future.

Counsel Assisting tendered nine exhibits:

- a general tender bundle consisting of 56 documents, including three statements prepared by witnesses who did not provide oral evidence
- eight statements prepared by witnesses who gave oral evidence at the hearing.

In preparation for this hearing, staff of the Royal Commission developed seven propositions directed at ways of meeting the accommodation needs of older people receiving, or who might receive, aged care services. A document setting out these propositions was included in the general tender bundle and was also provided to the panel witnesses prior to giving oral evidence.[1] Counsel Assisting explored these propositions with the three panels.

21.1.2 Accommodation suitable for ageing in place and aged care services

In 2014, the Productivity Commission report *Housing Decisions of Older Australians* confirmed that the majority of older people's preference is to remain at home as they age, with the Australian Government expanding home care services as the use of residential aged care declines.[2]

At the same time, research conducted in 2010 by the Australian Housing and Urban Research Institute showed that 61.1% of people over the age of 65 years considered it important to move to a home specially designed for older people if they were to develop a disability or increased need for assistance. Within that same study, only 56.3% of people with special care requirements regarded their current dwelling as suitable to meet their needs.[3]

The term 'ageing in place' was used during the hearing to primarily refer to people's desire to remain in their community as they age. It is often ageing at home but also includes the idea of locating and moving into what is regarded as more suitable accommodation of people's choice and which avoids or delays the need to enter institutional residential aged care.[4]

Movement to 'more suitable' accommodation in old age is commonly referred to as 'downsizing'. National Seniors Australia conducted a study in 2017 on its members' reasons for downsizing and potential policy measures to encourage this.[5] According to National Seniors Australia, downsizing is a 'major consideration for Australian homeowners when they enter retirement'.[6] Dr Brendon Radford, Manager of Policy and Advocacy at National Seniors Australia, stated that as people get older, it is much more difficult for them to downsize. He told us that while people should not be forced to downsize, there should better options available if they choose to do so.[7]

Research conducted by the Australian Housing and Urban Research Institute in 2014 found that over the preceding decade, older people were increasingly living in larger houses of three or more bedrooms. The research found that the most common motivator for people over the age of 50 years to downsize was a 'desire for a change in lifestyle or an inability to maintain a large house or garden'.[8]

The Australian Housing and Urban Research Institute found that there were three main barriers to downsizing: finding suitable, age-friendly accommodation in desirable locations; financial disincentives, including the cost of moving and impacts on eligibility for the Age Pension; and psychological and practical barriers such as emotional attachment to the existing home.[9]

The first panel of witnesses at Sydney Hearing 3 focused on issues surrounding the development of and move to accommodation suitable for ageing in place and receiving aged care services. This panel consisted of the following witnesses:

- Dr Brendon Radford, Manager of Policy and Advocacy, National Seniors Australia
- Mr Simon Schrapel AM, Chief Executive Officer, Uniting Communities
- Ms Peta Harwood, Manager, Development Services Branch, Brisbane City Council.

Supply of suitable housing that people want

Dr Radford told us that from National Seniors Australia's perspective, the current housing market is not providing the housing that older people want or need.[10]

Brisbane City Council has adopted initiatives for the development of accommodation suitable for ageing in place.[11] Ms Harwood explained that in 2015, Brisbane City Council research indicated that in the future there would be a predicted shortfall in the supply of purpose-built retirement and aged care accommodation. Brisbane City Council sought to improve the supply of suitable accommodation within existing communities so people can maintain their social connections.[12]

National Seniors Australia submitted that more 'seniors friendly housing options' are required as a means to encourage downsizing.[13] Dr Radford stated that people would like more housing options within their local community.[14] He said that if there was housing that suited their needs, older people would consider moving to a more suitable new home earlier.[15] Desirable options include: accessible design; single level, preferably on the ground floor; low maintenance size and fixtures; at least two or three bedrooms to accommodate visitors; an office, or separate bedrooms for health reasons; affordable heating and utilities; privacy; and an 'easy care' garden or outdoor area.[16]

Mr Schrapel told us about a Uniting Communities development, U City, located in Adelaide's central business district. The development includes 41 retirement living apartments, 21 Specialist Disability Accommodation apartments and 18 disability accessible short-stay serviced apartments, as well as commercial, retail and hospitality accommodation.[17] Mr Schrapel stated that the urban location of U City had been a 'draw card as people seek inner-city living options that can support their lifestyle and which doesn't "pigeon hole" them into a community defined by age or disability'.[18] We heard that the building was designed to 'make the most of the richness of diversity', by encouraging the use of public spaces and allowing residents to 'take advantage of the benefits of engaging with others'.[19] Mr Schrapel stated that this design was for:

> a new and emerging group of older citizens who do not want to be corralled into a single demographic living environment and who seek ongoing participation in community life.[20]

21.1.3 Accessible design

Livable Housing Design Guidelines

Following the National Dialogue on Universal Housing Design, Livable Housing Australia formulated the Livable Housing Design Guidelines in 2010. The Livable Housing Design Guidelines set out design features for housing to meet people's changing needs across their lifetimes.[21] The guidelines have three performance levels:

- Silver, focusing on the key structural and spatial elements critical to ensure future flexibility and adaptability of the home
- Gold, which provides for more generous dimensions for most of the structural and spatial design elements and introduces additional elements in kitchens and bedrooms for accessible housing
- Platinum, which provides design elements that would better accommodate ageing in place and people with higher mobility needs.[22]

In 2010, the National Dialogue for Universal Housing Design, which represented government, the housing industry and community sectors, set an aspirational target for all new homes to meet at least the Silver performance level by 2020. In 2018, it was estimated that the current voluntary approach was 5%, although stakeholders argued that it may be closer to 10%.[23] National Seniors Australia agreed that the efforts to ensure basic accessibility standards under the National Dialogue are failing in part because they are voluntary.[24]

At the time of the hearing, the Australian Building Codes Board was undertaking a Regulation Impact Assessment on options for minimum accessibility standards for housing based on the Livable Housing Design Guidelines for potential inclusion in the National Construction Code.[25] The July 2020 Consultation Regulation Impact Statement, prepared by the Centre for International Economics for the Australian Building Codes Board, examined the need for accessible housing based on findings from academic literature and its consultations. The Consultation Regulation Impact Statement summarised that accessible housing can potentially:

- reduce the incidence of falls for people with mobility limitations
- reduce care needs
- reduce costs associated with home modifications
- avoid the need for people who acquire a mobility-related disability to move to more suitable accommodation
- reduce the length of hospital stays
- increase the ability of people with disabilities and the elderly to participate in society
- reduce inappropriate or premature entry into aged care or other institutional care.[26]

Incentives for increasing the supply of accessible housing

Each witness on the first panel spoke of the need to encourage the development of suitable accommodation that meets people's needs and expectations.

Dr Radford stated that increasing the development of accessible accommodation can either be done by providing incentives for development, or imposing a minimum standard for compliance.[27]

Mr Schrapel told us that, from his perspective, there are two ways that the Australian Government can encourage further development of accessible accommodation for ageing in place: capital grants and an additional rental subsidy.[28]

The witnesses discussed specific options to incentivise construction of suitable accommodation.

Consideration of an occupancy subsidy for accessible accommodation

The panel considered whether a rental subsidy similar to the Specialist Disability Accommodation supplement could be implemented for accommodation that meets accessibility standards when that accommodation is occupied by a person over a certain age.

The National Disability Insurance Agency has published the *NDIS Specialist Disability Accommodation Design Standard* which sets out prescriptive design requirements for Specialist Disability Accommodation under the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020* (Cth).[29] The Design Standard explains that Specialist Disability Accommodation is accommodation meeting the Design Standard which may be funded under the National Disability Insurance Scheme for those who have extreme functional impairment or very high support needs.[30]

Mr Schrapel told us that the Specialist Disability Accommodation at U City meets the Platinum performance level of the Livable Housing Design Guidelines.[31] Mr Schrapel explained that U City's accessible apartments receive Australian Government funding for rental contribution when occupied by residents with Specialist Disability Accommodation approval within their National Disability Insurance Scheme plan.[32]

Mr Schrapel said that U City's retirement living apartments meet the Gold performance level of the Livable Housing Design Guidelines. He said while this is not required under South Australian legislation, he considered the Livable Housing Design Guidelines best practice in the design of apartments for people as they age and become reliant on mobility aids. He explained that meeting this performance level increased the cost of construction of the apartments by about 10% which 'ultimately gets passed through to the residents through entry pricing'.[33]

Mr Schrapel stated that a rental subsidy provided for independent retirement accommodation that meets certain accessibility standards could encourage development of accessible accommodation options by providing developers with certainty of return on investment for an ongoing period of time.[34] He suggested that such a rental subsidy should be provided upon construction as a general incentive, rather than only being received when a dwelling is occupied by someone of a certain age. He considered that providing the subsidy on a universal basis would facilitate ageing in place because 'A lot of people don't think forward in terms of what their needs might be as they age and their mobility might decrease'.[35]

Ms Harwood believed that the ongoing revenue provided by a rental subsidy would encourage development of accessible accommodation.[36]

Ms Harwood noted that the Brisbane City Council's Universal Housing incentives of infrastructure charge reductions were not limited to a particular age and were designed to cater to the accessibility needs of all residents including people who are ageing, people with disability or families with young children.[37]

Dr Radford was attracted to the simpler application used by Brisbane City Council of eligibility to an incentive program for all types of housing, rather than an occupancy payment limited to a certain age.[38]

Initiatives by local government

Ms Harwood told us about ways in which the development of appropriate housing for ageing in place can be encouraged at a local government level.

In 2015, Brisbane City Council became aware that the need for retirement and aged care housing options within Brisbane was expected to increase by 50% by 2027. A report commissioned by the Council found that, to meet the anticipated demand, the development industry would need to deliver over 220 retirement dwellings per annum, double what was forecast to be delivered.[39]

The Council, after consultations, developed initiatives to facilitate the supply of suitable housing and enable Brisbane residents to continue to live within their suburb and community as they grow older. The Council's goal was to ensure that there is a diverse range of housing options for the ageing population.[40] The Council's initiatives involved three main elements:

- changes to the Brisbane City Plan to offer a more streamlined approach for retirement facilities and aged care facilities
- a Universal Housing Design Incentive providing a 33% reduction of infrastructure charges for qualifying developments
- streamlined assessment of development applications.[41]

We were told that Brisbane City Council is the largest local government in Australia and may have resources that smaller local governments do not.[42] Ms Harwood suggested that other councils may be able to implement some of the measures it adopted, dependent on State or Territory planning legislation. She stated that this includes changes to the assessment process, such as free pre-lodgement meetings and assigning 'Key Account Managers' to develop an understanding of the industry which can 'easily be picked up'.[43]

Mr Schrapel said that Adelaide City Council was encouraging greater density and diversity of living options in the central business district, which meant there were no planning or zoning impediments for the U City development.[44]

Need for joint effort by government

We heard that there is a need for action at all levels of government to increase the supply of suitable accommodation. Ms Harwood saw the benefit of each level of government working together. She stated that, although the Brisbane City Council is trying to incentivise more purpose-built retirement accommodation and residential aged care facilities in Brisbane, the Council is unable to influence building codes nor to mandate accessible design.[45]

Dr Radford commended Brisbane City Council for encouraging developers to take up the Livable Housing Design Guidelines, but stated that 'the other alternative' was minimum standards imposed within the Building Code to ensure new housing meets the standard.[46] He added that there may be a need for government compulsion to ensure that there is sufficient supply of suitable housing for ageing in place in the future.[47] Mr Schrapel considered that the voluntary adoption of accessibility standards should be promoted first:

> I think developers would need some lead time if we were going to actually introduce…a requirement to meet a particular standard. But I do think, over time, that's probably where we should be heading.[48]

The witnesses agreed that a National Strategy for Housing for Ageing should be implemented by the Australian Government with the State, Territory and local governments.[49]

Mr Schrapel stated that a National Housing Strategy would make 'eminent sense' and provide policy direction for a range of issues by:

> dealing with issues of people who are experiencing homelessness right through to home ownership and how to deal with all of those issues in a way that actually get[s] better housing outcomes.[50]

He criticised the current system stating 'we do have this patchwork which creates a number of inequities between the States and Territories which don't have any logic to them'.[51]

Reform beyond the aged care system to facilitate ageing in place

Dr Radford stated that there are a lot of older people who are asset rich and income poor, with insufficient income to supplement their Home Care Packages and remain at home.[52] While this creates barriers to access to suitable accommodation for ageing in place, it also provides opportunities for reform beyond the aged care system.

Stamp duty

We heard that stamp duty is a barrier to downsizing for those who own their home.[53] Dr Radford considered that replacing stamp duty with a land tax might not address financial disincentives faced by people wishing to downsize. He said any change of this kind would have to be effected carefully and over a long period of time, because older Australians would not necessarily be prepared to pay land tax if they have paid stamp duty in the past.[54] Mr Schrapel believed that a national housing strategy would be necessary to address the different tax regimes between the States and Territories and the resulting inequities.[55]

Age Pension means testing

National Seniors Australia stated that the exemption of the family home from the Age Pension means test creates a disincentive to downsizing, as proceeds of selling the family home affect pension eligibility.[56]

The Grattan Institute, in its 2019 report entitled *Generation Gap: ensuring a fair go for younger Australians*, stated that younger Australians are not making the same economic progress as previous generations, whereas older Australians are wealthier than ever before.[57] The report found that many Age Pension payments are made to households with substantial property assets, with half of government spending for Age Pensions going to those with more than $500,000 in assets. The report concluded that the Australian Government should change the Age Pension asset test to 'include the value of the family home above some threshold, such as $500,000', explaining that 'these people have enjoyed substantial support from taxpayers over many years, yet will pass on a significant amount of their wealth to their heirs'.[58]

However, surveys conducted by National Seniors Australia showed that older Australians oppose the idea of a means test on their homes for the Age Pension.[59]

Pension Loans Scheme

The Pension Loans Scheme is a subsidised reverse mortgage scheme providing a regular income stream through Centrelink to older Australians who meet the age and resident requirements for the Age Pension (or other similar payments), but are ineligible or only receive partial payment due to their income or assets.[60] In 2015, the Productivity Commission explained that the Pensions Loans Scheme was intended to be part of a never-implemented Age Pension asset tests but was now 'in effect a stranded policy' which was 'inefficient and ineffective' with 'multiple design flaws'.[61] The Productivity Commission explained there was low awareness of the Scheme among consumers and it is unavailable to full pensioners who might need it most. It said that while the Scheme is available to part-pensioners, they are likely to have other streams of income and likely to need assistance with large one-off expenses, rather than a small fortnightly income.[62]

National Seniors Australia recommends a reduction of the Pension Loans Scheme interest rate to encourage uptake of the scheme.[63] The interest rate under the Scheme came down from 5.25% to 4.5% in late 2019, but Dr Radford considered it still 'a bit too high'.[64] Dr Radford stated that older people would be encouraged to use the Scheme if its interest rate was reduced to an attractive rate and the Australian Government better promoted it. He stated that increased uptake of the Scheme would allow older people the opportunity to use equity built up in the family home to supplement government funded home care services and remain at home.[65]

In its report *Generation Gap: ensuring a fair go for younger Australians*, the Grattan Institute explained that if its recommended reform to the Age Pension means test of including the home were adopted, seniors with little income who live in a high-value property should then be able to take advantage of the Pension Loans Scheme. This would involve borrowing income up to the rate of the Age Pension against the security of their home to replace lost pension income after failing the means test.[66]

Implementation of a universal pension

National Seniors Australia recommended the replacement of a means tested Age Pension with a universal pension. National Seniors Australia submitted that this would remove the disincentive to downsize.[67] Dr Radford explained that a universal pension would take away incentives to overcapitalise on housing and 'people would be more likely to put their money into investments that generate income'.[68]

While acknowledging that there are political impediments to changing the tax system, Dr Radford said that National Seniors Australia has received general support for this idea from their members and the broader community.[69] He agreed that an argument against the removal of means testing is that it could lead to intergenerational wealth disparity, but said that amendments to the tax system could ensure that this does not happen. He stated that:

> provided you get those settings right, then it will be fair. And that's something that we need… the system is supposed to encourage people to save money, and that's not what is happening in the current setting.[70]

21.1.4 An innovative example: cohousing

As an example of how older people have made their own arrangements to find suitable housing for ageing, we heard from two witnesses about 'cohousing'. Ms Maria Brenton and Ms Hedi Argent gave evidence together of their experiences as members of the 'New Ground' Older Women's Cohousing Community in Barnet, North London, known as 'OWCH'.

Ms Brenton is a Senior Cohousing Ambassador of the United Kingdom Cohousing Trust and previously served as an independent project consultant for Older Women's Cohousing Community, and is a non-resident member of the community.[71] Ms Argent was the first member of the community to move into New Ground in December 2016.[72] Ms Brenton told us that the community is the only established cohousing community exclusively for women in the United Kingdom, and was established to address the issue of women becoming lonely and isolated in older age.[73]

Ms Brenton explained that growth in cohousing was a response to the 'growing demand among older people…for less paternalistic forms of accommodation and care'. This model is based on the assumption that maintaining autonomy will 'keep older people happier and healthier and reduce their need for formal health and care services'.[74]

Ms Argent told us that she became a member of OWCH nine years ago because of her desire to be part of a community.[75] She explained that she believed it was her responsibility to make plans for her old age as she had 'never intended for other people to decide what I would do in my old age'. When describing their community, she said:

> we are all independent…we are not done unto. We do it ourselves. We manage ourselves. And we are becoming old and staying independent. I think we are staying healthier than we would normally stay.[76]

New Ground is comprised of 25 self-contained apartments housing 26 women aged 51 to 91 years. It is a mixed tenure development with 17 long-term leasehold apartments and eight publicly subsidised rental units owned by a small housing association.[77] Ms Brenton explained that the number of residents was chosen to be large enough to permit the community to afford certain expenses of the development, such as a lift, but small enough to permit decisions to be made by consensus.[78] She said that the wide age range of the community ensures that the community remains viable and renewable. OWCH members co-designed the building to be 'entirely age-friendly and accessible and therefore a "last home" if so desired'.[79] The design included 'circulation spaces' for members to spontaneously meet to increase social cohesion of the group.[80]

We heard that all decisions regarding the community are made by consensus, with the group meeting monthly. Ms Argent explained that any potential member must get to know all members over a number of months, facilitated by a membership group.[81]

Barriers to seniors cohousing developments

Cohousing, while not new, has received little recognition in Australia. Collaborative housing arrangements such as cohousing communities can build stronger communities by supporting ways to share resources, pool skills and promote social connection.[82] A report prepared by the National Ageing Research Institute states that cohousing can provide benefits, such as offering an affordable way to downsize, retaining financial independence, and helping prevent isolation by keeping socially active.[83]

Ms Brenton said that the process of developing New Ground took 11 years because OWCH's members needed the cooperation and support of local authorities and it was 'not forthcoming'.[84] Ms Brenton stated that she believes there are no other senior cohousing communities within the United Kingdom due to ageism:

> We, I think a bit like Australia, are kind of stuck in the 19th century in terms of seeing older people as objects of care…There is a very strong streak of paternalism in our culture where older people are seen to need things done to them rather than be enabled to do things for themselves.[85]

Ms Argent advocated that, to make cohousing options easier to pursue, there needs to be a 'complete change of attitude towards ageing and old people'. She said that:

> Ageism is the thing that really stops the development…the whole thing is—it's like—it's easier and safer to put us away, really, somewhere; tuck us away somewhere and manage us and do it—do it all for us.[86]

The National Ageing Research Institute observed that cohousing projects take a great deal of initiative and planning and 'Australia's conservative lending institutions' are not likely to facilitate groups of older people to fund these forms of new accommodation. As such, cohousing initiatives are more likely to succeed if supported by the Australian Government by way of grants or collaboration with developers.[87]

21.1.5 Social and affordable housing for ageing and aged care

In the first panel, Mr Schrapel referred to a 'growing number of older people who don't own their own homes'.[88] He told us that trends on home ownership are shifting and there is a risk that older people will be unable to afford to remain in private rental accommodation upon retirement.[89] A 2011 report by the Australian Housing Urban Research Institute, based on census data from 1996 to 2006, reported a declining trend in the percentage of outright home-owners over the age of 65 years, and predicted increasing polarity in income levels, and increased demand for affordable housing.[90] While acknowledging the trend may be subject to inaccuracy due to the way in which data were defined and collected, the report projected that outright home ownership of older Australians would decrease from 81% in 2001 to 55% by the mid-21st century.[91]

Projections published in 2019 by the Australian Housing Urban Research Institute also show increasing housing insecurity.[92] According to this modelling, by 2031 over 200,000 older people will be living in private rental housing and in need of assistance with one or more activities of daily living.[93] The Productivity Commission found that renting in older age is associated with potential risks, including homelessness and impacts on mental health and wellbeing.[94] Homelessness for older Australians is rising, including for people not historically associated with homelessness—such as single older women.[95]

The Commonwealth Rent Assistance program provides a payment to eligible tenants in the private rental market who need assistance to pay their rent. The Australian Housing Urban Research Institute has forecasted Australian demographic and tenure changes and calculated that the number of eligible recipients under this program over the age of 55 years will increase by up to nearly 60% by 2031, outpacing the expected population increase of 35% for the same age cohort.[96] The Institute also predicted that the number of private renters over the age of 75 years who are eligible for social housing in Australia will more than double to 2031, increasing from 27.5% of the cohort to 34.2%.[97]

Counsel Assisting explored the need for social and affordable housing, and the potential investment in that type of housing from social impact investment, with the following witnesses on the second panel:

- Mr David Larmour, Acting Chief Operating Officer – Community of the Bethanie Group
- Ms Cathy Humphrey, Chief Executive Officer of Sacred Heard Mission
- Mr Michael Lynch, Executive Director of Impact Investing at Social Ventures Australia.

Defining social and affordable housing

A recent report entitled *Fixing Affordable Housing in NSW and Beyond*, prepared by Industry Super Australia for the NSW Community Housing Industry Council, defines 'social housing' as 'long term rental accommodation, subsidised by the government, for people on a very low or low income, who meet the required eligibility criteria'. It defines 'affordable housing' as housing managed by registered Community Housing Providers:

> that is appropriate for the needs of a range of low to moderate income households and priced so that these households are also able to meet other basic living costs.[98]

Social housing includes 'public housing' and 'community housing'. Mr Lynch agreed that 'public housing' was housing owned or leased by the State and Territory Governments and rented to members of the public.[99] 'Community housing' is defined by the *Fixing Affordable Housing in NSW and Beyond* report to be social housing provided by not-for-profit community housing organisations.[100]

The *Fixing Affordable Housing in NSW and Beyond* report further explains that affordable housing is government subsidised and intended for people on a higher level of income than social housing. Households do not have to be eligible for social housing to apply for affordable housing. The report also states that:

> As 'a rule of thumb, housing is usually considered affordable if it costs less than 30 per cent of gross household income or less than 75 per cent of market rent.[101]

Ms Humphrey thought it was 'good to see' affordable housing separated from social housing in these definitions to reflect the difference in approach of payment of subsidised market rent in affordable housing and lower 'public rent' in social housing. She considered this reflects the different levels of disadvantage between tenant groups.[102]

Need for social and affordable housing

Mr Larmour told us that Bethanie Group is a large not-for-profit Western Australian aged care provider of residential aged care services, home care services and retirement villages. He said that Bethanie Group's subsidiary organisation, Bethanie Housing Limited (Bethanie), provides social and affordable housing.[103]

Ms Humphrey explained that Sacred Heart Mission, a community services organisation based in St Kilda, Victoria, does not provide direct housing but works with providers to provide the support a person needs to sustain a long-term tenancy. The services that Sacred Heart Mission provides include residential aged care services, aged care services in the community, crisis accommodation and a range of individualised case management responses, including referrals to specialist services and assistance finding accommodation.[104]

Both Bethanie and Sacred Heart Mission work with people over the age of 55 years who experience premature ageing.[105] Mr Larmour stated that Bethanie typically deals with people who have experienced a 'lifetime of disadvantage'.[106] Ms Humphrey highlighted that the group of people Sacred Heart Mission assists to access housing often have significant chronic health conditions, mental health issues and prolonged substance abuse.[107]

Mr Larmour stated that social housing stock was at an 'all-time low in Australia' with not enough social housing to meet demand in Western Australia.[108] He said that approximately 14,000 people were awaiting housing in Western Australia at the time of the hearing, and 1800 of these were seniors. Mr Larmour said that older people wait on average two years to access suitable housing despite being placed on the Western Australian Government priority list for housing.[109]

Ms Humphrey told us that in Victoria there is a joint waiting list for social housing with the Victorian Housing Register in Victoria, and at the time had over 50,000 people waiting for housing. Older people are prioritised, but there are wait times of anywhere from three months to two years depending on their geographic area. Sacred Heart Mission also looks at the private rental market as an option for their clients in affordable housing.[110]

The Australian Housing Urban Research Institute estimated that in 2016 almost 250,000 Australians over the age of 55 years may have been eligible for social housing, but were in private rental accommodation, reflecting not the actual but the '*potential* length of waiting lists'. This number was projected to increase to up to around 440,000 in 2031, assuming unchanged social housing stock.[111]

Mr Larmour cautioned that:

> if we do not resolve the accommodation issues for older Australians moving forward and look at those in its entirety, the outcomes in the system will be that we will be required to build more and more hospitals to accommodate people, and we will be required to build more and more residential aged care homes to accommodate people when principally that is not the broader wish of the community.[112]

Accessibility standards in social and affordable housing

Mr Larmour explained that Bethanie's stock, inherited from the State Government and around 20 to 30 years old, was never designed for ageing and was not built to an appropriate accessibility standard to allow ageing in place.[113] He stated that at the time of construction of this housing, there was 'little thought given to accessibility and mobility' and in many cases modifications to allow greater flexibility are costly or not possible.[114]

Ms Humphrey considered that Melbourne's social and affordable housing stock was likely older than in Western Australia. She said that a lot of the low rise and high rise social and affordable housing in Melbourne was 'really old stock' which was 'not suitable for ageing in place' due to it not meeting appropriate accessibility standards. Ms Humphrey stated that affordable private rentals were usually older properties 'not conducive to ageing in place'. She stated that landlords would be 'highly unlikely to fund modifications' to make them suitable.[115]

Mr Larmour and Ms Humphrey both considered that mandating accessibility standards in future for new builds 'would be really important'.[116]

Social impact investment in social and affordable housing

Social impact investment

Mr Lynch described Social Ventures Australia as a not-for-profit organisation providing consulting services to government, foundations and service delivery organisations in the social sector. Social Ventures Australia has an Impact Investment team that works with partners to invest in organisations and projects which return positive social outcomes as well as appropriate risk-adjusted financial returns.[117]

Mr Lynch explained that social impact investing is different to other forms of investment as its success is measured by the social outcomes of the investment, as well as the financial returns.[118] Mr Lynch categorised three ways in which social impact investment takes place:

- investment directly in a social enterprise organisation that would generally borrow or take investment from a range of different sources[119]
- social impact bonds, which involve investment related to a service program under outcomes-based contracting, usually between a service provider and government, where a portion of the payment is conditional on the contracted social outcomes being met by the program[120]
- investment in capital works and projects, which Mr Lynch described as 'probably the greatest opportunity for investment [in] the broader housing space across social, affordable, disability and aged care'.[121]

The panel's evidence primarily explored investment in capital works. Statements tendered at the hearing also considered social impact bonds and accommodation support services.

HESTA's interest in social impact investment

Mr Lynch stated that Social Ventures Australia currently manages three social impact investment funds, the largest being a $71 million fund for H.E.S.T. Australia Ltd (HESTA) called the Social Impact Investment Trust. HESTA is the trustee for the Health Employees Superannuation Trust of Australia. Mr Lynch explained that the purpose of the Social Impact Investment Trust is to invest in 'businesses, housing projects and social impact bonds that deliver both financial returns and identifiable and quantifiable social impact'. This fund has invested in community housing, affordable housing and aged care.[122]

Ms Mary Delahunty, Head of Impact at HESTA, explained that any decision to invest with the Social Impact Investment Trust must 'deliver market-based financial returns for HESTA's members' and also deliver 'identifiable and quantifiable social impact outcomes'.[123] She said that as the majority of Health Employees Superannuation Trust of Australia superannuation fund members work in the health and community services sector, HESTA has a specific focus on identifying impact investments primarily in that area. This means that through investing in this sector HESTA 'is helping address social issues impacting not only the community but also its members'.[124] She said that HESTA's interest in social impact investing also seeks to support growth of the impact investment market more generally by encouraging other investors into the market through sharing case studies of their success.[125]

Ms Delahunty said that HESTA believes that health and aged care property assets are not 'as exposed to the economic cycle as other types of large scale commercial or retail property investments'. She acknowledged, however, that due to government involvement they can have other political, regulatory and operating risk factors which may influence their attractiveness as an investment.[126]

21.1.6 Attracting large social impact investment in social and affordable housing for older Australians

Mr Lynch and Ms Delahunty set out two matters requiring management to achieve expansion of social impact investment in social and affordable housing:

- the regulatory risk in government grant and subsidy programs
- the need for scalability to make investment financially viable.[127]

Regulatory risk in a subsidy or grant program

Mr Lynch explained that for social housing:

> it's very clear that it's very difficult to have an income model that would generate a sufficient return on investment to actually attract mainstream capital into that area without a significant intervention by government with some kind of subsidy or grant.[128]

From the perspective of HESTA as a social impact investor, Ms Delahunty confirmed that given below market rate returns for rent in social and affordable housing, 'some form of government support through either a land or income subsidy arrangement can change the risk and return dynamics of an accommodation project'. However, she said that government involvement, in turn, carries 'regulatory risk'. Regulatory risk comes from the possibility that government policy and regulatory regimes underpinning a subsidy or grant arrangement could change at the discretion of the government of the day. Ms Delahunty explained that investors will usually seek compensation for this risk through higher risk-adjusted return before investment.[129]

Options to manage regulatory risk

The witnesses explained a number of options to manage and mitigate regulatory risk. Mr Lynch said 'strong bipartisan support for any kind of subsidy program into aged care would be critical in attracting investment' to give confidence to investors that a program would continue in the event of change in government. He further thought the subsidy or grant program should have strong support in legislation such that there 'was very limited risk' of the Australian Government suddenly terminating the program.[130]

Ms Delahunty suggested strong contractual protections for investors where their investment is dependent on subsidy or grant payments to ensure that investors are compensated if the Australian Government terminates the contract.[131] She added that government support for systemic features could also increase the confidence of investors, such as by ensuring the sustainability and quality of aged care providers, providing tax incentives, and avoiding structural complexity to make a grant or subsidy program more accessible to investors.[132]

Scalability

Mr Lynch explained that there are not many large scale investment opportunities available for social impact investments within the market. He stated that it is important for large institutional investors, such as HESTA, to find investment opportunities that allow for significant investment.[133]

Ms Delahunty said that scale is important for large superannuation investors as the 'resources required to undertake due diligence for a small investment are in many ways similar to a large investment' and so efficiently deploying capital requires 'scalability'.[134]

Mr Lynch and Ms Delahunty both stated that to bring large scale capital investment to social and affordable housing suitable for ageing, the asset class must become more liquid, with an established market where products can be bought, sold and traded.[135]

Options to increase scalability

Mr Lynch stated that one means of increasing scale is to educate investors and show how investment can be made. A pilot development or proof of concept can be used to demonstrate that investment in an asset class can be scaled up.[136] Ms Delahunty's statement explained that HESTA had done exactly this by successful investment in small housing strategies through the Social Impact Investment Trust with Social Ventures Australia. Ms Delahunty explained that these investments are designed to grow the Australian impact investing market by attracting other institutional investors to make their own impact investments.[137]

Mr Lynch considered that the collection and publication of data on outcomes would also assist. He explained that to attract investors interested in social outcomes, it is important to provide investors with the data to show whether an investment has generated value in terms of defined outcomes, such as wellbeing or cost savings for the system.[138]

When considering scale in affordable housing in the absence of government subsidies or grants, Mr Lynch said there are a number of models that can work, but that 'something has to give in the structure to produce properties that are sold at a significant discount to market'. He suggested concessions could come from developers' profits, by contribution of land by governments, or other structural concessions. He explained that 'necessarily a cookie cutter approach' of structural concessions that can be replicated, rather than unique arrangements, were required for scalability.[139]

Programs to grow social impact investment in social and affordable housing suitable for ageing

The second panel discussed programs which, through appropriate regulatory risk management and scalability, could support growth in social impact investment in social and affordable housing suitable for ageing in place.

Accommodation occupancy subsidy

Mr Lynch considered that an accommodation subsidy could attract investment in accessible social and affordable housing.[140] The term of tenancy for an older person seeking to access social or affordable housing may be considerably shorter than that of a younger person with a disability receiving the Specialist Disability Accommodation supplement, where the subsidy is attached to the person. Mr Lynch suggested that attachment of the subsidy to the property may be more appropriate, being less challenging for investors and creating a long-term revenue stream.[141]

Ms Humphrey considered that encouraging development of accessible social and affordable housing by providing an accommodation supplement could 'actually work' to address the gap of available housing for disadvantaged older people.[142] Mr Larmour stated that such a supplement could also be used to make existing infrastructure meet accessibility standards so that it is fit for ageing in place.[143]

When we heard evidence from the first panel, Mr Schrapel, of Uniting Communities, told us that a supplement would increase development of accessible social and affordable housing for ageing, because it would provide certainty for developers 'not just at the point of construction, but over time'.[144]

Affordable housing tax credit

The *Fixing Affordable Housing in NSW and Beyond* report contains a number of recommendations to improve the supply of affordable housing.[145] One such recommendation involves a tax credit allowing investors to 'purchase tradeable tax credits in exchange for equity funding directed to regulated' Community Housing Providers.[146] Mr Lynch considered that this would be an 'interesting opportunity to replicate an NRAS-type [National Rental Affordability Scheme] structure'. He said that there was 'definite merit' in a tax credit of this type.[147]

Ms Delahunty noted in her statement that a National Rental Affordability Scheme, if re-introduced, 'could be designed to be more accessible to institutional investors' to encourage greater uptake.[148]

Financial corporation investment fund

The *Fixing Affordable Housing in NSW and Beyond* report suggests that an independent entity could be established by the Australian Government to invest in affordable housing developments.[149] Mr Lynch believed that it would be more efficient to establish a fund than create another entity. He said the National Housing Finance and Investment Corporation has provided low cost financing for community housing providers very successfully. He suggested that this entity could be extended rather than creating something new.[150]

Social impact bonds for navigation or support services

Mr Lynch explained that social impact bonds are a type of social impact investment which provides a funding mechanism to enable social service providers to enter into outcomes based contracts with government. He told us that when a service provider enters into an outcomes contract 'a portion of payments are dependent on the results achieved by the program'. Investors in social impact bonds raise capital to fund upfront delivery costs for the social service provider and share in the financial risk of achieving the targeted outcomes.[151]

We heard evidence that for people experiencing disadvantage, providing accommodation may not be enough and support programs may also be required to locate and keep them in suitable accommodation for ageing. Ms Humphrey explained that the group of people who need social housing are 'really hard to reach' without advocates or family members assisting them to manage access to services. She said it was a group that 'we really need to assertively outreach and connect with to navigate that pathway into a service response'. Ms Humphrey agreed that Sacred Heart Mission was acting in a 'broad navigator role' for clients in dealing with the social and affordable housing sectors.[152]

Ms Humphrey told us about the importance of housing support services in the context of Sacred Heart Mission's Journey to Social Inclusion Program, which provides case management and service coordination for younger people who have experienced long-term homelessness. Ms Humphrey explained that this program is funded through a social impact bond and a 'payment-by-results contract'. Funding for the contract comes through private, public and not-for-profit sources.[153]

Ms Humphrey suggested that a program to intervene early to prevent people falling out of housing is required. She supported an extension of the Assistance with Care and Housing program. The Assistance with Care and Housing program is a sub-program under the Commonwealth Home Support Programme. This sub-program is currently block funded for service providers to engage directly with, and provide targeted advocacy and support to, people at risk of homelessness.[154] Ms Humphrey told us that the program is 'currently really underfunded and under-resourced and there's not enough programs of that type across Australia'.[155]

National strategy on housing for ageing for policy leadership and funding

Mr Larmour told us that Bethanie would be supportive of a national strategy for housing, but that this strategy should not exist in isolation. He emphasised that a national strategy should link with the health care system and that 'if the ultimate goal is to age in place' a person's care needs, not accommodation, is the 'most significant factor'. He explained that at the end of a person's life, as their functional capacity declines and risk of hospitalisation increases, if their care needs are not met, they will be denied the opportunity to remain in their home.[156]

Mr Larmour considered that the issue of the long waitlist for housing is a problem requiring both policy and funding to resolve. He stated that the first thing required is the development of policy to recognise and target funding specifically for older Australians and provide consistency across States and Territories. He said that the national policy 'needs to be clear on the outcome that is seeking to be achieved'.[157]

Mr Lynch believed that it would 'be an effective use of resources by governments to create an enabling environment to encourage social impact investment' but that this would require 'on-going co-ordination and leadership from governments'.[158] He stated that Social Ventures Australia believes there is 'a strong case' to create a National Office of Social Impact Investing to play the role of building a large and robust social impact investing market. This would be done through providing a means for people with innovative models for social impact opportunities to connect with relevant Australian Government agencies to drive outcomes through investment and testing.[159]

Ms Humphrey considered that targets were critical within a national strategy to ensure accountability for States and Territories and drive their commitments. She said that at the Australian Government level there needed to be stimulus in the form of social impact investment, or the National Housing Finance and Investment Corporation should stimulate affordable housing growth so that there is less reliance on the State and Territory public housing systems alone.[160]

21.1.7 Physical design of residential aged care in the future

While it may be the preference of most, for some people remaining at home may not be possible and it may be necessary to enter a congregate care setting due to a variety of factors, including loneliness and isolation, a need for greater care support, or a need for home modifications.[161] Witnesses on the third panel gave evidence about the design of residential aged care.

Counsel Assisting asked the witnesses to consider the introduction and implementation of principles for accessible and dementia-friendly design in residential aged care, and encouraging or requiring a move away from institutional models of care. The panel consisted of the following witnesses:

- Mr Robert Pahor, Director of Spowers Architects
- Adjunct Professor Stephen Cornelissen, Group Chief Executive Officer of Mercy Health
- Mr Frank Weits, Chief Executive Officer of ACH Group.

Institutional residential aged care

Mr Weits said that ACH Group defines traditional 'institutional care' as a 'one size fits all' approach with 'burdensome bureaucracy and red tape where individual decision-making and choice are restricted'.[162]

Professor Cornelissen said that institutional care is provided in larger facilities with 'medicalised models that look and feel like hospitals'.[163] He stated that this model exists in both the physical environment and also the staffing model and culture. He described common physical features of institutional care as including: long corridors with nurses' stations, noisy environments with call bells and announcements over a public address system, and bedrooms organised into large wings, each with one central dining room and lounge.[164]

Professor Cornelissen acknowledged that there are benefits of the institutional model. He stated that this model can be more efficient through staffing arrangements and task-based orientation. There is also a smaller chance that staff members may become overly-familiar with residents.[165]

In his statement, Dr Stephen Judd, then Chief Executive Officer of HammondCare, said that the key characteristics of institutional care are inflexibility, hierarchical systems, and 'a disabling effect' on residents.[166] He provided examples of these features respectively as:

- Inflexibility: large central kitchens which do not permit flexibility in meals and meal times to suit resident preferences.[167]
- Hierarchical: nursing structures where registered nurses direct other staff leading to a 'task-focused' workplace rather than building relationships with residents.[168]
- Disabling: where mealtimes, interactions, commercial design and movement reflect 'the rhythms' of the organisation, not the resident—saying to the resident that the resident is not in control.[169]

Professor Cornelissen set out the drawbacks of the institutional model stating that the task-based nature of the staffing model 'tends to de-humanise the resident' and does not build relationships. He continued that residents 'are more likely to experience loneliness, boredom, isolation and depression', and that institutional settings tend to have less freedom of movement with 'locked doors and less access to the natural environment'.[170]

As explored further below, we also heard that institutional settings are not suited to the needs of people living with dementia. The New South Wales Agency for Clinical Innovation prepared a resource outlining key principles for the design of inpatient units for people living with dementia. This resource states that larger facilities increase agitation and are confusing to these residents.[171]

Designing deinstitutionalised residential aged care in the future

Mr Pahor gave the simple example of eliminating handrails on walls and lifting rails on ceilings as an attempt to 'deinstitutionalise' traditional residential aged care settings. He said that from the perspective of an architect, removal of these features was possible but the aged care provider needed to ensure they have a 'management protocol in place' to replace them.[172]

Professor Cornelissen agreed that the example of removing handrails was 'very logical in every sense'. He added that nursing stations were also not required, and instead Mercy Health has developed a model where they use a 'study nook' in the 'main area of the lounge room'. He said that the approach should be 'that we go to work in someone's home, that they don't come to live in our workplace'.[173]

Professor Cornelissen said that the design of the built form should reflect location and geography. For example, in Queensland it may be more appropriate to have outdoor flowing areas between separate residences, whereas in colder climate locations it may be more appropriate for all residences to be located under a single roof.[174]

Mr Pahor referred to his experience of the 'evolving' principles in Australia of designing 'clusters'. This involves breaking down the rooms of a larger facility into areas that are potentially stand-alone but integrated with the facility as a whole. He said that the exact nature of a design will depend on a range of factors, including the site, geometry, and planning considerations.[175]

Mr Pahor considered it is 'paramount' to incorporate accessibility and dementia-friendly design principles in residential aged care.[176]

Accessibility

Construction standards for residential aged care are set out in the Building Code of Australia, contained in the National Construction Code under which residential aged care buildings are Class 9c 'aged care buildings'.[177] The Livable Housing Design Guidelines do not apply to Class 9c residential aged care buildings under the National Construction Code.[178]

Mr Pahor explained that the National Construction Code requirements for residential aged care do not cater for dementia-friendly design. He considered it would be beneficial if such designs were included in the early planning stages, including at the planning approval or development approval stage.[179]

Professor Cornelissen commented that the regulatory requirements for Class 9c buildings raise 'considerable issues' when trying to move towards a 'domestic-type home product' both for affordability but also in domestic 'look' when applied to innovative models. He gave the example of Mercy Health refurbishing 'servery' kitchens in three small households, each housing 10 people. He stated that Mercy Health was required to install grease traps worth $50,000 each, which he said was 'probably dearer than the entire kitchen' and 'neither makes it very liveable or normal'. He said the standards for 100-bed facilities need to be 'challenged' when applied to small facilities.[180]

Mr Pahor suggested that the Livable Housing Design Guidelines are a good guide as a starting point in design rather than an end product for national standards for accessible design. He was not overly familiar with the National Disability Insurance Scheme's Specialist Disability Accommodation Design Standard, but agreed that such guidelines may help as more of an end product.[181] Professor Cornelissen saw 'merit' in having national standards for accessible design but cautioned that the Livable Housing Design Guidelines may be too vague. He doubted that there would be many facilities built in the previous 25 years which would not meet the highest level performance level of the Livable Housing Design Guidelines, Platinum.[182]

Dementia-friendly design

Dr Judd explained that good design can provide sensory cues which can become 'incredibly important' for older people, particularly those with dementia, when interpreting their surroundings.[183]

Professor Cornelissen said that dementia is not a homogenous disease, and nor are the people who live with it a homogenous group. He explained the 'need to cater for their entire social elements and dementia being just one part of that treatment'.[184]

Mr Pahor said that there is not full agreement among his clients on how to deliver dementia care. He said that generally Spowers has been trying to develop an approach where dementia residents are not separated from the rest of the facility and, where possible, not separated from the public.[185]

Dr Judd stated that residential aged care design should promote autonomy and independence with residents able to maintain their own routine, while also being 'enabling, helping residents to compensate for function that might be diminished'. He said that to reduce confusion, aural and visual stimuli should be reduced.[186] Dr Judd explained that other dementia-friendly design principles used by HammondCare revolve around reinforcing personal identity, maximising independence, enhancing self-esteem and confidence, being orientating and legible, and being welcoming to visitors and the community.[187]

Mr Pahor set out what he considered to be some 'fundamentals' of dementia design: 'human scale', providing less 'noisy areas, perhaps less stimulation, being able to be seen, freedom of movement and familiar spaces'. He suggested that these features should not just be dedicated to a 'dementia area' of a residential facility, but that they are 'good principles throughout the facility'.[188]

The Victorian Department of Health and Human Services published the *Dementia-friendly environments: A guide for residential aged care services* design principles on their website. This guide is targeted at Victorian public sector aged care facilities but is available for use by private sector providers. The design principles recognise that the 'critical aspects of a dementia-supportive environment' are the person's experience of a facility and opportunity for autonomy. These aspects are dependent on the physical layout and social environment of the facility which the design principles address.[189]

Mr Pahor said employing dementia principles throughout the facility would give the provider greater flexibility, such that a person who entered the facility without significant symptoms would not necessarily need to be moved if they experienced decline. He considered that requiring residents to move to dedicated dementia wings 'contradicts the sense of being familiar with surroundings'.[190]

Professor Cornelissen explained that some of Mercy Health's facilities that are older than seven years have secure dementia wards. He said that Mercy Health would prefer that these wards did not exist and that the provider was working slowly to eliminate secure dementia wards. He added that such a process can take anywhere from nine to 18 months for a facility. He stated that over the coming five-year period, facilities that are 10 or 12 years old could be reinvented. He said that while awaiting redevelopment, it is possible to make secure wards less institutional through a change to treating the human being rather than treating the disease.[191]

Grouping residents

Professor Cornelissen said that new residents who come to a new build of a small household model with Mercy Health have a high degree of choice about where they reside in the facility. He explained that residents could have input into the house they may move into, taking into consideration the people with whom they might have shared interests. Mercy Health does not segregate disease processes, they try to let people live where 'they have the right social connections and…relationships can flourish'.[192] Professor Cornelissen said that all Mercy Health's facilities are 'ageing in place sites' and people are grouped based on relationships. He explained that 'the only time they may move is if the symptomatology became at risk to them or others and that is very infrequent'.[193]

Mr Weits explained that ACH Group cohorts residents according to need into groups of people living with dementia, people without dementia and those with high care needs, with the exception of one site where reablement was the main focus. Mr Weits stated that he appreciated the most appropriate model for dementia was an inclusive, small-scale environment with a relationship-based care model. However, he added that (while not always), he did hear from some residents who did not have dementia that they would like to live with a group of people who also do not have dementia. Mr Weits said ACH Group was 'working through the options for the future' so that it can cohort people the way those people want to be grouped.[194]

Integration with the community

Mr Pahor considered that from a simple design perspective there was no reason why it would not be possible to have small homes in the community without the need for a larger institutional framework. He thought the parameters that may influence that model may be town planning issues and restrictions.[195] Mr Weits referred to the Dutch models of community residential aged care where there was societal acceptance and working with the community, with no panic if a person with dementia 'wanders' to the local shops.[196] Professor Cornelissen noted that a larger facility with a 'village concept' that integrates services could create a meaningful environment.[197]

University of New South Wales research from 2020 suggests that community integration requires a supportive operational environment, a supportive social environment, and a supportive built environment. Built spaces and layout need to facilitate interactions within the facility and provide ease of access to and from the facility.[198]

National aged care design principles and guidelines

Counsel Assisting asked the panel about a proposition for national design standards.[199]

Mr Pahor agreed that flexible national aged care design principles to encourage consistency 'would be a big benefit'.[200] Mr Weits and Professor Cornelissen could also see a place for a national set of aged care design principles and guidelines with some caveats.[201] All three panel witnesses considered that design principles should not be too restrictive.

Mr Pahor thought that the principles should be mindful of 'site-specific issues', not 'one approach solves everything' and flexible enough for further innovation.[202]

Mr Weits saw design principles operating at the design phase early in development as a guideline, and not in the specific construction phase or as a specific requirement for how to build. He would welcome design principles flexible enough to cater for the needs and preferences of all people in residential aged care.[203]

Professor Cornelissen also emphasised flexibility because people and communities are not homogenous where one design can fit everywhere. He thought that built form is only one part of the solution, and that the second part is an effective operational model. He considered without both 'a relationship human rights-based model' and 'a built form that facilitates that, we actually don't change the system at all'.[204] Professor Cornelissen said that Mercy Health would want to see the aged care regulations change to move towards human rights and relationship-based care with building regulations to facilitate that model of care.[205]

The Victorian Department of Health and Human Services stated that their dementia-friendly design principles address aspects of the social environment. It considered that the Victorian Planning legislation and the National Construction Code, technical schemes which deal with built form, did not appear to be the 'appropriate context' for embedding the principles of dementia-friendly design. However, a requirement in the National

Construction Code to implement dementia-friendly design guidelines in future construction may be appropriate.[206]

The Victorian Department of Health and Human Services submitted that any attempt to codify dementia-friendly design principles or guidelines needs to consider how the principles will continue to remain relevant and reflect evolving evidence and best practice.[207] The Department stated that developing a 'National Design Guideline' which could build on the Victorian model and could be linked to the Aged Care Quality Standards may incentivise uptake of dementia-friendly design in residential aged care.[208]

Small home models of care

Professor Cornelissen described the 'small household model' as looking 'like it could be found in any typical home across Australia', stating that this:

> allows staff, residents and visitors to easily help get a cup of tea or coffee, have a snack, assist with the cooking, meet, converse or just sit and chat like they would have in their own home.[209]

Dr Judd identified the key design features used by HammondCare's 'small cottage-model' as including: comfortable and familiar; intuitive, easy to navigate and enabling; providing autonomy and independence; compensatory; secure and safe; and connected to community.[210]

Dr Judd explained that HammondCare's small homes model revolves around a physical design that is 'comfortable and familiar', with domestic features that 'encourage normal daily life and activities'.[211] Both Mercy Health and HammondCare adopt open plan kitchens, access to outdoor areas, domestic and personal furniture and decoration, and a reduction of institutional elements such as signage for their small homes models.[212]

Professor Cornelissen explained that Mercy Health had begun to implement a 'small household model'. He said the most visible change in this model from the traditional model was that instead of residents eating in their rooms or a large dining hall, they have a small kitchen and dining area and eat sitting together with their 'household' around a dining table.[213] Professor Cornelissen mentioned that another important feature of the small household model was the ability to leave the smaller area and go to a different physical destination to get the stimulation of an outing.[214]

Professor Cornelissen said it was 'unequivocal' that the small household model was preferable to the traditional institutional setting, referring to both international research and Mercy Health's own review.[215] He explained the model's design:

> facilitates people being involved, being in relationships and it also facilitates a lack of loneliness, a lack of isolation, particularly institutional isolation, and also an increase in meaningfulness. We know that those three factors all have material effect on premature death in elderly people.[216]

While this model is often referred to as benefiting residents with dementia, Professor Cornelissen stated that Mercy Health believes that the small household model paired with relationship-based care is 'good for everybody who needs aged care'.[217]

Mr Weits said that he favoured the 'household model' and that people in residential aged care with dementia 'deserve the household model'. However, he cautioned against a 'one-size-fits-all household model' as he thought 'then we create the institution of the future'.[218]

Professor Cornelissen stated that it is important to remember that the 'built form is only one part of resolving aged care issues' and an 'effective operational model' must go 'hand-in-glove' with the physical design.[219] He explained that as well as the changes to the physical design as outlined above, Mercy Health's small household living environment requires consistent staff within a group of residents to maximise the opportunities for relationship development between residents and staff. Staff must also be trained to be 'resident focused rather than solely task-focused'.[220]

Transition to a small homes model

Professor Cornelissen said that 'as we move to more models built on relationships and more models built on small scale living opportunities, we will get varying degrees of success'.[221] He cautioned that we cannot assume we can suddenly 'turn the entire system around' and eliminate larger institutional care.[222]

Professor Cornelissen explained that of Mercy Health's 35 facilities, two had been purpose built with Mercy Health's small household model and four had been refurbished into that model. He told us that Mercy Health is 'trying to get those philosophies right where we can create those same sort of meaningful hubs and communities throughout all built form'.[223]

Professor Cornelissen stated that Mercy Health is looking continuously at how to deinstitutionalise their aged care homes. He stated that while there are limitations on the ability to make major built form changes, they are in the process of removing some of the institutional elements of facilities such as nurses' stations.[224]

Dr Judd believed that there would be few larger 'institutional' services that would be suitable for transition to the small home model. He considered that the majority 'will need to be retired, demolished, and redeveloped'. He explained that HammondCare has had limited success transitioning their larger services.[225] Professor Cornelissen did not disagree with Dr Judd, but said that due to the variation in the current system, there will be varying degrees of success in changing the operating model and built design in transitioning to a small homes model.[226]

Ms Lucy O'Flaherty, Chief Operating Officer of Glenview Community Services Inc in Tasmania, stated that the implementation of a small homes model at Glenview's single facility had been a success. She said that Glenview is of the view that the model has facilitated identifying changing care needs earlier, due to its 'improved relationships with consumer, their families and…external health providers'.[227]

Ms O'Flaherty explained steps taken by Glenview to transition to a small house model included ensuring that each household has sufficient equipment to prevent staff from having to leave the house during a shift, creating unique mealtimes, and call bells escalating within each house to promote teamwork and peer support within the house.[228] The use of colour and contrast has been used to 'break down the perception of long corridors'.[229]

Alternative models for residential aged care

Mr Weits cautioned that, 'it might be tempting to then say everyone in the industry needs to build small scale living with household models and lots of kitchens and the like', but there may be a variety of different residents with different needs in aged care in future. He said someone who is palliative or seeks reablement requires a built form that is specific to those needs.[230]

Mr Weits provided details of ACH Group's ViTA short-term 'health hotel', including larger private rooms, acute rehabilitation places and smaller communal areas.[231] He stated that the future of aged care should not be a 'passive respite model' but an 'intense reablement model' to equip a person with 'the tools to go then back home and hopefully stay at home much longer'.[232]

Mr Weits proposed that, although in the future a new build will likely be based on small home model design principles, a more individual-focused 'health hotel' approach could be applied to older residential style buildings that cannot be repurposed for a small-scale built form because this may be too difficult or capital intensive.[233]

Professor Cornelissen agreed with Mr Weits that a 'one size fits all' model for aged care is not desirable.[234] However, he emphasised that small household models and rehabilitation were not mutually exclusive:

> with the right sort of backend supports, and this includes good clinical support, good allied health support and gymnasium and wellness functions, you can still achieve that in the right institutional field regardless of where that is.[235]

Incentives to move to more suitable physical design in residential aged care

While Mercy Health does plan on transitioning all their 'traditional style homes', Professor Cornelissen stated that they have not considered how long this may take due to funding constraints.[236] He explained that if Mercy Health had unlimited capital and a 'managed process', it could probably completely transition their facilities to the small household model in eight years, but in reality it would be 'quite a while' before that could be achieved.[237]

Dr Judd considered that not all providers will require incentives to transition as some are 'driven by a passion to provide high quality care'.[238] He stated that transitioning the whole residential aged care sector to a small home or cottage model would require policy change by the Australian Government. He suggested that the Australian Government could incentivise transition by directing subsidies to the model by offering an increased subsidy for facilities implementing 'evidence-based models' and reduced subsidies for those operating under a 'traditional' institutional model.[239]

Dr Judd suggested that if the Aged Care Approval Rounds are to continue, they should be restricted to small home models.[240]

Professor Cornelissen suggested that an additional daily fee could be made available for small household models to help providers cover the higher square metre per resident capital costs and increased costs of a multi-skilled workforce.[241] He considered that with a sliding scale of fees to reward the built form, 'we could see industry change at a much faster level'. He said he was 'not so much convinced' by a capital grants incentive as he thought that it rewards the building but not the operation of the model.[242]

Mr Weits stated that capital grants and recurrent funding for highly rated facilities could overcome some of the barriers to adopting accessible design.[243]

The Victorian Department of Health and Human Services submitted that it incentivised the implementation of its dementia-friendly design principles in the Victorian public sector aged care though capital grants. It considered that opportunities to incentivise dementia-friendly design at the national level included: linking guidelines to the Aged Care Quality Standards, introducing a dementia-friendly certification process, and capital grants.[244]

Mr Weits stated that in the increasingly complex environment of the future, residential aged care providers will be challenged to provide greater clarity about where they add value for customers in their service.[245] Professor Cornelissen suggested that residential aged care should not been seen as 'the last resort' option. He expected that consumers would be more discerning and have higher expectations of aged care in the future.[246]

Endnotes

1 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 1, RCD.9999.0420.0001.
2 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 9, RCD.9999.0410.0253 at 0347.
3 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 14, RCD.9999.0398.0251 at 0403; 0470–0471.
4 See, for example, Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8765.8–14; T8775.21–33; Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8774.11–22; Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8804.9–14; Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8805.6–30; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 7, RCD.9999.0398.0895 at 0903; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 1, RCD.9999.0420.0001 at 0001 [2]; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 23b, RCD.9999.0408.0153 at 0195.
5 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8733.18–21; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 6, RCD.9999.0398.0863 at 0866.
6 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 6, RCD.9999.0398.0863 at 0866.
7 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8738.8–10; T8738.45–8739.5.
8 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 8, RCD.9999.0398.0744 at 0744.
9 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 8, RCD.9999.0398.0744 at 0746.
10 Transcript, Sydney Hearing 3, Brendan Radford, 14 August 2020 at T8736.16–18.
11 Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers, RCD.9999.0441.0001 at 0012 [42].
12 Transcript, Sydney Hearing 3, Peta Harwood, 14 August 2020 at T8737.10–14; Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers, RCD.9999.0441.0001 at 0007 [22]–[23].
13 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0007.
14 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8748.13–20; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0007.
15 Transcript, Sydney Hearing 3, Brendan Radford, 14 August 2020 at T8738.36–38.
16 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 7, RCD.9999.0398.0895 at 0906–0907.
17 Exhibit 19-3, Sydney Hearing 3, Statement of Simon Schrapel, RCD.9999.0426.0001 at 0002.
18 Exhibit 19-3, Sydney Hearing 3, Statement of Simon Schrapel, RCD.9999.0426.0001 at 0005.
19 Exhibit 19-3, Sydney Hearing 3, Statement of Simon Schrapel, RCD.9999.0426.0001 at 0006.
20 Exhibit 19-3, Sydney Hearing 3, Statement of Simon Schrapel, RCD.9999.0426.0001 at 0005.
21 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 21, RCD.9999.0408.0001 at 0008.
22 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 21, RCD.9999.0408.0001 at 0012.
23 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 23b, RCD.9999.0408.0153 at 0177.
24 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0008.
25 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 23a, RCD.9999.0408.0445.
26 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 23b, RCD.9999.0408.0153 at 0186.
27 Transcript, Sydney Hearing 3, Brendan Radford, 14 August 2020 at T8748.1–4.
28 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8749.43–8750.2.
29 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 22, RCD.9999.0408.0069; *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020* (Cth), pt 3 div 3.
30 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 22, RCD.9999.0408.0069 at 0075.
31 Exhibit 19-3, Sydney Hearing 3, Statement of Simon Schrapel, 7 August 2020, RCD.9999.0426.0001 at 0002 [3]; 0010 [8].
32 Transcript, Sydney Hearing 4, Simon Schrapel at T8749.25–36; see *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020* (Cth), pt 3.
33 Exhibit 19-3, Sydney Hearing 3, Statement of Simon Schrapel, 7 August 2020, RCD.9999.0426.0001 at 0008.
34 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8750.4–29.
35 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8750.24–8751.4.
36 Transcript, Sydney Hearing 3, Peta Harwood, 14 August 2020 at T8751.33–36.
37 Transcript, Sydney Hearing 3, Peta Harwood, 14 August 2020 at T8751.29–33; Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers, RCD.9999.0441.0001 at 0010 [32]–[36].
38 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8751.41–45.
39 Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers, 11 August 2020, RCD.9999.0441.0001 at 0007 [23].
40 Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers, 11 August 2020, RCD.9999.0441.0001 at 0006 [19].
41 Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers, 11 August 2020, RCD.9999.0441.0001 at 0002 [13]–0003 [14].
42 Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers,11 August 2020, RCD.9999.0441.0001 at 0001–0002 [8]; 0009 [30].
43 Transcript, Sydney Hearing 3, Peta Harwood, 14 August 2020 at T8748.36–42; Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers, 11 August 2020, RCD.9999.0441.0001 at 0012 [43].
44 Exhibit 19-3, Sydney Hearing 3, Statement of Simon Schrapel, 7 August 2020, RCD.9999.0426.0001 at 0005; 0007.
45 Transcript, Sydney Hearing 3, Peta Harwood, 14 August 2020 at T8741.27–42.
46 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8748.1–22
47 Transcript, Sydney Hearing 3, Brendan Radford, 14 August 2020 at T8748.24–29.
48 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8751.12–25

49 Transcript, Sydney Hearing 3, Peta Harwood, 14 August 2020 at T8742.1; Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8740.15; Transcript, Sydney Hearing 3, Brendan Radford, 14 August 2020 at T8742.14.
50 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8740.25–29.
51 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8740.21–23.
52 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8736.28–31.
53 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0007.
54 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8739.39–T8740.8.
55 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8740.10–29.
56 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0003.
57 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 10, RCD.9999.0398.0792 at 0794.
58 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 10, RCD.9999.0398.0792 at 0842.
59 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0003.
60 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 9, RCD.9999.0410.0253 at 0430.
61 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 9, RCD.9999.0410.0253 at 0290; 0430.
62 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 9, RCD.9999.0410.0253 at 0430–0431.
63 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0005.
64 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8744.12; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 9, RCD.9999.0410.0253 at 0430.
65 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0005.
66 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 10, RCD.9999.0398.0792 at 0842.
67 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 5, RCD.9999.0398.0001 at 0005–0006.
68 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8742.29–33.
69 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8743.16–17.
70 Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8743.39–T8744.2.
71 Exhibit 19-2, Sydney Hearing 3, Statement of Maria Brenton, RCD.9999.0395.0001 at 0001 [4].
72 Transcript, Sydney Hearing 3, Hedi Argent, 13 August 2020 at T8716.24–28.
73 Exhibit 19-2, Sydney Hearing 3, Statement of Maria Brenton, RCD.9999.0395.0001 at 0004 [12]; Transcript, Sydney Hearing 3, Maria Brenton, 13 August 2020 at T8714.41–46.
74 Exhibit 19-2, Sydney Hearing 3, Statement of Maria Brenton, RCD.9999.0395.0001 at 0003 [9]
75 Transcript, Sydney Hearing 3, Hedi Argent, 13 August 2020 at T8713.43–47.
76 Transcript, Sydney Hearing 3, Hedi Argent, 13 August 2020 at T8719.6–18.
77 Transcript, Sydney Hearing 3, Maria Brenton, 13 August 2020 at T8715.17–20; T8718.11–15; Transcript, Sydney Hearing 3, Hedi Argent, 13 August 2020 at T8715.42.
78 Transcript, Sydney Hearing 3, Maria Brenton, 13 August 2020 at T8716.9–17.
79 Exhibit 19-2, Sydney Hearing 3, Statement of Maria Brenton, RCD.9999.0395.0001 at 0004 [12]; 0005 [16].
80 Transcript, Sydney Hearing 3, Maria Brenton, 13 August 2020 at T8720.44–8721.2
81 Transcript, Sydney Hearing 3, Hedi Argent, 13 August 2020 at T8720.11–20; T8715.28–38.
82 Sydney Hearing 3, general tender bundle, tab 11, RCD.9999.0410.0192 at 0196.
83 National Ageing Research Institute, *Models of Integrated Care, Health and Housing*, A report prepared for the Royal Commission into Aged Care Quality and Safety, Research Paper 7, 2020, p 28.
84 Transcript, Sydney Hearing 3, Maria Brenton, 13 August 2020 at T8725.4–7.
85 Transcript, Sydney Hearing 3, Maria Brenton, 13 August 2020 at T8724.46–8725.4.
86 Transcript, Sydney Hearing 3, Hedi Argent, 13 August 2020 at T8725.42–8726.2.
87 National Ageing Research Institute, *Models of Integrated Care, Health and Housing,* A report prepared for the Royal Commission into Aged Care Quality and Safety, Research Paper 7, 2020, p 28.
88 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8736.36–42.
89 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8740.35–8741.2.
90 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 18, RCD.9999.0398.0591 at 0601.
91 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 18, RCD.9999.0398.0591 at 0625–0626.
92 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 26, RCD.9999.0398.0122 at 0218–0219.
93 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 26, RCD.9999.0398.0122 at 0136.
94 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 9, RCD.9999.0410.0253 at 0306
95 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 25, RCD.9999.0410.0054 at 0059; 0075; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 26, RCD.9999.0398.0122 at 0209; 0213.
96 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 26, RCD.9999.0398.0122 at 0225–0226.
97 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 26, RCD.9999.0398.0122 at 0228–0229.
98 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 38, RCD.9999.0439.0060 at 0076–0077.
99 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8758.29–34.
100 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 38, RCD.9999.0439.0060 at 0076.
101 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 38, RCD.9999.0439.0060 at 0077.
102 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8759.5–35.
103 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8757.21–27; Exhibit 19-5, Sydney Hearing 3, Statement of David Larmour, RCD.9999.0400.0001 at 0001 [6].

104 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8757.37–45; Exhibit 19-6, Sydney Hearing 3, Statement of Catherine Humphrey, RCD.9999.0399.0001 at 0002 [8]–[13].
105 Exhibit 19-5, Sydney Hearing 3, Statement of David Larmour, RCD.9999.0400.0001 at 0005 [12]; Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8762.18–23.
106 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8761.21–22.
107 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8762.19–23.
108 Exhibit 19-5, Sydney Hearing 3, Statement of David Larmour, RCD.9999.0400.0001 at 0003.
109 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8760.13–8761.8.
110 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8762.27–36.
111 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 26, RCD.9999.0398.0122 at 0226–0228.
112 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8781.1–6.
113 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8775.1–7; Exhibit 19-5, Sydney Hearing 3, Statement of David Larmour, RCD.9999.0400.0001 at 0006.
114 Exhibit 19-5, Sydney Hearing 3, Statement of David Larmour, RCD.9999.0400.0001 at 0004.
115 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 atT8775.21–8776.11.
116 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8775.13–15; Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8775.31–33.
117 Exhibit 19-7, Sydney Hearing 3 Statement of Michael Lynch, RCD.9999.0421.0001 at 0001 [6]–0002 [8]; Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8758.6–13.
118 Exhibit 19-7, Sydney Hearing 3, Statement of Michael Lynch, RCD.9999.0421.0001 at 0005 [29].
119 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8768.23–27.
120 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8768.29–31; Exhibit 19-7, Sydney Hearing 3, Statement of Michael Lynch, RCD.9999.0421.0001 at 0010 [53].
121 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8768.34–37.
122 Exhibit 19-7, Sydney Hearing 3, Statement of Michael Lynch, RCD.9999.0421.0001 at 0002–0003 [15].
123 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0005 [27].
124 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0006 [30].
125 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0006 [30].
126 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0006 [32].
127 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8768.43–8769.13; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0008 [44]–[45]; 0010 [50].
128 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8763.43–46.
129 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0008 [44]–[45].
130 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8771.32–45.
131 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0008 [45]–[46].
132 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0009–0010 [48].
133 Exhibit 19-7, Sydney Hearing 3, Statement of Michael Lynch, RCD.9999.0421.0001 at 0005.
134 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0010 [50].
135 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8778.10–36; Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0010 [49]–[52].
136 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8772.4–17.
137 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0010 [51]–[52].
138 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8782.10–29.
139 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8768.46–8769.13.
140 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8770.5–14.
141 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8771.4–33.
142 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8774.1–7.
143 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8774.11–16.
144 Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8752.5–15.
145 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 38, RCD.9999.0439.0060 at 0119–0125.
146 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 38, RCD.9999.0439.0060 at 0066.
147 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8776.26–45.
148 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 3, RCD.9999.0419.0001 at 0009–0010 [48c].
149 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 38, RCD.9999.0439.0060 at 0066.
150 Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8777.34–41.
151 Exhibit 19-7, Sydney Hearing 3, Statement of Michael Lynch, RCD.9999.0421.0001 at 0010 [53].
152 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8762.5–47.
153 Exhibit 19-6, Sydney Hearing 3, Statement of Cathy Humphrey, RCD.9999.0399.0001 at 0004 [22]; 0008 [45]–[49].
154 Exhibit 19-6, Sydney Hearing 3, Statement of Cathy Humphrey, RCD.9999.0399.0001 at 0003 [17]; 0006 [39]–0007 [41].
155 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8781.10–23.
156 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8764.24–41; T8766.27–41.
157 Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8767.4–18.
158 Exhibit 19-7, Sydney Hearing 3, Statement of Michael Lynch, RCD.9999.0421.0001 at 0008.
159 Exhibit 19-7, Sydney Hearing 3, Statement of Michael Lynch, RCD.9999.0421.0001 at 0008 [42]–[43]; Transcript, Sydney Hearing 3, Michael Lynch, 14 August 2020 at T8773.14–26.

160 Transcript, Sydney Hearing 3, Cathy Humphrey, 14 August 2020 at T8767.23–30.
161 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0030 [151].
162 Exhibit , Sydney Hearing 3, Statement of Frank Weits, RCD.9999.0427.0001 at 0003 [11].
163 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0006 [30].
164 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0006 [31]–0007 [32].
165 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0008 [40].
166 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0009 [49].
167 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0009 [50].
168 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0009 [51]–0010 [52].
169 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0010 [53]–[54].
170 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0008 [41].
171 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 29, RCD.9999.0410.0001 at 0008.
172 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8791.20–30.
173 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8796.41–8797.25.
174 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8800.38–8801.7.
175 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8786.27–35.
176 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8786.36–45.
177 Australian Building Codes Board, *National Construction Code*, 2019, Vol 1, sch 3, p 640.
178 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 21, RCD.9999.0408.0001 at 0015.
179 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8791.32–47.
180 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8793.1–22.
181 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8792.1–20; see Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 22, RCD.9999.0408.0069.
182 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August at T8792.42–47.
183 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0008 [47].
184 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8788.37–42.
185 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8787.1–7.
186 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0007 [40]–[42].
187 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0005–0006 [36].
188 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8787.13–21.
189 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 4, WIT.9771.0001.0001 at 0002 [8]–0003 [9]; 0001 [2].
190 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8787.1–40.
191 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8789.3–30.
192 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8787.42–8788.10.
193 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8788.12–24.
194 Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8789.34–8790.26.
195 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8804.9–14.
196 Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8804.16–29.
197 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8804.31–39.
198 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 28, RCD.9999.0409.0001 at 0280.
199 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 1, RCD.9999.0420.0001 at 0004–0005.
200 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8791.7–12.
201 Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8794.23–32; Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8792.22–36.
202 Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8791.7–18.
203 Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8794.23–43.
204 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8792.26–36.
205 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8802.4–17.
206 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 4, WIT.9771.0001.0001 at 0001 [2]–0002 [4].
207 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 4, WIT.9771.0001.0001 at 0002 [5]–[7].
208 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 4, WIT.9771.0001.0001 at 0003–0004 [13].
209 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0013 [67].
210 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0006 [37]–0008 [45].
211 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0006 [38].
212 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0006 [38]; Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0014 [75].
213 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0013 [67]–[70].
214 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8799.9–17.
215 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8796.7–8.
216 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8796.20–24.
217 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8796.12–14.
218 Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8795.42–46.
219 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8792.29–32.
220 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0011 [57]–[58].
221 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8800.24–31.

222 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8796.39–41.
223 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8797.27–43.
224 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0007 [36]–0008 [37]; Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8799.1–7.
225 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0017 [97].
226 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8800.21–31.
227 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 2, WIT.0778.0001.0001 at 0003 [12].
228 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 2, WIT.0778.0001.0001 at 0002 [8].
229 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 2, WIT.0778.0001.0001 at 0003 [13].
230 Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8794.34–41.
231 Exhibit 19-6, Sydney Hearing 3, Statement of Frank Weits, RCD.9999.0427.0001 at 0009 [38]–0010 [41].
232 Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8795.4–16.
233 Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8802.19–47.
234 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8799.19–8800.6.
235 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8799.47–8800.2.
236 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0022 [109a]–[109b]; 0023 [110]–[111].
237 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8801.9–16.
238 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0016 [92].
239 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0016 [90]–[93].
240 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 39, WIT.1367.0002.0001 at 0016 [96].
241 Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0024 [117].
242 Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8799.19–32.
243 Exhibit 19-9, Sydney Hearing 3, Statement of Frank Weits, RCD.9999.0427.0001 at 0009 [37].
244 Exhibit 19-1, Sydney Hearing 3, general tender bundle, tab 4, WIT.9771.0001.0001 at 0003 [12]–0004 [13].
245 Exhibit 19-6, Sydney Hearing 3, Statement of Frank Weits, RCD.9999.0427.0001 at 0004 [18].
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22. Sydney Hearing 4: Home Care

22.1 Hearing overview

22.1.1 Introduction

We held a public hearing on home care in Sydney, New South Wales, from 31 August to 2 September 2020.

Our Terms of Reference require us to inquire into challenges and opportunities in aged care raised by 'changing demographics and preferences, in particular people's desire to remain living at home as they age' and 'how to ensure that aged care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care-related matters'.[1]

In preparation for Sydney Hearing 4, staff of the Office of the Royal Commission developed 10 draft propositions relating to requirements for the delivery of high quality and safe care to older people in their homes and in the community. The propositions were published on our website and were provided to witnesses on or about 7 August 2020.[2] On 22 August 2020, an outline of Counsel Assisting's proposed new service arrangements was provided to witnesses, expanding upon the draft propositions and modifying proposition HC2.[3] Senior Counsel Assisting explored the propositions and proposed new service arrangements with witnesses during the hearing.

We heard oral testimony from 28 witnesses covering five key themes concerning home care arrangements, being how best to:

- respect the preferences and choices, boost control and enable independence of the people seeking support and care in their homes
- transition to arrangements that are easy to use, efficient and can deliver care that meets assessed needs
- ensure that the services will be provided safely and that they will be of high quality
- ensure that providers and the workforce have the capability to provide the services that are needed
- ensure that proposals are achievable for the long term, in a sustainable manner.

22.1.2 Older people want to remain living at home

Research Papers authored by Flinders University and Ipsos, commissioned and published by us, confirm that older people want to stay at home as they age.[4]

A 2015–16 Australian study found that each hour of additional home care per week is associated with an appreciable 6% lowering of the chance that the person will ever have to enter residential care. The study also found that people who were predominant users of social support services remained in their own homes for longer.[5]

Mrs Rosemary Milkins PSM cared for her late mother at home for 17 years. Speaking about her mother, Mrs Milkins told us that 'we wanted her to retain her dignity and her ability to live her own life in an environment that was very familiar to her'.[6] In response to suggestions that Mrs Milkins arrange for modifications in her mother's home, she said that her mother 'didn't really want to do any of that because she felt that it took away from her the home she had lived in' for decades.[7]

Mr Rodney Foreman and Mrs Rosalie Foreman told us about their 'goal' of Mrs Foreman exiting residential aged care to resume living at home with Mr Foreman.[8] After having a stroke, Mrs Foreman entered Aminya Nursing Home for the Aged in Mannum, South Australia. Mr Foreman moved into an independent unit situated at the back of the Aminya complex, so he could visit Mrs Foreman as often as he wanted. As a result of the stroke, Mrs Foreman was told that she would never walk again. The Foremans did not accept this and Mr Foreman paid for additional physiotherapy sessions each week to achieve a number of short-term goals, including Mrs Foreman walking with assistance and being able to get in and out of a car.[9]

Mrs Foreman described her first time walking again following the stroke as feeling 'very good'. As her mobility improved, she started spending nights at the unit with Mr Foreman.[10] Mrs Foreman had received referrals through the Commonwealth Home Support Programme and tried to access funding towards an electric bed and a mobile commode for the independent living unit. Despite being eligible for the Commonwealth Home Support Programme and Home Care Package services, they experienced difficulty accessing support as Mrs Foreman was deemed to be in a residential aged care facility.[11] Mr Foreman said:

> In theory she was eligible but because she was deemed to be in aged care, in a facility, it was very difficult to get—we basically didn't get much access to that. I had myself assessed so that I could get some assistance as social support individual, which with a cooperative provider here we were able to do stuff on a minimal basis. We parted with a lot of money to get to where we've got to. But that's the nature of the beast, I guess.[12]

When the frequency of overnight stays at Mr Foreman's unit increased, Mr Foreman was informed that Mrs Foreman was only permitted a certain number of nights away from the residential aged care facility, or 'she would be deemed to have left the aged care facility'. Once it was apparent to Mr Foreman that there would be restricted visitation rights to the aged care facility due to COVID-19, he decided to 'bite the bullet and get her out'. At the time of the hearing, Mr and Mrs Foreman had been living together in the independent living unit for four and a half months.[13] Mrs Foreman stated that being able to leave residential aged care and living with her husband at their unit made her 'very happy'.[14]

22.1.3 Choice, control and independence

The first theme explored by Senior Counsel Assisting with witnesses was how best to respect the preferences and choices, boost control and enable independence for people seeking support and care in their homes.

Mrs Milkins said that she was appalled by people's attitudes to aged care. She explained:

> I suppose what we need to remember is they were all young once and inside that old body is still the young person, the person that's got value.[15]

This sentiment is reflected in the evidence we heard from Ms Eileen Kramer, a 105-year-old working dancer, choreographer, writer and artist, who told us that there is too much emphasis on age.[16] She said:

> I don't feel old, I don't want to behave old. But I realise that the spirit has a house to live in and that house is our body, so we have to look after that. And that's what aged care is about, in a way. We have to look after that house so that our spirit can enjoy life. Mine does.[17]

Mr Robert Fitzgerald AM, NSW Ageing and Disability Commissioner, said that there has been a very significant anti-ageism campaign in relation to:

> the recalibration of the way in which we see older people in the Australian community… whereby we see and value older people as important parts of our community, not simply seeing them as people that are fading.[18]

He added that 'the greatest risk that all of us face in the Australian community is when we become invisible, and older people tend to become invisible'.[19] He said:

> We deal in the world of people that are slowly losing cognitive capacity. But the assumption has to be, in the first instance, that they have cognitive capacity and that's very important.[20]

Mr Fitzgerald explained the need for 'safeguarding' of people who may be vulnerable to abuse or other risks. He told us that the ability of a person to make or influence decisions on their own behalf is one of the most important parts of safeguarding.[21] He emphasised the importance of ensuring that older people are 'not only at the centre of the service delivery system, but they're an active participant in it'. Mr Fitzgerald said that often the focus is placed on the provider, to the exclusion of participation by the older person. He added that older people need to be given 'the capacity to make decisions on behalf of themselves and to influence decisions made on their behalf'.[22]

Associate Professor Lee-Fay Low, Ageing and Health Research Group, Faculty of Medicine and Health, University of Sydney, said that 'we should be supporting people to have a say in their care'.[23] Associate Professor Low asked us to recommend a 'culture shift' away from 'home care' where we are 'doing things for older people', to 'home support', which involves supporting and enabling people to live well so that they 'stay autonomous, as independent as possible with support from services'.[24]

Associate Professor Low said that while the purpose of home support is to 'provide services that enable all older Australians to live at home while optimising their quality of life', the caveat 'as long as it's safe to do so' could certainly be added.[25] She explained that autonomy is not necessarily the opposite of safety:

> Actually, lots of people do want safety. They sometimes just want psychological safety and, you know, that's why people don't want to go into residential aged care. They want the safety of home...
>
> we should be thinking holistically about people and safety isn't just physical safety, it's not just preventing falls, it's that the person's lonely and actually might be safer and they have companionship and it might be better for them in residential aged care, but only if they feel it is a safe place for them to live.[26]

Mrs Milkins said that the aged care system should allow older people to 'be living with dignity and maximising their capacity to be independent and make their own decisions'.[27] She gave the analogy of helping a child who is struggling to open a cap or a lid, explaining:

> we open it a little bit to allow them to finally take it off, so they feel that strength of being able to do it for themselves. And with old people it's entirely the same because the more that you take away from them in your attempts to help them, the more lacking in independence they become and their lives really, really change.[28]

Mrs Milkins told us about an incident after her mother experienced some confusion with her medication. A nurse locked her mother's medication in a 'big red box' without any consultation with Mrs Milkins or her mother.[29] Mrs Milkins said that her mother was 'furious' because:

> what it showed to her, this symbolic red box was, you are a fool now, you are daffy, you can't work it out for yourself, you're stupid, so we're taking it away from you, your toys and we're putting you in the naughty corner.[30]

Professor Jos Schols, Professor of Old Age Medicine, Maastricht University, told us that in the Netherlands there has been a lot of effort to improve the concept of shared decision-making, which is closely connected with consultative care planning. Professor Schols explained:

> So if you provide care via a care plan and you see that the care is getting complexer and complexer, during the regular evaluations, you discuss with the client and his family whether it's still possible to get the care at home or not and normally in a rational way, this always gets to the right solution. Sometimes there are some problems if you talk about people who are cognitively disabled because they do not always understand evaluations, and then you have to take some other measures together with their families.[31]

Care management and care coordination

Ongoing care management or care coordination is not funded as a separate service under the Commonwealth Home Support Programme.[32] Care management is commonly provided to people receiving Home Care Packages using funds from packages, and appears to account for on average 13% of total package expenditure. This figure is separate from administration or package management fees, which account for on average a further 15% of package expenditure.[33]

Mr Brian Corley, Chief Executive Officer, Community Options ACT Inc., explained that under the Commonwealth Home Support Programme, the Community Options model is to work with clients, develop a package of care around their support needs and then implement that with support staff and with coordination services.[34] He said:

> the system needs to be made compatible with the wants and aspirations of older Australians and that is a primary focus of people to continue to live at home for as long as that is practical and appropriate for them. That should be the policy goal.[35]

Mr Corley explained that the targeting of care management or coordination is important. He described it as 'a valid and vital service for those who need it', but said that if it is not directed to the people who need it then 'it's a waste of time'.[36] He also said:

> It should be appropriately supported and delivered by qualified and trained staff, and it should be done in partnership with the person, not in control. I like your notion of shared responsibility, but the care manager needs to be clearly working for the person.[37]

Mr Corley explained that 'many people in their Home Care Package will be paying for case management and not getting it'.[38] He stated that for care management to be successful, a precondition is that it is recognised as fundamentally important and is appropriately funded. He said:

> Our experience of the NDIS [National Disability Insurance Scheme], it's badly targeted and underfunded and people who need lots of support coordination in that world get not enough and some people who don't need it get a lot, and so there's balance that needs to be applied here...
>
> being funded for, you know, 15 hours a year to provide support coordination to a person with complex support needs is woefully inadequate, and that causes real issues and it causes providers like ourselves to do vast amounts of effectively pro bono work for the National Disability Insurance Scheme.[39]

Mr Corley said that there needs to be capacity for care management to be 'front-ended as people are trying to enter the system', to ensure that particularly vulnerable people do not 'drop out of support' due to difficulties with navigating the process and complexities surrounding their support needs.[40]

Ms Susan Emerson, Registered Nurse, member of the National Aged Care Alliance and the Australian College of Nursing, expressed caution over the terminology to be adopted, including use of the terms 'care management' or 'case management'. She explained that the 'language needs to be clear', because when she hears those terms, she thinks 'of it from a nursing perspective and of course there are other interpretations of that'.[41]

Ms Emerson said that the Australian College of Nursing 'firmly believes that care coordination should be carried out by a registered nurse or an allied health professional'.[42] She spoke about the benefits of involving nurses 'across the continuum'. Ms Emerson said:

> if we can have…a way of calling in expert advice from nurses and other allied health professionals all the way along there that's quick to respond, we will be able to prevent complexities and complications and support people to live their lives well.[43]

Self-management or shared management?

In a literature review prepared to inform the *Increasing Self-management in Home Care Project* conducted by COTA Australia, Dr Carmel Laragy concluded that there is a range of better outcomes for older people who self-manage their care, when certain conditions are applied.[44]

When discussing the concept of self-management, Dr Laragy explained that there are many people who want to self-manage their funds. She went on to say that those people who self-manage their funds 'find it more efficient, more effective, they get more of what they want. My question would be why wouldn't we let them do it?'[45]

The Final Project Evaluation Report, *Increasing Consumer Self-management in Home Care,* stated that in 2017, only about 48% of home care providers offered a self-managed option to consumers.[46]

Draft proposition HC3, which proposed a shift from self-management to shared management of home care and supports, attracted some critical responses.

Mr Peter Scutt, Founder and Chief Executive Officer, Mable Technologies Pty Ltd, expressed the view that shared management should only be offered as a choice and that self-management is a critically important option for people, particularly those with a desire to build capacity. He said there is a fear that the provider would have an undue amount of influence over the provision or choice of services should self-management be withdrawn as an option.[47] COTA Australia shared similar concerns in its written response to draft proposition HC3.[48]

Dr Laragy also expressed concerns over the proposed shift from self-management to a shared management model, describing the move as a 'restrictive practice'. She stated that the proposition dismisses evidence from numerous studies about the benefits to individuals of self-management.[49] COTA Australia strenuously opposed the proposal to shift the principles and emphasis of consumer directed care away from self-management to 'shared management'.[50]

In contrast, Associate Professor Low noted that 'it is not clear from the literature what differential benefits there might be between self-management and shared management'.[51] Dr Fiona Macdonald, Senior Research Fellow, School of Management, RMIT University, held a similar view.[52] She explained that:

> There is a limited body of research internationally on outcomes of self-managed care systems and it is difficult to draw clear conclusions from this research due to the fact that studies are often assessing outcomes of different arrangements defined as self-management. Systems vary in funding and in the extent to which care provision and care employment are regulated. However, despite a growing body of research on personalised care in England, there remains very little evidence to support a view that self-management provides any clear benefits over shared arrangements while it does carry additional risks, including for care workers.[53]

Mr Michael Lye, Deputy Secretary, Ageing and Aged Care, Australian Department of Health, said that the Department was uncertain about the definition of the term 'shared management'.[54] In a post-hearing submission, the Australian Government questioned the need to shift from self-management to shared management. It submitted that aspects of shared management are already part of the current system:

> Within the existing approach to consumer directed care, self-management as an option means that a consumer is involved in designing and directing their care and taking a lead role in making decisions to manage their package. Under self-management, the existing rules apply to the use of aged care funds, and so self-management does not mean consumers can use the funds for non-aged care related purposes.[55]

How Home Care Package funds are used

The Australian Government has indicated that there is evidence of the Home Care Package budget being used on 'items that have questionable purposes'.[56]

Mr Ahilan St George, Director and Co-Founder, Vitality Club, submitted that in relation to Home Care Packages 'what services are available, and what money could be spent on was not well understood or explained'.[57]

The Australian Government developed the Home Care Packages Program Operational Manual for home care providers, released in March 2020.[58] Mr Corley submitted that it is largely up to the provider to interpret these guidelines when responding to client requests on how they can use their funds. He added that 'Pathways to raise questions with the Department are limited with most requests being through Myagedcare and responses provided is to just refer back to the program guidelines'.[59]

Dr Laragy expressed the view that an aged care-related need should be defined:

> very broadly because the standards defined it very broadly, to promote independence, and to promote enjoyment of life. I think when we assess that we have to take a very broad psychosocial model of health framework which does include people's wellbeing and how they choose to live their life.[60]

In relation to the lack of visibility of Home Care Package spending, Dr Nicholas Hartland PSM, First Assistant Secretary, Aged Care Policy and Regulation, Australian Department of Health, said:

> We are worried about, you know, the Home Care Package Program has benefits around flexibility, but the funding arrangements don't allow us to understand what was actually delivered by service type within that program as a matter of course.[61]

The Australian Department of Health commissioned StewartBrown to undertake an analysis of a survey conducted on a large sample of home care providers for financial year 2018–19, and this analysis provides insights into how Home Care Package Program funding is currently spent. StewartBrown's survey analysis reveals that there were proportionately small amounts of Home Care Package funding spent on nursing care (registered nurse and enrolled nurse or other licensed nurse) and allied health care. A person receiving a Level 4 Home Care Package received approximately 2% of their total

hours of service per fortnight in nursing care, and approximately 1% of their total hours per fortnight on allied health.[62]

Dr Hartland acknowledged that the Australian Department of Health is concerned about these results. He explained that some people with Home Care Packages also access Commonwealth Home Support Programme services in the nursing and allied health categories. Dr Hartland said:

> I don't know that that would change the conclusion that you would arrive at, which is this does appear to be something that needs to be addressed in the Policy Reform Agenda because you would be expecting that those sort of intensive, more clinically-based services would be directed more to people with high acuity than people with low acuity.[63]

When asked about achieving a balance between the absence of delivery of nursing and allied health care and expenditure on items that improve quality of life, Dr Laragy said that this could be managed through the planning process. After an assessment is done, parameters could be set up as to what money can be spent on, similar to the National Disability Insurance Scheme.[64]

Associate Professor Low said that often older people will compare the price of receiving home care gardening services with paying their own, private gardener. However, that 'kind of price point doesn't take into account the care management, the support, the social supports that come with the package'.[65] Associate Professor Low explained that:

> older people don't want to feel like they want to waste their money on stuff that they don't need and sometimes we need to—it's our job to convince them that this is a useful thing and they should at least try it.[66]

22.1.4 Simplification of service arrangements

The second theme addressed during Sydney Hearing 4 was concerned with arrangements that are easy to use, efficient and can deliver care that meets assessed needs.

Integration of home care programs

Draft proposition HC2 proposed a transition to an integrated program of care at home, by combining the Commonwealth Home Support Programme and the Home Care Packages Program, which would serve to eliminate fragmentation within the system.[67] This proposition advocated separate funding for four categories covering:

- social support (including social and recreational activities, meals and transport)
- assistive technology and home modifications
- respite care (including at home, in the community and in facilities)
- care at home (including care management, clinical and nursing care, personal care and assistance, domestic assistance and home maintenance, reablement strategies, and end-of-life and palliative care).

Draft proposition HC2 further proposed that a person's funding allocation should be based on assessment by a range of health professionals and determined by need. This funding allocation would be an annual budget, paid by government and sufficient to cover the services required from a provider of the person's choice.

In response to this proposition, Australian Unity submitted:

> The disparity between the two primary current funding models, and the customer experience challenges this creates, does not support customers viewing the transition as part of a continuum of care based on their evolving needs.[68]

Dr Hartland said that the Australian Department of Health describes the Commonwealth Home Support Programme as 'an entry level program' which 'typically caters for people with lower needs'.[69] This aligns with the observation of Ms Jaclyn Attridge, Head of Home and Community Care Operations, Uniting NSW.ACT, that the original intent of the Commonwealth Home Support Programme was 'about entry level' support.[70]

Despite this intent, Dr Hartland said that the Commonwealth Home Support Programme has 'always had in it fairly high needs customers'.[71]

Ms Sharyn Broer, Chief Executive Officer, Meals on Wheels SA, raised concerns about the disparity in consumer contributions (that is, co-payments) between accessing Meals on Wheels services via the Commonwealth Home Support Programme compared to Home Care Packages. She proposed an 'evening out of the Government contribution so that it's completely transparent and understandable to the consumers about what they're accessing'.[72]

Dr Hartland said that the Australian Department of Health has observed 'incentives for people with high levels of income not to take lower level Home Care Package places and to remain on CHSP [Commonwealth Home Support Programme]', describing this as 'distortions…that ought to be addressed'.[73] He said that the Department would 'certainly accept a proposition' about ensuring that 'resources are allocated to people with the right level of need'.[74]

Mr Michael Lye, Deputy Secretary, Ageing and Aged Care, Australian Department of Health, expanded on Dr Hartland's point:

> it's an artefact of having three distinct programs and not an overriding logic and a continuum of care. And so you certainly have in CHSP [Commonwealth Home Support Programme] it trying to do more than what we would see in the future...[75]

Mr Corley stated that the objective of the current aged care system is not clearly articulated and can often be misinterpreted as 'creating a conveyor belt' to stream older people from entering at one point, moving to another system and ending up in residential aged care (often earlier than may be necessary). He said that, for most Australians, their actual experience was not like that, and for many older people, their only interaction with

the aged care system will be via the Commonwealth Home Support Programme.[76] He told us about the demand for Commonwealth Home Support Programme services from Home Care Package Providers:

> As a CHSP [Commonwealth Home Support Programme] provider we're already under increasing pressure from Home Care Package providers seeking our CHSP services to effectively top up their packages, and I think that needs to be carefully monitored because a significant proportion of the people currently waiting for a Home Care Package would be receiving CHSP services and if those services are no longer available, a significant portion of those people would find themselves in extreme difficulty.[77]

Mr St George expressed concerns about transitioning to a combined home care system. He acknowledged that the Home Care Package system is an effective means of delivering long-term care. However, he believed that it is currently struggling under the quantity and caseload provided.[78] He said:

> So there are about 120,000 people receiving a Home Care Package with about 100,000 people waiting for a Home Care Package for about 6 to 18 months. The CHSP [Commonwealth Home Support Programme]…is grant funded by services about 800,000 to 900,000 people per year and I find it difficult to imagine a situation where the Home Care Package system can absorb those 900,000 people to deliver seamless care and immediate care for 1.2 million people when they struggle with the current 200,000 people.[79]

Dr Hartland did not accept Senior Counsel Assisting's suggestion that, in light of the criticisms levelled at the Home Care Package program, it is 'failing' to provide services tailored to the needs of individuals. He considered that the program 'does have some benefits and the flexibility and choice and innovation it's driving is helpful'.[80] He acknowledged that a 'greater line of sight between assessed need and service outcomes' is required to ensure that people are receiving the services that they have been assessed for, and how they are accessing those services.[81]

Grant funding and individualised funding

Mr Fonda Voukelatos, General Manager, Strategy and Business Development, Uniting AgeWell, said that 'we need to move to a fully accessible, more simplified system that actually builds on the strengths of individuals', so that 'as people's needs change over time, that they should move to an individual program' along with those who enter the system for the first time with complex care needs.[82] Mr Voukelatos told us that UnitingCare Australia agreed with 'the domains that have been proposed' in draft proposition HC2.[83]

Mr Lye stated that categories were 'sound' and that the Australian Department of Health 'broadly share[s]' the views expressed in draft proposition HC2. He said that 'the issue is around how we get from where we are now to this world'.[84] In its post-hearing submission, the Australian Government submitted that it supports:

> (a) merging CHSP and HCP programs into one integrated program of care at home; and
>
> (b) having a typology against which services are grouped, with entitlement based on an independent needs assessment.[85]

The Australian Government submitted that the shift to a needs-driven system must be underpinned by a 'robustly developed funding classification system' that identifies people with similar characteristics, costs and risks to ensure, amongst other reasons, that people are treated equitably in the system.[86] The Australian Government outlined the relevant models and studies it has commissioned, and submitted that any recommendation to develop a funding classification for a needs-driven system should have regard to those models and studies.[87]

Dr Laragy expressed the view that 'flexibility is central' to funding for home care. She submitted:

> While separate categories of funding may be needed for budget and accountability purposes, rigid definitions and boundaries can be stifling and counterproductive. There needs to be flexibility between category boundaries to deliver user friendly services and better outcomes.[88]

Dr Laragy told us that she agreed 'in principle' with draft proposition HC2, but that the 'the social and the care at home' categories proposed in the draft proposition are likely to merge in reality. She described the categories as 'too restrictive' and instead recommended adopting a 'broader perspective'.[89]

Ms Broer described the importance of retaining grant-funded arrangements for some categories of services. She said that a service such as Meals on Wheels requires block funding given the 'high fixed and capital costs associated with the service, along with a reliance on volunteer labour'.[90] Ms Broer added:

> We really support the notion that meals, community transport and social support are included in a discrete category and that category is grant-funded and it's because those services are often bundled together to create a social connection experience for older people.[91]

Ms Broer said this social connection is 'critical to supporting the confidence of people to live independently and it's a light-touch way of reducing loneliness and isolation of people within the community'.[92] She added that another example of the benefit of grant funding was the ability to 'be able to stand up services rapidly' during the pandemic.[93] Carers Australia expressed similar views in its post-hearing submission.[94]

Mr Corley was broadly supportive of a transition to a more unified funding stream for home care. He told us that ensuring that services from any of the four service categories proposed were available simultaneously (and were not mutually exclusive) was 'the correct approach'.[95]

Mr Corley recommended the retention of a 'safety net' of services that would be available for quick deployment when, for example, someone is waiting for an assessment or a person's health condition changes dramatically. For these reasons, Mr Corley said 'I don't fully support that it's all individualised'.[96]

Mr Corley noted that one of the benefits of the block funding mechanisms of the Commonwealth Home Support Programme was to allow providers to 'respond much more quickly and flexibly to client needs' and enable them 'to meet urgent requests for service immediately as required'.[97]

Australian Unity submitted that a purely individual funding model would potentially create:

> delays or blockages to agile service delivery, unless providers also have access (through a criterion-based, provider-initiated, fast-turnaround application model) to some amount of 'pooled' or 'block' funding.[98]

Assessment

Mr St George said that there is a significant problem with people being 'lost in the system'.[99] He said that having a single assessment workforce is 'probably the most important reform issue', and that the merging of Aged Care Assessment Teams and Regional Assessment Service teams could go a long way towards creating 'a more seamless journey for a client going through the aged care system'.[100]

Associate Professor Low told us about the need to avoid duplication of assessments and efficiencies that could be achieved with better information sharing.[101] She suggested that the assessment team could help facilitate the transition to the home care provider.[102] She added that rather than performing the assessment which arrives on 'someone else's desk', that instead:

> real people talk to each other in hand-over involving that person and their family so that there's some kind of group negotiation of what that person's plan is. Especially for complex cases.[103]

Associate Professor Low's proposal was that in some cases it will be appropriate that consultation occur between the assessment team, the person and their family, and the person's chosen provider, before finalisation of the assessment.[104]

Dr Laragy said that the assessment should consider how the person's needs can be addressed through community support and be 'far more creative'. [105] She agreed with the need to remove duplication of assessments, adding that there should be principles built into the standards and the ways of operating that would guide providers about how to offer information. She explained that giving guidance would:

> give people the confidence to know what their choices are and the parameters and to know what's possible in the future, to have…alternatives to residential care, alternatives to hospital and a clear understanding of what's available in the primary healthcare setting to keep them safe and at home and give them confidence that the system will not abandon them. We know that many, many people are dying at home without packages that they need. So we would need a bridge to build that confidence, to let people know and to support them.[106]

Ms Emerson highlighted that the assessment is essential, but cautioned that the system needs to differentiate between low-level services because 'we don't want to be doing intrusive, comprehensive assessments for the lawn mowing service'.[107]

Mr Lye made similar comments, explaining that:

> you need to be able to make quite a rigorous assessment for those who have more complex needs…because it's going to drive significant expenditure, it needs to be, to some degree, independent or, you know, be able to discriminate between different individuals' needs.[108]

He added that 'there is a bit of work in terms of how we get from where we are now'.[109]

Dr Hartland explained that in terms of numbers of assessments currently undertaken per year, there are approximately '186,000 in the ACAT [Aged Care Assessment Team] and 250,000-odd in the RAS [Regional Assessment Service] system'. He said that the Australian Department of Health 'strongly supports' the proposition that assessment needs to be scaleable and flexible, noting that while consideration needs to be given to volume constraint issues, 'the first order of issue is actually how do you do it'.[110]

Clinical oversight

In a submission to the Royal Commission, the Australian Nursing and Midwifery Federation indicated its support for the integration of registered nurses into the assessment, case management and 'care finder' roles.[111]

Ms Emerson recommended that we look to our international counterparts 'to see the benefit of reintroducing clinical care and assessment right along the continuum'.[112] She explained that what nurses bring to a partnership with the older person is an understanding of 'what's important to the older person and to make decisions abouthow their care is provided'. She outlined how the system needs to be:

> flexible to be able to allow for that autonomy, the low-level light touch, but as I said earlier, where partnership will enhance the outcome for the older person by the assessment process, by listening to them, and by bringing in the right responses.[113]

Professor Schols told us that in the Netherlands, the assessment of need for home care is completed by 'district nurses' who are employed by the health care insurance providers, and that the district nurses also manage the team that provides the home care.[114] He explained that the district nurse:

> determines the care indication and the extent of care which is needed and there is a strong contact between the district nurse and the general practitioner. It's often the general practitioner who advises the family to seek for home care services via this Act because he or she sees that there are problems in the home situation and that nursing care is needed.[115]

Dr Laragy said there needs to be a very thorough assessment by appropriate people, including nurses or medical people, but that the 'default position' should not be that older people have a 'professional' running their home care services. Instead, the system should allow people to take more control unless there are reasons to stop it.[116]

Mr St George suggested adopting a more preventative model where people receive an assessment every three months. He said this proactive management of people would help identify where someone is declining before there is a critical incident.[117]

Navigation and accessibility

Associate Professor Low said that home support should be accessible. She said 'it should be easy to figure out how to get services, it should be equitable so we might be actually supporting people who have less social determinants of health…more'.[118] Associate Professor Low added that the aged care system needs to provide more support for people to understand what services, supports and options are available for them to be able to make informed decisions.[119]

We have heard that navigation of the current home care system is far from straightforward. For example, the Australian Nursing and Midwifery Federation submitted that although there is a range of services available to choose from, there is:

> often insufficient information available about those services to make informed choices. Consideration also needs to be given to the capacity of the individual to make those informed choices. This is often related to an individual's ability to navigate the complexity of the system rather than a cognitive decline in the individual.[120]

This is also apparent in the evidence of Mr Foreman, who told us that 'I struggled to find my way through what was available, what wasn't available, how to go about applying for it, those sorts of things'.[121]

22.1.5 How to ensure quality and safety

Witnesses gave evidence in response to a third theme posed by Senior Counsel Assisting, being how to ensure that home care services will be provided safely and that they will be of high quality.

Funding

Mr Corley told us 'if you want high quality you've got to price that in. There's no other way around it'.[122]

Mr St George said that it is crucial to have 'a much greater increase in pricing transparency around these costs in order to really ascertain what the true value of these costs are to each organisation'. He explained that 'to form the matrix of adequate pricing…we have to understand that we're pricing quality'. He said we need to ascertain 'what the lowest common standard of care we're willing to accept is and how all organisations need to work together in terms of resourcing and funding to achieve that standard'.[123]

Associate Professor Low submitted:

> Pricing should account for the supportive structures beyond direct service delivery which facilitate organisations to deliver high quality care. There should be annual reporting of how government funding has been spent on on-cost, which should be publicly available. This would help the Australian Government when adjusting prices and help service providers understand their financial performance relative to other providers.[124]

The Australian Nursing and Midwifery Federation submitted that 'Funding to support the transition to high quality care must include workforce funding' and that 'accountability and transparency measures' of providers should attach to the increased funding.[125]

Australian Unity submitted that:

> a duty to provide high quality and safe care must apply to providers. However, this must be supported by flexible funding mechanisms being available in 'real time' to accommodate customer changes in care while formal re-assessments are determined.[126]

Regulation and safeguarding

Proposition HC6(c) proposed improved regulatory measures and HC6(d) proposed safeguarding measures for people receiving aged care at home.

Mr Fitzgerald explained that regulatory compliance 'drives cultural change, both within society and institutions'.[127]

Ms Janet Anderson PSM, Aged Care Quality and Safety Commission, told us that 'market entry is an important regulatory tool and it is one of the ways in which the sector can be satisfactorily regulated'. However, she also said that the complexities of achieving a line of sight to individuals' homes 'mean that we need to be looking to other means of assuring ourselves that the providers know what they're doing'.[128]

Mr Fitzgerald told us that 'the highest risk for older people in the aged care system is within the home'. As identified by Ms Anderson, Mr Fitzgerald explained that 'the risks that occur at home are quite substantial because there is not the line of sight that you normally see in residential services'.[129] He added that:

> there's no doubt at all that good quality regulation and oversight proportionate to both the risk and the nature of the services being provided is essential. But it's only part of the suite of measures that are necessary to bring about a safe environment.[130]

Mr Fitzgerald said that the aim of safeguarding is to 'ensure that older people living in the family and in community contexts are able to live free of abuse, neglect and exploitation'.[131] He explained:

> It's not just about policies and procedures and if it was only that, it will fail. It's about the relationships that the vulnerable person, or the person at risk has with people, people that as carers, whether they're paid or informal, the service delivery system, the legal supports and systems and a number of other component parts.[132]

Ms Anderson cautioned that:

> because there are numbers of new, less-tutored providers, and the very substantial geographical dispersions of these providers into the remotest part of Australia…a one size fits all here would be absolutely impossible and that a staging of consideration would need to be carefully calibrated on both a risk basis, but also a capability basis, understanding the sector in its diversity.[133]

Ms Anderson told us that 'there would be many, many small, bespoke community providers who would not know where to start on some of these provisions'. She suggested that providers 'can rise to a challenge but they need support, they deserve support and guidance and advice'.[134]

In post-hearing submissions, the Australian Government submitted that it 'supports strengthening regulation of home services as outlined in propositions HC6(c)(i)-(iii) to promote additional protections for consumers'. The Australian Government further submitted that measures should be 'risk-based and proportional'.[135]

Aged Care Quality and Safety Commission

The Aged Care Quality and Safety Commission publishes quarterly sector activity reports. The reports for the first three quarters of financial year 2019–20 were tendered.[136] By comparison with the Commission's assessment contact and quality review activity in the preceding year, the quarterly reports in financial year 2019–20 showed a sharp decline in activity.[137]

In a submission to the Royal Commission, the Community and Public Sector Union, a trade union representing workers in the Aged Care Quality and Safety Commission, referred to the stress on the assessor workforce. It stated:

> 61% of the assessor workforce said they had considered leaving the ACQSC in the past 6 months because their workload was unmanageable.[138]

In response to a notice from the Royal Commission to give information, the Aged Care Quality and Safety Commission provided information about the decline in compliance activities undertaken as regulator in the home care sector, stating (amongst other things):

> The level of home care service compliance activities has been impacted by:
>
> (a) A high turnover in the assessor workforce. Despite several rounds of recruitment and training of new quality assessors in 2019, there has been a high level of attrition across the assessor workforce. This is partly due to the retirement of a number of experienced quality assessors and others taking up employment opportunities elsewhere in the aged care sector[139]

Ms Anderson acknowledged that contractors are 'a characteristic of our workforce and we are now working harder than ever to ensure that our recruitment processes ensure that we have sufficient staff to do the job we have to do'.[140] Senior Counsel Assisting suggested to Ms Anderson that it appeared the number of full time equivalent employees working on home care compliance activities dropped from about 40–50 employees in 2018–19 to about 10 employees in 2019–20. She said she could not confirm those numbers as they 'don't do the calculation that way' and said that her assessment teams work across both home and residential aged care'.[141] Ms Anderson told us that she expected to 'appoint over 40 additional frontline staff in this financial year', and that will 'significantly amplify our opportunities to undertake the in-person activities'.[142]

After responding to a question about whether 40 additional frontline staff would be sufficient, Ms Anderson said that she 'would understand' if the Royal Commissioners made a recommendation for a 'thorough capability review of the Aged Care Quality and Safety Commission'.[143]

Ms Anderson also described how, since March 2020, staff of the Aged Care Quality and Safety Commission commenced calls to consumers to 'get closer to the consumer and hear more clearly in an unfiltered way their voice'.[144] She confirmed that there was currently no Consumer Experience Report generated based on interviews conducted during home care quality reviews, but explained that 'we are very keenly looking at ways of ensuring that we can fairly produce reports on those consumer interviews in the short to medium term'.[145]

Assessment

Mr Fitzgerald said safeguarding for older people has to 'start from the assessment of the needs of the individual and the risks and the vulnerabilities that that person has at the earliest particular point in time'.[146]

Ms Kathryn McKenzie, Director, NSW Ageing and Disability Commission, told us when asked about questions contained in the National Screening and Assessment Form, aimed at identifying 'higher level of risk or indicators of potential risk to individuals', that 'the feedback that we get from the sector and from individuals is that those questions are not always asked in the assessment process for various reasons'. She suggested this might be because the assessor may be uncomfortable asking those questions because it may cause stress for the older person, or it may not always be safe to ask the older person those questions because of who else is present for the assessment. Ms McKenzie emphasised the importance of consistency in 'asking some of those more difficult questions, but also providing the safe space in which to ask and to obtain information relating to those risks'.[147]

Serious incident response scheme

Mr Fitzgerald told us that:

> reportable schemes have to be capable of delivering and what we've got in many of the reportable schemes is they're too expansive in what's being sought to be reported. As a consequence, the agencies are not capable of dealing with the reports in the way that is required.[148]

Mr Fitzgerald added:

> a reportable incident regime can look good and they are essential and we would support it in the home care provision for older people. But they need to be well-targeted, they need to be adequately funded and then they need to refer matters to other agencies at a State level that can deal with matter...Otherwise, we will overwhelm all the systems to the point that they become incapable and the community will lose respect in those systems within a very short period of time'.[149]

In post-hearing submissions, the Australian Government indicated its support in-principle for a Serious Incident Response Scheme in home care settings.[150]

Community visitors scheme

Mr Fitzgerald and Ms McKenzie drew our attention to the NSW Official Visitors Scheme, a key focus of which is to engage with residents to identify issues to be raised with service providers and other bodies for resolution. However, the scope of that scheme does not include people living in private residences. In contrast, as Mr Fitzgerald and Ms McKenzie pointed out, the Community Visitors Scheme in aged care includes visits to private residences. But the aged care Community Visitors Scheme has a different focus—to provide companionship and social connections.[151]

Mr Fitzgerald told us that there is a 'cohort of older people that would benefit from having some more formal visiting program', although he identified issues with any community visitors scheme as including:

> Who would identify that person? What would be the risk factors that would trigger such intervention? Does the person have the option of opting out of that, in other words, saying they don't want visitors?[152]

Mr Fitzgerald and Ms McKenzie suggested that 'there may be merit in a hybrid approach':

> in which visitors visit people living in private premises, but with a role to identify and raise matters of concern with appropriate bodies in relevant circumstances…the option of having independent checks should be available to people who are receiving in-home supports as well as those who have been assessed as eligible but are waiting for a service.[153]

Advocacy

Mr Fitzgerald told us that people in vulnerable environments need to be able to obtain advocacy.[154]

Ms McKenzie said that in the disability sector, 'access to advocacy isn't premised on receiving specialist disability services', explaining that:

> Advocates provide assistance to citizens of New South Wales, the Disability Advocacy Services New South Wales provide assistance to people with disability more broadly and interaction with mainstream and other supports, the whole range of concerns that people with disability have and that would be great to see replicated in the ageing space.[155]

Home care quality indicators

Draft proposition HC6(e) proposed the development of a system of data monitoring based on a suite of home care quality indicators.

Associate Professor Gillian Caughey, Principal Research Fellow, Registry of Senior Australians, was the lead author of the report *International and National Quality and Safety Indicators for Aged Care*.[156] She was also an author of the report *Recommendations for Home Care Quality and Safety Indicators in Australia*.[157]

Associate Professor Caughey told us that 'a lot of our work was extensively done in the residential aged care setting and then the home care quality indicators following on from that'.[158] She explained that 'there is a large overlap' between the home care and residential aged care quality indicators. However, she recommended indicators specific to home care, being polypharmacy, wait time for Home Care Packages, chronic disease management plans and medication reviews.[159] Associate Professor Caughey said:

> for the home care population, there is significant potential to provide the services that are provided by the Government. So a medication review is provided by a clinical pharmacist and it's subsidised by the Government, as is chronic disease management plans provided by the general practitioner. And these services, if you like, really do have the potential to improve health outcomes…these are services that are available that potentially can help to keep people at home for longer…[160]

Associate Professor Caughey agreed that the home care quality and safety indicators identified in *Recommendations for Home Care Quality and Safety Indicators in Australia* could be the subject of reporting in home care without any further data collection activity being needed.[161] This is because the indicators were 'what we could actually examine using data we have available'.[162] Noting that indicators may evolve over time, Associate Professor Caughey said 'the data is all there' and 'it would be remiss not to actually use the data to provide this outcome monitoring system'.[163]

When asked about possible uses of the Registry of Senior Australians' outcome monitoring system indicators, Associate Professor Caughey said:

> one of the things that we really want to highlight, the reason for this is not to necessarily just to point out where care is done badly, it's also to point out where care is done really well.[164]

Associate Professor Caughey explained that, internationally, indicators are published online at various reporting intervals, and in her view 'it's important in terms of improving transparency of the system and also to help people making informed decisions about what care providers they ultimately choose to have their loved one cared for'.[165] She described the ultimate goal as being to:

> provide insight into where care is being done well and potentially where care can be improved so that then the providers themselves can identify potentially these shortcomings to implement quality improvement programs, targeted strategies, if you like, to understand why, potentially, care is suboptimal and then to hopefully implement change to result in improved quality and safety of care for their care recipients.[166]

Professor Schols told us that organisations providing home care or institutional care in the Netherlands are obliged to have 'an intrinsic quality system which is audited by an external organisation every year'. Such organisations 'have to provide quality indicators to the Dutch National Healthcare Institute'.[167]

Professor Schols explained that the Dutch Health Inspectorate aims to visit an organisation every year, but in practice it may be every two or three years. However, the Dutch Health Inspectorate looks at the data provided by the organisation every year.[168]

Professor Schols told us of the development of a more comprehensive way of looking to quality of care, and that 'all data from the National Healthcare Institute may be used to develop such a picture which looks to quantitative data, qualitative data, financial data and staff experience data'.[169]

22.1.6 Capability to provide services and the home care workforce

The fourth theme advanced by Senior Counsel Assisting during the hearing was how best to ensure that providers and the workforce have the capability to provide the services that are needed in the future. Emerging from this theme were issues concerning the aged care workforce, including employment and engagement arrangements.

Ms Attridge told us that:

> what we need to do is make home care and aged care more generally an attractive place to work so that we can attract and retain the types of people and the quality of the workforce that we need to respond to the underlying need that we know is there.[170]

Mr St George expressed the view that 'training also needs to be more targeted and more streamlined in terms of the holistic client journey'.[171] He added that 'with the community sector being under-developed, it is very difficult to provide staff with, like, career progression in a structured environment, something that the hospital is very, very good at'.[172] Mr St George cautioned that:

> moving to a package set of funding for care at home…could be a difficult transition…it could require a significant up-skilling of an assessment workforce to determine the package needs and the level of contribution that people should be able to get…[173]

Ms Broer suggested that for future growth:

> additional, appropriate funding that covers the cost of quality and safety and training of staff and volunteers will enable us to provide a richer level of training to the volunteers around person-centred care.[174]

Mr Corley told us that:

> A person-centred service happens at the point of service. …And we spend a lot of time working with our providers to get consistency of support worker and to allow that relationship to develop at the point of service so that there's a level of trust between the person, their family and the support worker.
>
> And I think if you're really going to transform this system, it's focusing at that point of relationship and investing in those workers and investing in the families to develop that relationship.[175]

Employment and engagement arrangements

The *Report of the Inquiry into the Victorian On-Demand Workforce* reveals that between 2014 and 2018, the number of independent contractors in health and social care increased by 29%, from 70,700 in 2014 to 91,700 in 2018, compared with a 19% increase in the overall worker numbers for that industry over the same period.[176]

Draft propositions HC6(a) and (b) raised various proposals for reform of the arrangements through which the home care workforce is engaged. One such proposal was that the 'engagement of contract and sole trader aged care workers, including through online worker brokerage platforms and labour hire arrangements, must be regulated'.[177] We heard evidence from two online platform operators, Mable Technologies Pty Ltd (Mable) and Hireup Pty Ltd (Hireup).

Mr Peter Scutt, Founder and Chief Executive Officer, Mable, explained that under its business model, the workers are 'independent contractors in most cases providing services directly to their clients'.[178] Mable described its business operation as:

> a safeguarded online marketplace or platform that directly connects aged care and disability support consumers with independent support workers, nurses, therapists and other service providers in communities around Australia.[179]

Mr Scutt submitted a document entitled 'Mable supplementary submission – Mable Care Manager/Coordinator feature' in response to a request from staff of the Royal Commission.[180] Mr Scutt told us that through the features outlined in the document, the Mable platform provides visibility to a home care provider of the activities being undertaken via the platform. Although there is no direct means by which the care manager may communicate with a worker retained by the client, it would be possible for a care manager to 'log in as the client' and send a message to a worker.[181] Mr Scutt confirmed that Mable is 'not directly regulated' to provide the 'level of visibility' it does.[182]

Referring to the workers that provide services through Mable, Mr Scutt said 'they're not our employees, we're not contracting with them other than as a client or customer of the platform'. Mr Scutt explained that in respect of any relationship between the worker and the approved provider hosting the Home Care Package, his view was that 'at best they [the provider] may be considered to be subcontracting those services but I think it's really the client engaging those services directly'.[183] He acknowledged that such a relationship results in a situation where 'The provider doesn't direct the worker. We don't direct the worker. '[184]

Mr Scutt explained that Mable can offer lower unit rates for the provision of personal care services because of the reduction in the administration and care management fees.[185] Mable submitted that its platform 'enables consumers and independent workers to agree rates directly', and that:

> A Support Worker Platform fee of 10% is deducted from the agreed rate. A consumer Platform Fee of 5% is added to the Agreed Rate.[186]

Mr Scutt clarified that these fees are 'unrelated' to an administration charge for administering a Home Care Package.[187] He said it was the approved provider's responsibility to do care planning.[188] We do not know what approved providers charge for care planning under this model. According to StewartBrown home care data for the 2018–19 financial year, the average fee charged by approved providers for care planning was 13% and the average charge for administering a Home Care Package was 15%.[189]

Hireup describes itself as 'an NDIS [National Disability Insurance Scheme] registered online platform for people with disability to find, hire and manage support workers who fit their needs and share their interests'.[190] Ms Jessica Timmins, Head of Service, Hireup, explained that the decision to use an employment model was 'a really profound one for Hireup and has really driven our culture and the way we think about supports'. She said:

> I think our founders believed that the duty of care that's created when you are an employment model can lead to higher quality support outcomes for people with disability and so we really wanted support workers to feel part of our team and committed to those same quality outcomes.[191]

Ms Timmins explained that the employment model offers Hireup's employees a range of options including tailored learning and development opportunities, regular check-ins and financial support to workers who are voluntary firefighters. It also offers supports to employees who may injure themselves on the job to assist with Workers Compensations claims and scheduling alternate duties while they are unable to work.[192]

Mr Corley told us that Community Options ACT Inc. subcontracts all of its providers, and one of the requirements is that any provider must deploy its own employees.[193] Although Mr Corley 'wouldn't argue that subcontracting across the whole system should be widespread', he said:

> it allows a certain flexibility and a certain nimbleness for us to reallocate resources, change providers, change workers when that's in the best interest or request of our client.[194]

Ms Attridge told us that UnitingCare Australia's experience has been that 'in terms of monitoring and checking the quality of the care, that is far simpler when you're employing the staff directly'. She explained this is because employees 'have access to your systems, to your care plans...They are aware of your policies and your training programs'.[195]

Mr St George agreed that 'direct employment is significantly easier to control' because:

> It's significantly easier to train and ensure quality and in terms of incident reporting, complaints management and stuff, it's also significantly more streamlined through direct employment. With subcontractors, it's very difficult to know, to get them to deliver a model of care as opposed to just a service and I think that as the aged care system develops, that's what needs to happen.[196]

Impact for workers

In a statement to the Royal Commission, Professor Paula McDonald, Professor of Work and Organisation and Associate Dean, Research at the Queensland University of Technology, commented that while platforms 'embrace features of the on-demand economy such as incentivising responsiveness and worker flexibility', there is also a range of 'direct and indirect costs of doing business that are apportioned to workers and also clients by digital platforms'. These costs to the worker include 'vehicle expenses, insurances, the provision of police checks, commissions, and costs associated with tiered services and options'.

Professor McDonald further stated that 'a substantial array of tasks referred to as "time out of life", are mandatory for engaging with the platform but are unremunerated', including:

> creating and updating online profiles, managing on-demand and fragmented work schedules through the platform app, travelling to clients' homes, developing individual service agreements and the self-resolution of disputes.[197]

She concluded that the apportioning of these costs of the labour process to the worker, in addition to the lack of paid leave, superannuation contributions and 'other protections in Australian employment regulation, suggests an inevitable erosion of the hourly rate of pay set by the worker'.[198]

Dr Macdonald identified risks arising for workers from the independent contracting model that might also extend to on-demand casual arrangements. Dr Macdonald told us about the absence of:

> a relationship providing support and oversight supervision, absence of access to training, absence of peer support mechanisms…absence of any support for decision-making when encountering changes in care needs, unpredictable issues, things that happen all the time'.[199]

Dr Macdonald also identified 'the absence of employment protections and benefits that come with being an employee for contractors which both are risky for the worker as well as present risks for the person that they're providing support to'. She stated that many workers on platforms are advertising their services for less than the equivalent of the relevant award.[200]

Mr Scutt told us that workers on the Mable platform:

> can be better off and have choice and control and flexibility in managing their own work arrangements and the client can be better off in terms of a lower fee and more hours of work… More hours of support translates to more hours of work available for that support team.[201]

In a post-hearing submission, Mr Scutt submitted that Mable 'provides opportunities for care workers on its platform to upskill and further develop their career paths', and that it:

> protects care workers on the platform by setting user terms to ensure their services cannot be engaged for less than minimum wage, taking into account superannuation and Mable platform fees.[202]

As to why workers choose platform work, Dr Macdonald told us that her research revealed:

> there are workers working very, very fragmented working hours, short shifts, with lots of unpaid time in between on work-related travel. Those workers are invariably the ones seeking other jobs or are multiple job holders…I do believe that workers in the care sector enjoy being able to not work for somebody, not work with somebody who they find it difficult to work with and will make that choice to not…if the workers that I see advertising on these platforms are similar to the workers that I've interviewed, they're not particularly motivated by being their own boss…the nature of the labour market is such that it's not…one in which workers are looking for this kind of work to have a level of control that they would not otherwise have with an employer, other than to find work that fits into the hours that they have left remaining after…their other work and other activities have taken up their time.[203]

Professor Andrew Stewart, John Bray Professor of Law, Adelaide Law School, University of Adelaide, gave evidence about the mechanisms for improving wages and working conditions for aged care workers. Professor Stewart told us that one way would be to use general existing mechanisms, another way would be through the aged care regulation system, and the third option would be a combination of the two.[204] However, he identified challenges for workers without an employer:

> Trying to achieve everything from the aged care regulatory system would pose an enormous number of challenges, particularly if we were trying to do this for workers who were accepted not to have an employer. If you're employed, even if you're employed as a casual, you automatically become entitled to a range of benefits and protections; minimum wages, controls on working hours, shift lengths, Workers Compensation insurance is necessarily going to be there for you. If you earn enough in a given month, you're entitled to superannuation. So all of these benefits automatically apply if you're an employee. If you're not an employee then, generally speaking, they don't.[205]

Compliance with a duty to provide safe and high quality care

Professor Stewart told us:

> An independent contractor, by definition, ordinarily is less subject to direction but more than that, as I tried to explain, for businesses that are seeking to avoid an employment relationship, often to lower the costs of running their business, they have a clear incentive to try and minimise at least the appearance, if not the actuality, of the control that they might otherwise direct relevant workers.
>
> So if you are trying on the one hand to ensure that service providers have to have certain and discharge certain responsibilities about the care and quality of services that they provide, allowing them to minimise their direction and control over their workers, to me doesn't make a lot of sense.[206]

As noted above, Mr Scutt told us that under the Mable model, the responsibility for care management remains with the home care provider. He said:

> in the case of a Home Care Package recipient, the home care provider is not only responsible for the administration of the funding, they're responsible for the care management. So there will always be a care manager working with the client and, you know, around individualised care plans and making sure that they're able to access the services they need in relation to that.[207]

Mr Scutt told us that workers that offer their services via the Mable platform 'sign up as members of the platform and they accept the terms of use including abiding by codes of conduct'.[208]

Section 96-4 of the *Aged Care Act 1997* (Cth) provides that:

> a reference in this Act to an approved provider providing care includes a reference to the provision of that care by another person, on the approved provider's behalf, under a contract or arrangement entered into between the approved providers and the other person.

Although there is no contract between the approved provider and the independent contractor sourced through Mable, Ms Amy Laffan, Assistant Secretary, Aged Care Reform and Compliance, Australian Department of Health, considered it was clear that section 96-4 would deem services provided by an independent contractor to be services provided on behalf of the approved provider.[209] Ms Laffan conceded there is 'some separation' of responsibility for quality and safety with the ability to direct and control the care provided.[210] She said that there is 'the connection of payment', as 'to access the Commonwealth funds, that person, selected by the care recipient, would need to get those funds from the home care provider'.[211] Mable submitted that it generates invoices on behalf of the support workers for payment collection.[212]

Ms Laffan indicated support for a proposition that home care providers be:

> bound by a duty to ensure that the aged care they provide…is of high quality and safe…akin to…a common law duty to have regard to what might be the foreseeable risks of the modes of care obtained and under this statutory duty, the approved provider will be held accountable for any failures, including failures on the part of directly-engaged workers…[213]

Ms Laffan's view was that 'those requirements already exist' as a result of the operation of the 'aged care standards'.[214] She acknowledged that an express general duty of this kind being placed on approved providers 'would certainly make it clearer'.[215]

In a post-hearing submission and with reference to section 96-4 of the Aged Care Act, the Australian Government submitted that:

> Approved providers must provide care that reflects the views and preferences of the older person, and in a manner that supports consumers being treated with dignity and respect and making informed choices about their care. The Commonwealth submits that these obligations on approved home care providers extend to home care services provided on behalf of the approved provider under a subcontract or other arrangement.[216]

The Australian Government further submitted that it would support 'clarifying the obligation in a situation in which an approved provider is providing home care services through a 'digital labour platform' scenario and the development of guidelines…and further information for approved providers who use digital labour platforms and about the obligations on those approved providers'.[217]

In a post-hearing submission, Mr Scutt stated that:

> Mable is not an aged care provider and we are not funded to provide services.
>
> Mable's duty of care relates to duties as the builder and operator of the platform, which incorporate all of the safeguards that form part of the platform.[218]

Implications of workforce arrangements for quality and safety of care

Questions were raised during the hearing about the extent to which particular workforce arrangements might affect the quality and safety of home care.

Mr Scutt said that through Mable 'the provider can rely on the operations of the platform for part of the answer to responding to complying with the quality standards', giving the example of the screening process undertaken by Mable. Mr Scutt said that:

> the provider is able to, through the oversight functionality here, understand the services that have been engaged by the client, the qualifications of those workers, they can see the shift notes, they can see incident reporting, they can see the qualifications of those workers, and they have a direct dialogue with their client in are they getting the outcomes they are seeking.[219]

Ms Timmins explained that in making the decision to become a registered provider under the National Disability Insurance Scheme, Hireup considered that this registration not only 'bolsters our existing commitment to quality and safety but also provides a framework for the safeguards that we need to put in place'.[220] Ms Timmins described the regulatory framework which applies to Hireup as a registered provider registered under the National Disability Insurance Scheme as giving guidance and direction. She said it forces Hireup to think innovatively 'across every step of the journey for the person with disability' which leads to 'continuous improvement' in how they provide quality and safe outcomes.[221]

Professor Schols's view was that it is better for aged care workers to be directly employed for quality control and supervision.[222] Of the experience in the Netherlands, he said:

> there were some quality issues raised because when the care is provided by a contractor who actually fits to the national regulations, then they are supervised by the healthcare inspectorate. They were also contractors, independently contracted, which did not actually fulfil all regulations…You sometimes see quality issues raised later in time and that has been an issue and we are working on it, to actually take care of the fact that even when someone has a personal budget, he or she should contract a provider which has been contracted by the insurer.[223]

Dr Jim Stanford, Director, Centre for Future Work, The Australia Institute, told us that:

> the idea that merely facilitating communication between a client and a contracted service provider, or even an agent of the client, if it's a care manager, that's still not somebody who is in the house with the client and necessarily aware of what the client is needing and experiencing on a day-to-day basis, that that will, somehow, ensure the quality of the service delivered, I would say that idea is naive and, in fact, dangerous.[224]

Dr Macdonald also cautioned:

> where employment regulation is poor and the funding provides an incentive to engage labour as cheaply as possible, and the employment regulation allows that, then you will get poor outcomes.[225]

Dr Stanford referred to his research into stability of work, quality of work and the quality of services that are delivered under the National Disability Insurance Scheme. He said that:

> even when the providers are engaged on an employment basis, and that overwhelmingly now is a casual employment basis, there are, I think, very significant risks and problems that are raised in terms of how the work is organised…I'm sceptical of the efficiency of these platforms for delivering quality service. I think there's risks to both the client or the customer and the workers of this type of arrangement, and I think that those risks would be more severe in the case of a contractor model…[226]

Dr Stanford explained that not only is it relevant whether a worker is an employee or a contractor, but it is also relevant whether an employed worker is employed on a casual or permanent basis. He stated:

> in general it's safe to say that the evidence is consistent that the more stable is the job, the higher quality is the care that those people are going to provide and there's a continuum. It's not just a black and white argument, are you a contractor or an employee? There's also an issue about the stability of work arrangements for employees, and people who are in very fragmented and insecure casual-type relationships will have similar challenges to their ability to do the job to the quality that they would like to and that the clients want to see. In my reading of the literature that we did as preparation for that research, that correlation between job stability and quality of service that's delivered is quite robust.[227]

Requirement to employ care workers

Counsel Assisting tested a proposition that 'Providers should be required to deliver a set percentage of their care hours through the care workers they employ directly'. Professor Stewart described this as 'too arbitrary an approach'.[228]

Professor Stewart proposed that any provider that is licensed to provide home care services should, as a general rule, be required to employ the workers who provide that care, and not engage them as independent contractors. He explained that the two main reasons for this approach are first to ensure that providers can meet quality standards, and second to advance the objective of improving wages and working conditions for the aged care workforce.[229]

Professor Stewart recommended that a provider that is licensed to provide home care services should be allowed to source care workers from a labour hire agency only to cover temporary needs, and that the provider should be obliged to ensure that such workers are employed.

Professor Stewart also proposed that where a business operates as a home care service intermediary, by facilitating the direct engagement by a client of a home care worker but not seeking to control or manage the provision of care, it should be obliged to ensure that all workers using its services are licensed to perform such work.[230]

22.1.7 Sustainability of reform

The final theme advanced by Senior Counsel Assisting was how best to ensure that any proposals for a future aged care system are achievable for the long-term, in a sustainable manner.

Of a future system, Mrs Milkins said:

> It should be brave, it should be innovative. It should actually fix some of the issues that people constantly talk about, rather than pointing at others: it's not me, it's yours. It needs to be more audacious than it is. It clearly is the lost land. And that really is an indictment of our values. It needs, above all, stronger leadership.[231]

When considering the capability of providers to respond to reform in the aged care sector, Mr Lye said:

> There are certainly some very sophisticated organisations in the aged care sector but there's also potentially a tail of services who are probably smaller and less able to adapt quickly. And that certainly in the NDIS [National Disability Insurance Scheme] that resulted in, you know, some level of concern and I think, you know, you'd be concerned about service continuity in some instances.[232]

My Lye agreed that it will be necessary for government to undertake a market analysis and invest in market and capability development to ensure the availability of suitable and competent providers capable of providing the full range of home care services. However, Mr Lye added that 'we're not starting from zero here' as there is 'a considerable amount of work done in the disability space'.[233]

Regional and community involvement

Mr Corley expressed his views about regional planning models as follows:

> I would strongly urge Government to relook at regional planning models for aged care services. I think a lot of the decision-making is centralised, even state offices aren't necessarily involved in making decisions, as we understand it, about funding or things like that. So I would strongly urge a regional focus involving local health authorities, involving local providers, involving local communities as much as possible.[234]

In response to a question from Senior Counsel Assisting on the lack of regional capability of the Australian Department of Health, Mr Lye stated that the regional offices were 'largely capital city based' but that the offices 'have a great deal of knowledge of local providers. They are quite aware of local service provisions'. Mr Lye went on to identify different approaches to ensuring that services are readily accessible at the local level, including:

- 'a model where the Australian Government uses an entity like Services Australia as that touch point in the local community'
- 'distributed to the non-government sector or to a third party like it's done in the NDIS [National Disability Insurance Scheme] where you have a combination of shop fronts for NDIA [National Disability Insurance Agency] but also local area coordinators in local communities'
- 'a function that sits within the Department of State, like the Department of Health'.[235]

Whatever model is chosen, Mr Lye concluded:

> But you don't want…people who are using the system to be confused by having a plethora of actors who they engage with and not understanding who's responsible for what.[236]

Noting that 'Australia will not be able to afford to fund the social supports that are necessary to minimise risk for vulnerable older people in and of itself', Mr Fitzgerald drew our attention to the important role of the community. He said:

> And so we have to reengage the community, as we have done through the COVID period, in being part of the solution, part of the solution to this issue. The notion of community development, the notion of community inclusiveness, the notion that the community itself is part of the solution is something that Australia has lost. COVID has demonstrated, beyond any shadow of a doubt, that a society doesn't function well when that's gone. And in the case of older people, those community connectedness, the neighbourhood connectedness, is very important.[237]

Informal carers

In a statement, Mr David Panter, Chief Executive of ECH Incorporated, stated that 'carer stress' is one of the key factors in a person's premature admission to residential aged care. He added that:

> an ideal system should be able to deal with these system issues to ensure that someone doesn't end up in residential aged care when it is not necessary or desired.[238]

Draft proposition HC8, Carers Leave, raised a potential new measure to protect the workforce participation rights of informal carers. Proposition HC8 stated:

> The National Employment Standards under Part 2-2 of the *Fair Work Act 2009* (Cth) should be amended to provide an:
>
> - entitlement of up to two years unpaid leave to care for an older person, for long term permanent and casual employees with a return to work guarantee
> - entitlement to flexible work arrangements for the purpose of caring for an elderly person (as opposed to the right to request them).[239]

Professor Stewart explained that there was precedent for the first entitlement. He stated:

> There is an easy precedent for the first one which is up to two years unpaid leave to care for an older person. The *Fair Work Act* already provides for exactly that form of leave for care for a newborn child or a newly-adopted child…
>
> I see no reason why that couldn't and shouldn't be extended to cover care for an older person. So the model is there to be extended.[240]

Regarding the second entitlement, Professor Stewart supported the proposition to strengthen flexible work arrangements. He told us that this issue was subject to an ongoing debate to strengthen flexible work arrangements not just for 'the benefit of care for the elderly, but arguably for the benefit of many, many other caring arrangements as well'.[241]

In a post-hearing submission, Carers Australia submitted that 'primary carers in Australia experience considerably poorer employment outcomes, with a 52.2% employment to population ratio compared to 75.9% for people without caring responsibilities'. According to Carers Australia:

> supporting carers to participate in employment and/or ongoing education and training is pivotal to enabling their social and financial inclusion and greater social and economic outcomes for community and government.[242]

However, Carers Australia also said that:

> far more analysis, thought and consultation needs to go into this matter, especially as it requires changes to the Fair Work Act which would impact on all carers, not just carers of the aged.[243]

22.1.8 Funding and financing of home care in the Netherlands

Professor Schols gave us an overview of the home and community care arrangements for older people in the Netherlands.

He said that in 2015, the Netherlands commenced 'long-term care reforms' aimed at 'downsizing…the level of care in institutions'.[244] Professor Schols explained the reasons for these reforms were that:

> it was too expensive and healthcare, we are very worried that we can't pay our healthcare services in the future so that's why we started to downsize the care in institutions. It also fits in the preferences of older people themselves who want to age in place as long as possible. And how did we try to achieve it? We have tried to achieve it by making a long-term care reform and changing the laws.[245]

Professor Schols said that to decrease the number of people in institutional care settings, the Netherlands undertook reforms to 'empower the informal care at home and also the formal care at home'. The Netherlands also made 'it more difficult to get an indication for residential care' such that it is only the 'people with very complex problems who get care in institutions'.[246]

He explained that in the Netherlands, care is provided under 'three laws related to home care and long-term institutional care':

- 'People who need social support can apply to the Social Support Act, for which they have to go to the municipality and the municipality can offer them standard services or customised services'
- 'People who need nursing care at home can apply to the Health Care Insurance Act and this will enable them to get personal care or nursing care at home and the Health Care Insurance Act also provides the care provided by a general practitioner, a physiotherapist in the community and also hospital services'

- 'People who need 24-hour residential care, so care in a care home, can apply to the Chronic Care Act and the Chronic Care Act base their stay and their care they get in these care homes'.[247]

Professor Schols told us that the Social Support Act was 'financed from tax money and personal contributions' which was managed by the Government and distributed to the municipalities based on factors such as 'composition of the population in a specific municipality and to other characteristics such as the number of inhabitants, the number of old people…the average income of people, et cetera'.[248]

In contrast, he explained how the Chronic Care Act and the Health Care Insurance Act are financed through compulsory premiums paid by people during their working lives.[249] He said that for those two Acts, the premiums are 'determined by the Government' based on 'a percentage of someone's income'.[250]

Professor Schols emphasised that the premiums are paid during a person's working life, 'but when people actually get the care, later, they also have to pay an own contribution'. He said:

> But that's when they get the care, and that own contribution, in addition to the premium they have paid during their work life, is also depending on the income they have after their pension. [251]

In response to a question from Senior Counsel Assisting on whether the collection of premiums fully funds community care or whether there is a requirement for additional top up from taxation revenues, Professor Schols stated:

> I think this is very important question because you see, in general, and in many countries, that the costs for healthcare, they grow every year. So mostly they have to be topped up, yes.[252]

Professor Schols said that 'the services you get from all three Acts, can be provided in kind, or you can, in all three Acts, get a personal budget'.[253] Senior Counsel Assisting asked Professor Schols 'roughly speaking', the percentage or proportion of people who choose to take their care as a budget, rather than in kind. Professor Schols responded:

> between 85 and 90% is offered in kind. But I think in the future, personal budget will grow in number and what you see especially in the Netherlands is that especially younger people who read them in very well into the services that are possible, especially the younger people who need chronic care, use more the services via a personal budget than the older people aged 70 and above.[254]

Professor Schols explained that 'people with very complex needs who want to stay at home' may do so 'until the maximum of the care package'. He said:

> So if it's even more expensive to stay at home and even more care is needed and more money is needed, then they actually have to go to an institute.[255]

Endnotes

1 Commonwealth of Australia, *Letters Patent*, 6 December 2018, subparagraph (c)(i), paragraph (e).
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3 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 59, RCD.9999.0474.0004.
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21 Transcript, Sydney Hearing 4, Robert Fitzgerald, 1 September 2020 at T8950.35–38.
22 Transcript, Sydney Hearing 4, Robert Fitzgerald, 1 September 2020 at T8950.24–30.
23 Transcript, Sydney Hearing 4, Lee-Fay Low, 2 September 2020 at T9011.19–20.
24 Transcript, Sydney Hearing 4, Lee-Fay Low, 2 September 2020 at T9008.13–20.
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27 Transcript, Sydney Hearing 4, Rosemary Milkins, 1 September 2020 at T8925.16–18.
28 Transcript, Sydney Hearing 4, Rosemary Milkins, 1 September 2020 at T8927.30–33.
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30 Transcript, Sydney Hearing 4, Rosemary Milkins, 1 September 2020 at T8927.42–8927.46.
31 Transcript, Sydney Hearing 4, Jos Schols, 31 August 2020 at T8903.45–8904.4.
32 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 97, CTH.1000.0006.3164 at 3183.
33 Exhibit 20-1 Sydney Hearing 4, general tender bundle, tab 4, RCD.9999.0444.0001 at 0044 (Table 26).
34 Transcript, Sydney Hearing 4, Brian Corley, 31 August 2020 at T8842.10–11; T8842.19–21.
35 Transcript, Sydney Hearing 4, Brian Corley, 31 August 2020 at T8842.42–45.
36 Transcript, Sydney Hearing 4, Brian Corley, 31 August 2020 at T8857.2–4; T8857.13–15.
37 Transcript, Sydney Hearing 4, Brian Corley, 31 August 2020 at T8857.14–17.
38 Transcript, Sydney Hearing 4, Brian Corley, 31 August 2020 at T8857.4–5.
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41 Transcript, Sydney Hearing 4, Susan Emerson, 2 September 2020 at T9016.37–41.
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44 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 30, RCD.9999.0457.0001 at 0009.
45 Transcript, Sydney Hearing 4, Carmel Laragy, 2 September 2020 at T9014.19–24.
46 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 46, COT.1111.1111.0023 at 0007.
47 Transcript, Sydney Hearing 4, Peter Scutt, 31 August 2020 at T8888.13–23; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 47, RCD.9999.0469.0001 at 0009.
48 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 87, RCD.9999.0492.0003 at 0005.
49 Transcript, Sydney Hearing 4, Carmel Laragy, 2 September 2020 at T9014.18–19; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 40, RCD.9999.0461.0001 at 0004–0005.
50 Submission of COTA Australia, Sydney Hearing 4, 11 September 2020, RCD.0012.0071.0001 at 0002.
51 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 44, RCD.9999.0462.0001 at 0005.
52 Transcript, Sydney Hearing 4, Fiona Macdonald, 1 September 2020 at T8978.27–8979.23; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 48, RCD.9999.0468.0001 at 0001.
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58 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 98, CTH.1000.0006.3290.
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60 Transcript, Sydney Hearing 4, Carmel Laragy, 2 September 2020 at T9014.5–8.
61 Transcript, Sydney Hearing 4, Nicholas Hartland, 2 September 2020 at T9040.39–42.
62 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 4, RCD.9999.0444.0001 at 0047 (Table 28).
63 Transcript, Sydney Hearing 4, Nicholas Hartland, 2 September 2020 at T9050.28–9050.3.
64 Transcript, Sydney Hearing 4, Carmel Laragy, 2 September 2020 at T9027.20–9028.13.
65 Transcript, Sydney Hearing 4, Lee-Fay Low, 2 September 2020 at T9024.23–32.
66 Transcript, Sydney Hearing 4, Lee-Fay Low, 2 September 2020 at T9024.34–36.
67 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 1, RCD.9999.0459.0001 at 0002.
68 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 52, RCD.9999.0472.0001 at 0008.
69 Transcript, Sydney Hearing 4, Nicholas Hartland, 2 September 2020 at T9049.9–19.
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80 Transcript, Sydney Hearing 4, Nicholas Hartland, 2 September 2020 at T9051.38–40.
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82 Transcript, Sydney Hearing 4, Fonda Voukelatos, 31 August 2020 at T8851.34–44.
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84 Transcript, Sydney Hearing 4, Michael Lye, 2 September 2020 at T9054.17–22.
85 Commonwealth of Australia, Post-hearing submission, Sydney Hearing 4, 11 September 2020, RCD.0012.0072.0002 at 0004 [6].
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101 Transcript, Sydney Hearing 4, Lee-Fay Low, 2 September 2020 at T9012.33–44.
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112 Transcript, Sydney Hearing 4, Susan Emerson, 2 September 2020 at T9016.45–9017.1.
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122 Transcript, Sydney Hearing 4, Brian Corley, 31 August 2020 at T8856.21–22.
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137 See Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 53, RCD.9999.0473.0001; tab 54, RCD.9999.0473.0041; tab 55, RCD.9999.0473.0051.
138 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 22, AWF.600.01806.0002 at 0004.
139 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1712 [12].
140 Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9040.1–14.
141 Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9037.18–31; T9043.17–26.
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147 Transcript, Sydney Hearing 4, Kathryn McKenzie, 1 September 2020 at T8951.26–8952.4.
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158 Transcript, Sydney Hearing 4, Gillian Caughey, 1 September 2020 at T8935.2–4.
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23. Sydney Hearing 5: Funding, Financing and Prudential Regulation

23.1 Hearing overview

23.1.1 Introduction

We held a public hearing in Sydney, New South Wales, from 14 to 22 September 2020, about funding aged cares services, financing the aged care sector and prudential regulation.

We heard evidence from 44 witnesses and received 171 documents into evidence, including 42 witness statements. Reference was also made to the statements of Paul Versteege, Policy Manager, Combined Pensioners and Superannuants Association New South Wales, Martin Warner, Chief Executive Officer of Home Instead Senior Care, and Dr David Panter, Chief Executive of ECH Incorporated, which were tendered during the course of Sydney Hearing 4.

Evidence on ways to finance aged care was given by a number of prominent Australians, including the former Prime Minister, the Hon. Paul Keating, as well as Australia's longest serving Treasurer, the Hon. Peter Costello AC. We heard about international financing mechanisms from Professor Naoki Ikegami of St Luke's International University, Tokyo, and Dr Pieter Bakx of Erasmus University, Rotterdam.

The funding of aged care was discussed with a number of leading academics and policy thinkers, including Professor Flavio Menezes, Professor of Economics at the University of Queensland, Mr Grant Corderoy of StewartBrown, and Professor Kathy Eagar, Director of the Australian Health Services Research Institute at the University of Wollongong.

Prudential regulation was explored with a number of witnesses, including the former Chair of the Aged Care Financing Authority, Mr Michael Callaghan AM PSM. Representatives from the Australian Government also gave evidence, including the Secretary to the Australian Treasury, Dr Steven Kennedy PSM, the Secretary of the Australian Department of Health, Dr Brendan Murphy, and the Aged Care Quality and Safety Commissioner, Ms Janet Anderson PSM.

As we heard from Dr Murphy, 'the system does need significant redesign…including in the costing and funding and transparency of that system'.[1]

23.1.2 The financial state of the aged care sector

In the course of the hearing, Counsel Assisting examined a number of witnesses about the current financial state of the aged care sector. The evidence presented a challenging landscape.

Mr Corderoy told us that 2012 was a 'breaking point' for the sector, and that since that time there has been a 'continual deterioration' in financial performance and that 'every year it's deteriorating a little further'.[2]

The panel of witnesses representing the 'Big Four' Australian banks made statements that reflected this point of view. Mr Sam Morris, Head of Health, Corporate and Institutional, at the Australia and New Zealand Banking Group, stated that there has been a 'general decline in profitability and cash flow of aged care clients' in recent years.[3] Mr John McCarthy, Head of Corporate Health at the National Australia Bank, noted it was 'particularly challenging for the smaller operators to continue to thrive and flourish' within the sector.[4] Mr Chris Williams, Executive General Manager, Major Client Group, Business Banking at the Commonwealth Bank of Australia, told us that 'there is probably no other industry the Commonwealth Bank supports where I would be able to say that more than 50% of the operators in the industry are either marginally profitable or loss making'.[5] Ms Thea Hordern, Head of Health and Aged Care at Westpac Banking Corporation, said that a specific driver of these issues was that wage rises were outstripping the indexing of income for providers.[6]

Dr Murphy said the regime of managing aged care funding through the Aged Care Funding Instrument causes financial problems for aged care providers, noting:

> We [have] had the ACFI [Aged Care Funding Instrument] system which we know caused significant problems…we accept that the system is under financial pressure at the moment, and definitely does need some financial resetting.[7]

Similarly, Mr Callaghan described a close connection between the decline in the financial performance of providers and decisions of the Australian Government in relation to the indexation of the Aged Care Funding Instrument.[8]

Mr Fahim Khondaker, Partner at BDO Australia, reported that in their analysis there was a significant variance in financial performance across the aged care sector.[9] Mr Khondaker said that while the bottom 25% of providers in terms of financial performance were making a loss, some of the top 25% of financial performers were making a good return.[10]

Despite this analysis suggesting that some providers are able to make good financial returns, the evidence from all of the aged care provider representatives echoed the same basic refrain: that current financial operating conditions were extremely difficult for them. Mr Chris Mamarelis, Chief Executive Officer of the Whiddon Group, described financial operating conditions as 'hugely challenging'.[11] Mr Nicolas Mersiades, Director of Aged Care at Catholic Health Australia, said the 'current funding system is not sustainable'.[12] Mr Ian Thorley, Chief Executive Officer and Managing Director of Estia Health Limited,

described 'margin compression' and a 'sector-wide…trend that is seeing serious decline in the sustainability of large amounts of the sector'.[13] According to Dr Linda Mellors, Managing Director and Chief Executive Officer of Regis Healthcare Limited:

> The funding situation is not sustainable and the staffing situation is not sustainable. So I think what we've seen in the evidence that's come before the Royal Commission is that the staffing and the funding are inadequate to deliver the current level of quality of care to older people in Australia, let alone the kind of care that we would all like to provide.[14]

We heard the financial situation for providers in regional and remote locations was particularly challenging. Mr Corderoy told us StewartBrown's data showed that:

> 55% of homes in the outer regional, rural and remote are running at an EBITDAR [earnings before interest, tax, depreciation and amortisation] loss which is effectively running at a cash loss, and that's greater than you see in the inner regional and major cities.[15]

Mr Williams concurred:

> when it comes to regional and remote locations, the harsh reality is that the cost base of operating facilities in those locations is even more structurally challenged than it would be in metropolitan zones.[16]

Similarly, Mr Morris also identified smaller 'single site operators' as being at particular financial risk in the current environment, stating that:

> they're less able to offer a competitive service at a lower cost with this declining margin because with scale comes diversity, and we've found larger operators are able to weather those types of risks in this environment.[17]

Mr Campbell Ansell, Managing Director of Ansell Strategic, described the importance to the residential aged care sector of Refundable Accommodation Deposits. He said that Refundable Accommodation Deposits have an important role in the development of new homes:

> The major banks are accustomed to providing finance and support for providers as they build new nursing homes, and generally speaking as residents are admitted to the new homes once they're commissioned, they will provide refundable accommodation deposits to the providers, and the banks generally expect to have most of their development funding repaid through those deposits.[18]

Mr Morris echoed these comments, stating that in the Australia and New Zealand Banking Group's view that Refundable Accommodation Deposits 'are certainly fundamental to aged care lending as it currently stands, both as a funding source for the sector and as a repayment mechanism'.[19]

Mr Ansell sounded a note of caution over this reliance upon Refundable Accommodation Deposits, especially in light of the ongoing COVID-19 pandemic, which was leading to reduced occupancy rates in aged care. He stated that not every resident who is discharged is necessarily being replaced, and that this has an 'obvious cash flow consequence if you're having to repay a lump sum'. He added that this is exacerbated by the majority of new arrivals in residential care 'not electing to pay a lump sum'.[20] This was highlighted in a report prepared by Ansell Strategic in August 2020 for the Australian Department of Health,

which estimated that $1.38 billion in Refundable Accommodation Deposits had left the sector since the beginning of February.[21]

Mr Corderoy's written statement summarised the financial state of the sector. He described the financial viability and ongoing sustainability of residential care as a significant and urgent concern. He noted a recent decrease in occupancy and Aged Care Funding Instrument revenue increases of just 1.5% a year, while costs of providing direct care increased at 6.8% a year. He said the cost of providing indirect care exceeds the revenue providers receive for providing them. Mr Corderoy stated that residential aged care services in outer regional, rural and remote locations face even more challenging circumstances.[22]

Approved providers of home care services reported different issues to those in residential aged care. Mr Martin Warner, Chief Executive Officer of Home Instead Senior Care, said the issue with home care funding was 'the flexibility of the system to fund, which seemed to be more important than the quantum amount'.[23] Mr Corderoy said that home care is arguably not underfunded. He identified unspent funds as a particular issue, stating that in excess of $800 million of funding in home care is not being spent, and that this itself is unsustainable.[24] However, Mr Versteege said that people stay on inferior Home Care Packages that do not meet their needs while awaiting their higher level package.[25]

23.1.3 Indexation of aged care subsidies

We heard from a number of witnesses about the indexation applied to aged care subsidies, including funding for residential aged care under the Aged Care Funding Instrument. In particular, we heard about decisions by the Australian Government to pause the indexation of the Aged Care Funding Instrument for certain periods between 2012 and 2019 and the effect of those decisions on the aged care sector.[26]

Prior to the hearing, the Office of the Royal Commission prepared a paper on historical expenditure on aged care. An initial draft of the paper was provided to the Australian Department of Health and revised following that consultation.[27] The paper showed a trend of expenditure constraints imposed by the Australian Government across the aged care system.

Indexation arrangements

The annual indexation applied to the basic subsidy for residential aged care is a composite index constructed by the Australian Department of Finance that comprises a wage cost component (weighted at 75%) and a non-wage cost component (weighted at 25%).[28] The home care basic subsidy and the majority of supplements are indexed by the same method.[29] A similar approach also applies to grants under the Commonwealth Home Support Programme, but the wage component is weighted at 60% and the non-wage component at 40%.[30]

Between 1999–2000 and 2018–19, subsidy levels increased by 70.3% in nominal terms, whereas provider input costs increased by 116.3%.[31]

Adequacy of indexation arrangements

The Australian Department of Health told us that 'the level of indexation has not been sufficient to cover the increasing cost of service delivery inputs over time'.[32] The Department stated that 'if this is not addressed…over time, it will result in pressure being put on service delivery'.[33] However, Dr Murphy said 'we don't have any evidence at the moment that there is an impact on quality and safety from financial performance'.[34]

In response to a suggestion that there had been an increase in adverse regulatory outcomes in 2017–18, Dr Murphy did not accept that this was attributable to anything other than increased regulatory scrutiny.[35] On the same panel, Dr Nicholas Hartland PSM, First Assistant Secretary at the Australian Department of Health, referred to increased regulatory scrutiny as a result of the events at Oakden Older Persons Mental Service.[36] Dr Murphy said that 'it just shows the regulator is doing a much more thorough job' and 'I don't think we've got any evidence to support the contention that care quality has declined because of financial pressures'.[37]

The Australian Department of Health conceded that there are structural issues with the aged care indexation methodology and with the Aged Care Funding Instrument.[38] In that context, the Department acknowledged that 'low indexation arguably encourages providers to make higher than appropriate funding claims' and 'may have contributed to residential aged care providers increasing the value of their claims'.[39]

In relation to the Aged Care Funding Instrument more generally, the Australian Department of Health identified that it 'is no longer an appropriate mechanism for determining the funding that providers need to meet the care of individual residents'.[40] The Department stated that the Aged Care Funding Instrument 'has resulted in a history of unpredictable and unstable funding outcomes for providers and Government' and that under the funding instrument, 'providers are encouraged to overstate actual levels of incapacity and support requirements and thereby "upscale" ACFI [Aged Care Funding Instrument] scores'.[41]

Dr Murphy acknowledged the need to address the level of indexation and for it to be determined in a 'more evidence-based way in the future'.[42]

Mr Nigel Murray, Assistant Secretary at the Australian Department of Health, said that 'indexation has not matched the rate of growth in wages…and costs in that period'. However, he emphasised that growth in Aged Care Funding Instrument claiming and funding must also be considered in that context.[43]

Indexation pauses

The Australian Department of Health provided a timeline and rationale for decisions of both political parties when in government to pause the indexation of Aged Care Funding Instrument for periods between 2012 and 2019.

In 2012, the Australian Government 'paused indexation for twelve months' and 'made changes to the ACFI [Aged Care Funding Instrument]…to address concerns of over claiming and to bring growth more in line with estimated sustainable funding levels'.[44]

In 2014–15 and 2015–16, Aged Care Funding Instrument claiming growth was 'again higher than expected'. In particular, in 2015–16 there was 'higher than anticipated claiming' under the Complex Health Care domain of the instrument.[45] To address this, the Australian Government implemented the following measures between 2016 and 2018:

- a 50% pause in indexation of the Complex Health Care domain on 1 July 2016
- a 12-month Aged Care Funding Instrument indexation pause on 1 July 2017
- a 50% pause in indexation of the Complex Health Care domain of the Aged Care Funding Instrument on 1 July 2018.[46]

The changes made to the Complex Health Care domain in 2016–17 were 'driven by the Commonwealth's concerns regarding the significant and unanticipated increases in ACFI [Aged Care Funding Instrument] expenditure…which could not be explained by a corresponding increase in the frailty of residents'.[47] The Australian Department of Health explained that:

> Natural growths in frailty would be expected to occur more gradually over time and be seen across all the ACFI [Aged Care Funding Instrument] domains. The patterns of claiming indicated the high increase in claim rates was being driven by changes in the claiming behaviour of providers, rather than increasing frailty of residents.[48]

When asked whether the indexation pauses were a proportionate response to some instances of what the Department perceived to be over-claiming, Dr Murphy said:

> We absolutely accept that the ACFI [Aged Care Funding Instrument]…and that was the only tool available at the time to deal with the massive growth in costs. I accept that in that there was a lot of providers were over-claiming. I don't blame them for it.[49]

The Australian Government submitted that:

> The intention of the indexation freeze was to respond to the unjustified spike in claims, and to mitigate the impact of actual and potential overclaiming behaviour of providers; it was not to entirely withhold or withdraw funding to the sector. Overall funding to the sector continued to grow.[50]

Dr Murphy and the Australian Government clarified that the behaviour on the part of providers was not illegal.[51] Dr Murphy said that the claiming behaviour of providers 'would certainly have placed an unpredicted fiscal pressure on Government'.[52]

Mr Callaghan told us that aged care providers do not receive adequate funds to provide the quality and level of care which is expected of providers and that there is a need to change the funding and financing arrangements of the aged care sector.[53] In that context, Mr Callaghan observed that the Australian Government's focus has been on 'ensuring that its expenditure on aged care is consistent with its overall fiscal position'.[54]

In relation to decisions of the Australian Government to pause indexation of the Aged Care Funding Instrument, Mr Callaghan told us that:

> The substantial decline in the financial performance of residential care providers in 2017–18 was influenced by the Government's changes to ACFI [Aged Care Funding Instrument] arrangements and mirrors a decline in the sector's financial results in 2012–13 following changes to ACFI (similar to those made in 2016 and 2017). Both occasions were a response to Government concern that growth in ACFI expenditure was running ahead of Budget forecasts and could not be justified by growth in resident's fragility, but rather involved some level of over claiming by providers. This was disputed by providers. …Under current ACFI arrangements it has proved difficult to resolve the extent to which changes in ACFI payments reflect the care needs of residents or the claiming behaviour of providers.[55]

Mr Callaghan referred to 'mistrust' between aged care providers and the Australian Government, which he perceived during consultations undertaken by the Aged Care Financing Authority in 2018 about the changes that had been made to the Aged Care Funding Instrument. He explained that from the approved providers' point of view, the message they heard from the Australian Government was that providers were involved in 'unethical claiming behaviour' with the Aged Care Funding Instrument.[56] Mr Callaghan considered that from the Australian Department of Health's point of view, the Department did not have confidence that 'what they were seeing in terms of the Aged Care Funding Instrument truly represented the underlying growth in acuity'.[57] Mr Callaghan's evidence regarding 'mistrust' was put to Dr Murphy, who responded that there are 'clearly points of disagreement about these issues' but that he was 'not sure that there's a global mistrust'.[58]

Mr Mersiades considered that the current funding system is 'predicated on an indexation formula which is based on a labour productivity expectation which is not sustainable' and 'involves a significant discount on the minimum wage adjustments'.[59] He told us that in the past, providers managed the 'punitive indexation arrangement through their claiming arrangement under' the Aged Care Financial Instrument.[60] Mr Mersiades said that 'over the life, of the ACFI [Aged Care Financial Instrument] the real increase has been something like 5% per annum', whereas under the current arrangements introduced in 2016–17, the 'real increase is as low as 0.5%'.[61] Mr Mersiades said:

> So you can see with punitive indexation, the low real increase, that there's no chance that the current system is going to be able to match cost increases, and also increases in consumer expectations, older people's expectations about the quality of care that they receive.[62]

Dr David Panter, Chief Executive of ECH Incorporated, gave his perspective on the value of funding under the Home Care Packages Program and Commonwealth Home Support Programme. In relation to the Home Care Packages Programme, Dr Panter told us that over the past 10 years costs of living have increased 'without any significant change in funding levels'. As a result, he said, the Home Care Package 'dollar value today "buys" less hours of service'.[63] Dr Panter told us that Commonwealth Home Support Programme deeds between the Australian Government and ECH Incorporated had been rolled over for several years and that, as a result, the funding secured by those deeds buys fewer hours.[64]

Professor Michael Woods, Professor of Health Economics at the University of Technology Sydney, gave evidence that indexation pauses have contributed to the 'very parlous state of many providers in being able to provide adequate levels of staffing and care'.[65] Mr Corderoy also linked the declining financial performance of the residential aged care sector with indexation. He identified the indexed increases not matching the actual cost increases of staff as one of a number of factors that influenced this decline between 2012 and 2019.[66] Mr Corderoy agreed with analysis in the Expenditure Constraints Paper regarding the impact of the particular indexation formula on the level of funding for aged care over time.[67]

Mr Corderoy said that the indexation pause in the 2018 financial year combined with the 'change in the ACFI [Aged Care Funding Instrument] basis for certain of the ACFI domains' represented a significant 'detrimental effect on the revenue stream for ACFI'.[68] In relation to the 2012 indexation pause, Mr Corderoy explained that there was 'a significant drop in the profitability of the sector in that year'.[69]

23.1.4 The need for immediate measures to improve the quality of residential aged care

Many of the propositions Counsel Assisting tested with witnesses at the hearing were longer-term reforms, dependent on the development of an independent pricing capability, which would take some time to implement.[70] In recognition of this, Counsel Assisting also tested a proposition to the effect that additional interim funding be provided for increased staffing, pending the implementation of a funding model for residential aged care homes that is casemix-adjusted and activity based.[71]

Witnesses were asked for their views on possible steps that were urgently needed to sustain or promote the viability of the aged care sector and aged care providers in the short term.

Mr Corderoy, in his statement, said there is 'an urgent requirement for additional funding' in residential aged care.[72] As mentioned above, he went on to propose that the Aged Care Funding Instrument indexation should be calculated based on the annual ABS [Australian Bureau of Statistics] Wage Price Index plus 1%, rather than by the current indexation mechanisms detailed earlier in this chapter.[73] In his oral evidence, Mr Corderoy confirmed this was intended as an 'appropriate interim measure' within 'the existing funding envelope', although he hoped there would be more significant changes to the funding model in the longer term. Mr Corderoy said that he believed 'these reforms really need to be enacted as soon as possible'.[74]

Mr Mersiades agreed, noting that the introduction of a new funding model is at least 24 months away. He said he believed that some not-for-profit providers may not have the cash reserves to last that long.[75] He considered the current indexation arrangements in aged care to be 'unsustainable'.[76] Mr Thorley said that the funding model that replaces the Aged Care Funding Instrument must be responsive to 'acuity creep'.[77]

Professor Henry Cutler, Director of the Macquarie University Centre for the Health Economy, called for an increase to funding and linked that to increasing staffing costs in the sector:

> I think that the Australian Government does need to make additional funding to aged care providers. As I said, though, you know, increasing staffing levels is not just about the staffing level; it's also about the quality of staff. So there needs to also be investment in training for staffing, and the quality of staffing, if that was also increased, is likely to improve quality as well.[78]

Dr Mellors proposed a different metric of recording staffing levels, that of 'worked hours per resident per day'.[79] She explained further that:

> my request for flexibility is that we look at the level, not just the hours, because different levels of staff provide different contributions, so for me it's also tied into the pay rates and the level, not just the hours of staffing.[80]

Nonetheless, Dr Mellors went on to say she would like to see an increase in staffing levels and she believed that is agreed across the board.[81]

Mr Thorley echoed Dr Mellors' comments regarding the approach to staffing in aged care, as did Ms Natasha Chadwick, Chief Executive Officer of NewDirection Care Bellmere Pty Ltd.[82] Specifically, Mr Thorley said 'the best way in which staffing increases should occur is to look at the resident need and assess what skills are required to support that need, and then the metrification or the numbers should come after that'.[83] Mr Thorley cautioned that we should be wary in assuming that additional staffing levels would automatically guarantee increased care.[84]

Mr Thorley then expressed the sentiments of many of the witnesses at the hearing when he said:

> the most pressing issue is to ensure there's adequate funding to ensure the current trends that are being described by StewartBrown are addressed. That's an immediate reform that all of the others need to follow closely.[85]

Mr Mamarelis joined those calling for immediate action: 'And I think that we obviously need additional funding. It's obvious that we need it, and we need it now more than ever.'[86]

The Australian Department of Health acknowledged there was need for a short-term change in addition to long-term reforms. Dr Murphy indicated general support for this proposition during the hearing, and in post-hearing submissions the Australian Government stated it 'agrees that there may be a need for additional funding to support providers prior to the implementation of a new funding model in residential aged care'.[87]

23.1.5 The need for independent pricing of aged care services

Among the most significant of the propositions Counsel Assisting tested with witnesses at the hearing was that which proposed that the future funding of aged care should be in accordance with prices and subsidy levels set by a process independent from the influence of both the Australian Government and service providers.[88]

Witnesses supported independent pricing of aged care services. Although stating that the Australian Government did not 'feel very strongly about it', Dr Murphy did indicate it supported 'the general principle of an independent transparent evidence-based price determination'.[89] He described the need for a system 'reset': 'I think we clearly accept that the system does need significant redesign and including in the costing and funding and transparency of that system'.[90]

Mr Mamarelis spoke of the need for independent pricing:

> I believe we need independent price setting. I think the examples of the past when we are caring for older Australians, and in Whiddon's case, we have thousands of people we care for annually, we can't operate in an environment where the Government just decides, for example, to put a funding pause on our revenues when we are planning around people's lives, we are planning around the people who care for those individuals and our funding is just withdrawn from us and literally at a minute's notice.
>
> I think the other part of the funding equation as well in terms of planning and long-term planning which is essential in the business of providing care, is the notice. You find out literally days before what you're about to receive for the next 12 months.[91]

Dr Panter also supported independent pricing and having 'an independent body that's looking at exactly what the cost and, therefore, reasonable price structure should be'.[92] Mr Thorley, Professor Cutler, Mr Corderoy and Mr Nicholas Brown, Acting Chief Executive Officer, Aged Care Guild, all supported independent pricing.[93]

Dr Kennedy also supported independent pricing, stating that independent price setting and independent assessment mechanisms would contribute to the vital element of the Australian Government having trust in the system.[94]

Aged Care Pricing Authority

Witnesses gave evidence about how independent pricing of aged care services might be done. Professor Woods and Mr Brown recommended that the Independent Hospital Pricing Authority be considered as a model for the independent pricing of aged care services.[95] Mr Callaghan said that the Independent Hospital Pricing Authority 'provides a useful model'.[96] In post-hearing submissions, the Australian Government said that 'there may be benefits in expanding the functions of existing expert health pricing bodies, such as the Independent Hospital Pricing Authority, to perform this function'.[97] Regis Healthcare Limited also recommended that the role of Independent Hospital Pricing Authority be

expanded to include aged care pricing, 'given that it already holds most of the systems, infrastructure, relationships and technical capability required'.[98] Professor Eagar said the entity responsible for independent pricing would depend on governance arrangements:

> I think it depends on the overall arrangements that are agreed for the governance. If aged care was to stay within the Department of Health then the sensible thing to do is to expand the role and function of the Independent Hospital Pricing Authority and make it an independent hospital pricing and aged care authority. They've got the skills, they've got the systems, but if, for example, there was a decision that the best thing to do was to establish a national aged care authority, a Commonwealth corporate entity, then you could put the pricing function in that corporate entity.[99]

A number of witnesses raised concerns about the way independent pricing should happen. Mr Mersiades said:

> Catholic Health Australia also strongly supports this recommendation, but we would note, though, that there would need to be some adaptation in terms of methodology that's applied in the aged care sector compared with the hospital sector. In aged care you're looking at long-term care, you're looking at quality of life, and you're looking at personal private contributions as well. So that just complicates the mix a bit.[100]

Mr Callaghan also cautioned that there are differences between the acute health sector and the aged care sector, including the Australian Government being the primary funder of services provided by non-Government providers, and that providers 'will not be devoting resources to this unless they get a return'.[101] According to Mr Callaghan, 'The concept, the benchmarking, the approach has to be tailored to the circumstances of the aged care sector' and the objectives of the pricing authority need to be clear.[102] Mr Callaghan said that 'you don't want an unfettered regulator that is going to rely on its independence and be out doing a whole range of things and setting prices' and that the authority must be accountable to Australian Parliament for its performance.[103]

Ms Hordern said Westpac Banking Corporation was not concerned with the introduction of an independent authority. However, it was concerned with whether a cap on profitability would be introduced as this would impact investment and competition in the aged care sector.[104]

There was some contention on the question of whether the pricing authority should determine prices, or merely recommend them to the Australian Government. Dr Murphy expressed concerns that the Australian Government would be 'locked into delivering a price'.[105] He said 'price needs to be transparently determined and recommended to Government, but whether Government should have the fiscal right to determine how that's manifested is a matter for debate'.[106] Professor Woods expressed a similar view:

> you are committing public expenditures of, in this case, very high magnitude, and I would continue to recommend that you separate out regulation from policy, and policy includes fiscal policy. So I'm very happy for it to transparently recommend pricing based on costs, and then it's a matter for the community to judge the Government on whether it follows that open and transparent and objective set of analyses.[107]

Professor Woods said that 'I think the pricing authority should recommend rates for various levels of service, and that the assessor should then determine how many hours that involves of what sort of mix'.[108] In post-hearing submissions, the Australian Government submitted that 'the ultimate determination of price should remain a decision for Government'.[109]

Mr James Downie, Chief Executive Officer of the Independent Hospital Pricing Authority, said that the determinations made by the Authority are binding on the Australian Government. He added that the Australian Government contribution is fixed by the price set by the Independent Hospital Pricing Authority with 'a cap on total Commonwealth expenditure growth of 6.5% per annum'.[110]

Professor Piggott, Scientia Professor of Economics and Director of the Australian Research Council Centre for Excellence in Population Ageing Research at the University of New South Wales, disagreed that the role should be limited to providing advice. He said that he 'would like it to be more binding'.[111] Professor Cutler said that 'there are good reasons why price should be set by an independent authority', including removing 'volatility to provider revenue' caused by policy change and ensuring transparent price setting.[112]

We also heard evidence about the role of an independent authority in developing funding models, such as casemix classifications, for aged care services. Mr Downie indicated that independent pricing could be implemented in aged care and said that 'There is no reason to believe that a casemix based funding system would not be effective in residential aged care'.[113]

Mr Downie also outlined the timing requirements for the implementation of a casemix model for residential aged care. He said that implementing the Australian National Aged Care Classification as the classification for aged care funding would take approximately two to three years if a new standalone agency was not established.[114] He suggested that establishing a standalone agency would have 'a significant lead time' and that the Independent Hospital Pricing Authority could undertake the work with a shorter lead time.[115]

Mr Downie said that stakeholder engagement is 'critically important' to the acceptance of the new system.[116] He added that it is 'critically important' that stakeholders trust the independence of the pricing authority.[117]

The need to define high quality aged care

Dr Mellors, consistent with evidence of Mr Mersiades and Mr Thorley, stated that for effective changes to be made to the current system, an explicit definition of what constituted good or quality care needed to be established, and that all other changes were contingent on such a definition being created.[118] These witnesses all considered that without such a definition, it would not be possible to determine whether immediate changes or the more fundamental longer-term changes were actually delivering good quality care. Mr Mersiades put it simply when he said that this question needed to be 'front and centre' of any reform.[119]

The determination of funding levels must relate transparently to the required level of quality of aged care. Mr Downie said that this kind of transparency is a 'significant challenge'.[120] Dr Panter agreed, stating that there is a lack of transparency regarding how the dollar value of the various Home Care Package levels 'relate to either need or the cost of providing services to match that need level'.[121]

Mr Downie detailed the role of the Independent Hospital Pricing Authority in determining the National Efficient Price for public hospital services, which has allowed for the implementation of activity based funding in hospital services.[122] The National Efficient Price determines the level of funding provided by the Australian Government for public hospitals 'and provides a price signal or benchmark for the efficient cost of providing public hospital services'.[123] Mr Downie spoke about the importance in that context of defining 'what the safety and quality measures are that you would like to include in the system'.[124]

Professor Cutler agreed that determining the level of quality is important:

> So prices must be set to the level of quality that we desire, rather than the current levels of quality, given that there has been a suggestion throughout the Royal Commission process that quality is not appropriate within the aged care sector. So that is an important component within setting prices, determining at what level of quality should the residential aged care sector achieve.[125]

Mr Downie also spoke about the importance of defining the safety and quality measures.[126]

The need for regular costing studies

We heard from witnesses about the need for regular independent resets of prices, based on reviews of the costs of providing high quality services. Dr Murphy agreed with Counsel Assisting's suggestion that subsidies have never been calibrated by a study of the actual costs of providing high quality care.[127] Mr Downie said sporadic price setting incentivises providers to 'upcode', which 'leads to price setters needing to make significant changes to price weights on a periodic basis, leading to significant disruptions to funding'.[128]

Mr Downie stated that data collection has been critical to the success of the national implementation of activity based funding.[129] He said that annual costing processes are 'crucial to the success' of activity based funding and that 'the availability of robust consistent data' is the 'most significant implementation challenge'.[130]

Mr Downie gave evidence about the need for annual costing studies:

> Annual costing studies ensure that the ABF [Activity Based Funding] system is self-correcting. For example, if there is a wide spread practice of increasing the coding complexity of patients, then over time the price weight will reduce, and as such the incentive to over code complexity is ameliorated.[131]

The Australian Department of Health agreed that upon implementation of an activity based funding model such as the Australian National Aged Care Classification model, costing studies would need to 'be undertaken to ensure that the cost weights attached to each class remain relevant'.[132]

Professor Woods concurred that regular costing studies are needed:

> Periodic cost reviews and price setting recommendations to government by an independent regulator would ensure transparency of process and provide some measure of assurance to providers and a basis for ensuring the viability of the sector as a whole.[133]

Professor Eagar proposed that annual costing studies are needed 'to inform the NEP [National Efficient Price] for the following year'.[134] Professor Eagar suggested that 'a Commonwealth aged care body or the Independent Hospital Pricing Authority could be tasked with undertaking or commissioning a national aged care costing study each year'.[135]

23.2 Funding for the indirect costs of aged care services

In testing propositions concerning independent pricing of aged care services, Counsel Assisting proposed that prices should be set so as to permit recovery of various indirect costs.[136] One aspect of this proposition was that providers should be required to 'acquit these amounts' (in accordance with another of the propositions).[137] In response, several witnesses gave evidence about the lack of funding for indirect costs incurred by aged care providers. Mr Callaghan, Mr Corderoy and Mr Brown all said that funding does not account for administration and overhead costs.[138] Mr Callaghan said administration and overheads 'have to be cross-subsidised somewhere else'.[139]

Mr Murray agreed with Counsel Assisting's suggestion that the costs of providing aged care services are not covered by funding because there is no revenue stream for administrative costs, and said 'we accept that it would be desirable to have additional funding come into the sector'.[140]

Dr Mellors detailed the importance of ensuring that indirect costs are adequately funded:

> Indirect costs are just as critical as the direct costs in terms of what they fund. So I think about things like clinical governance, quality and safety, work health and safety, technology, et cetera, all of those things contribute to the quality of care and experience of residents and also of our employees.[141]

Dr Mellors also said that indirect costs need to be 'properly costed' by an independent pricing authority.[142] COTA Australia agreed with the proposal that an independent pricing authority should set prices to enable providers to meet the indirect costs of delivering aged care services.[143]

Professor Cutler agreed with Counsel Assisting's suggestion that funding levels must include indirect costs necessary for the provision of particular services.[144]

Professor Woods also agreed with Counsel Assisting's proposal that pricing for indirect costs would be part of the pricing process.[145] He expressed the view that the proposition needs to explicitly:

> recognise that for the consumers to receive quality services they need to have viable providers, and if providers are not able to generate a return on their investment, they won't invest.[146]

Mr Thorley and Dr Mellors agreed that providers need to be able to generate a return on their investments.[147] Dr Mellors said that implementing a national efficient price would allow providers to 'return a profit or a surplus based on a national efficient price' and 'it's also important that we understand what a profit or a surplus is used for, and that we do need it for ongoing innovation and to provide returns'.[148] Mr Callaghan called for pricing that 'will incorporate a rate of return'.[149]

Mr David Bennett, Chief Financial Officer at Ryman Healthcare Limited, and Mr Mamarelis were both supportive of the proposition, stating that the additional funding could be ring-fenced for innovation and staff training. They considered that such funding is needed for innovation and staff education.[150] Ms Chadwick expressed concern about the proposition, stating 'I'm not sure how a model like ours could be, you know, one, properly priced and, two, acquitted'.[151] Mr Jonathan Gavshon, Co-Chief Executive Officer of Group Homes Australia, was also supportive of the proposition. However, he cautioned that being 'too prescriptive about where these costs need to sit and how they need to be acquitted' would compromise innovative models.[152]

23.2.1 Economic regulation of the aged care sector

Counsel Assisting tested a proposition calling for the pricing authority to exercise economic regulatory functions over prices for aged care services, unless the services are supplied through a workably competitive market. The proposition further stated that price regulation should apply to prices charged to people receiving residential aged care services for the ordinary costs of living, rent (accommodation) and additional services.[153]

Professor Woods gave his view on the economic regulation of aged care:

> What we should assume is that we don't actually have a perfect market and by no means is it a perfect market and therefore regulation plays an important role as does the transparency of reporting and accountability. And what should be ensured is that those providers who are there offering their services all meet at least an appropriate minimum standard so that any choice that is made is a choice that will provide care and support of a standard that society and the Government through its funding considers is the minimum appropriate.[154]

Professor Hjalmar Swerissen, Visiting Fellow of the Grattan Institute, said that 'the preconditions for an effective market and market competition are not present' in aged care because consumers do not have access to comparative information and cannot make informed choices.[155]

Professor Menezes gave his opinion on the appropriate scope for economic regulation of prices charged for aged care services.[156] He said that economic regulation is not needed in competitive markets and that 'the test of whether markets are competitive is an outcome-based test', which involves considering the 'prices that reflect the efficient costs of providing the services'.[157] He added that the setting of maximum prices by an independent economic regulator would need to occur when markets fail.[158] Professor Menezes said that the role of the economic regulator:

> is to identify where is the failure, why is there a need for intervention, and then the second part of that test is to determine what is the best way to intervene.[159]

Professor Menezes said that the setting of maximum prices by an independent economic regulator would need to occur when markets fail.[160] He explained that this will incentivise providers to 'pursue cost and process innovation'.[161] He said that poorly designed price regulation 'may have a negative impact on quality and product innovation, and affect the financial position of the providers'.[162]

Professor Menezes explained that price regulation refers to actually setting prices, while economic regulation is wider and can involve competition-style regulation which sets the rules to be followed, but does not necessarily set the price that must be charged.[163]

Professor Menezes did not support the implementation of rate of return or price cap regulation for residential aged care services because they 'are too costly and intrusive to be applied to set prices for 873 different providers'.[164] He did not support the implementation of rate of return regulation because 'if the provider is assured that that's going to have its costs reimbursed, this provider has no incentives to innovate, has no incentives to reduce costs and so on and so forth'.[165]

He argued for the regulation of care subsidies in residential aged care:

> once a resident enters a home, then that resident has no option but to make use of the services provided at that home, and given that that resident likes that countervailing power, right, of threatening to move away to rebalance that relationship, then it's a good case for regulating care subsidies.[166]

Professor Menezes did not support the implementation of regulation for accommodation prices:

> There does not seem to be a case to regulate accommodation prices. It is unclear that providers can exercise market power in setting accommodation prices when there is excess capacity. Moreover, the government has a number of levers that it can use to drive an increase in the supply of accommodation.[167]

Professor Menezes said 'the point I want to make is that I cannot make a case for establishing price regulation of accommodation across the board'.[168]

Professor Cutler also gave evidence about the scope of economic regulation in aged care. Like Professor Menezes, he did not support changing the current form of regulation of accommodation charges to a heavier form of regulation, due to the administrative costs of introducing such a regime outweighing any benefit.[169] He said that price caps for living expenses and for care are needed because the market is not competitive, and some providers take advantage of situations where there is not a strong relationship between price and quality.[170]

Mr Callaghan, Professor Cutler, Dr Murphy, Dr Mellors and Mr Thorley each varied in their support for the proposition concerning economic regulation.

Mr Callaghan expressed reservations about the implementation of price regulation, stating that a precautionary approach is very important and that 'more qualifications, more nuances, more outlining of the objectives of the pricing authority in exercising this function' is needed.[171] He explained that price regulation is 'often not the best way' to promote the market and protect consumers, and that price regulation can have significant negative consequences.[172] He cautioned against a situation arising like the cap on the basic daily care fee where the cap is below the cost of what is required to deliver hotel services.[173] Mr Callaghan suggested that alternative interventions could be implemented, such as subsidising vulnerable people who do not have the financial means to pay, and interventions in the form of providing more guidance, information and auditing activities.[174]

Professor Cutler supported the proposition. He said that the restrictions on competition due to the national aged care planning ratio and the Aged Care Approval Round, coupled with the inability of residents and their families to access information on quality and price, 'suggests that there should be some continued regulation of price on care'.[175] Professor Cutler said that the current arrangement 'sends a strong signal to providers that we're not going to tolerate accommodation being priced at an amount that is significantly higher than what the accommodation is worth'.[176] Dr Murphy also supported the proposition.[177]

Dr Mellors and Mr Thorley echoed Professor Cutler's views about the current system for the regulation of accommodation prices working well.[178] Dr Mellors said that the failure to review the threshold level for accommodation prices is problematic, and that the threshold should be reviewed at a certain point in time and reviewed thereafter at 'indexation or review points'.[179] Dr Mellors said she would only recommend more regulation 'in a thin market where there is inadequate choice for consumers'.[180]

23.2.2 Funding in less than workably competitive markets

We heard from a number of witnesses in response to a proposition that funding mechanisms should be implemented to encourage providers to deliver particular services in places where there is not a workably competitive market and help to ensure access to some aged care services.[181] The proposition was aimed at helping to ensure that older people have access to particular types of aged care services in places where there is not enough supply to ensure competition. It suggests that where there is insufficient market depth—or, in other words, a 'thin market'—the Aged Care Pricing Authority may make a determination enabling approved providers to be paid a loading to attract additional

approved providers to offer the relevant service types. Should this approach be unsuccessful, approved providers would be commissioned by the system manager, with funding delivered through a combination of block and activity based funding, sufficient for the delivery of required services for that area.[182]

In its statement, Australia and New Zealand Banking Group suggested that additional funding is required to improve the 'bankability' of providers in rural, regional and remote areas.[183] Westpac Banking Corporation also identified that aged care providers operating in rural, regional and remote places have weaker average profitability than providers operating in metropolitan areas. It noted that this, among other factors, limited Westpac's appetite to lend to aged care providers operating in these areas.[184]

Mr Brown commented on the higher costs of developing residential aged care facilities in remote areas, along with additional costs, such as providing staff with onsite housing.[185]

Mr Mamarelis explained that residential aged care facilities in rural and remote locations have been experiencing substandard and declining profits for a number of years, and that those facilities failing to deliver sustainable outcomes are supported by a care subsidy.[186] He described the current funding model for residential aged care facilities in thin markets as 'not satisfactory' and 'substandard'. He also explained that there are illogical inconsistencies in the funding for residential aged care facilities in rural and remote locations, such as where facilities located in areas of comparable operational cost are funded differently based on geographical boundaries.[187] Mr Mamarelis said that Whiddon Group relies on profits generated in residential aged care facilities in places such as large, metropolitan cities to cross-subsidise residential aged care facilities which are located in regional, rural and remote areas and making a loss.[188]

Mr Mersiades cautioned against relying on aged care providers to cross-subsidise delivery of aged care services in thin markets, as this is not equitable for those older people who may receive fewer services than they need while contributing to support services that are not financially viable.[189]

Mr Bennett agreed that the implementation of this proposition would encourage aged care providers to provide services in thin markets.[190] Dr Mellors said that financial incentives are required for aged care providers to operate in such markets, and recommended an activity based funding model, with higher cost structures for rural and remote areas.[191]

Mr Mamarelis said there was a question of how to encourage investment in aged care in small communities where returns will be low. He described the 'cost premium' attached to constructing and operating residential aged care facilities in rural and remote locations and said that incentives were needed to attract an adequately skilled workforce to these locations.[192]

Dr Murphy expressed general support for the proposition, confirming that the Australian Department of Health 'again support thin market arrangements' and that 'we have them already in a number of aspects of the aged care system'.[193] When asked specifically about commissioning services, Dr Hartland said 'absolutely, it needs to be part of the future'.[194] He told us that commissioning is a two-way process that 'needs to have a local understanding'. He said that while there does not necessarily need to be grant managers in each country town to achieve that, you certainly do need to have people that understand the circumstances of the provider with which they were engaging.[195]

Professor Cutler suggested that if loadings are unsuccessful, the possibility of the Australian Government commissioning a provider of last resort was an appropriate failsafe mechanism.[196]

Mr Corderoy explained his view that residential aged care facilities should be block-funded in a similar way to the Multi-Purpose Services Program. He detailed specific characteristics of remote residential aged care facilities that render them inadequately funded, such as a lower capacity to raise revenue through the Aged Care Funding Instrument, and staffing difficulties. He explained that the nature of residential aged care facilities in rural, regional and remote areas means that a provider's operational costs remain at the same high level, irrespective of the number of residents and corresponding amount of funding being received.[197]

23.2.3 Funding arrangements for aged care services

We heard from a number of witnesses in response to propositions developed by Counsel Assisting in relation to the appropriate funding arrangements for aged care services, outlined below.[198]

Care delivered in the home

Program arrangements for home care

We heard from a several witnesses about the interaction between funding models and the design of aged care services, particularly for services delivered to older people in their own homes. Program arrangements were not a specific focus of this hearing and this section only provides a brief overview of the evidence given.

Professor Eagar said that the objectives for both program design and funding needed to be the same, and that in her view the best approach was 'a balanced set of objectives' which promotes equity, responsiveness, practicality and technical efficiency.[199] She explained that while 'consumer choice' is part of a responsive system, it was incorrect to assume that 'choice is so good for you, that you have to have it whether you want it or not'.[200] Professor Eagar considered that the propositions put forward by Counsel Assisting in this hearing and in the Home Care Hearing would have the effect of moving many services into individualised funding bundles, which would have a deleterious effect on the Commonwealth Home Support Programme.[201]

Professor Eagar's preferred model of aged care services involved the creation of four streams:

- age-friendly community services, being whole of population initiatives, funded on a regional basis by block grants[202]
- primary aged care services, being 'those that can be accessed directly and without a formal comprehensive assessment', including domestic and social support, funded on a price and volume basis[203]
- secondary aged care services, being those required by people 'living at home with higher level needs', to be funded on a casemix basis, with some episodic services funded on a price and volume basis[204]
- tertiary aged care services, being those for 'people whose care needs are such that they can no longer live at home', to be funded on a casemix basis.[205]

Dr Hartland referred to a report prepared for the Australian Department of Health by HealthConsult. The report evaluated potential approaches to aged care program design and associated funding models. He said that there were similarities between HealthConsult's report and Professor Eagar's model.[206]

Professor Eagar raised a potential compromise between her proposed model and the propositions tested by Counsel Assisting, which as a key feature would give an older person a choice between managing a package of funds themselves or having their services provided to them by a single provider who would receive a block grant from the Australian Government.[207] Dr Hartland said he preferred Professor Eagar's initial proposal to her compromise model.[208]

Activity or block-funded services

Witnesses were asked about a proposition from Counsel Assisting proposing that activity or block funding be applied to certain types of services, including those provided on a one-off basis, such as respite or short-term enabling care, or those which are high-volume or relatively uniform in nature.[209]

Dr Panter said that caution was needed because the current Commonwealth Home Support Programme, which operates on a similar basis to Counsel Assisting's proposition, 'does not…fund providers to coordinate/manage care needs'.[210]

Mr Gavshon expressed cautious support for activity based funding.[211] His caution related to the potential granularity of the activity based funding requirements.[212]

Mr Mersiades said that activity based funded providers under the Commonwealth Home Support Programme do not face the same financial challenges as home care and residential aged care providers because of their grant funding structure.[213] This means they face the challenge of having to stretch their grant funds 'so that the maximum benefit is achieved for the maximum number of people in a supply constrained environment'.[214] Dr Mellors said that reablement programs should be available via a casemix basis, but that such programs might also be made available through block grants.[215]

Professor Cutler suggested that the funding model for high-volume or relatively uniform services might be delivered better through a simple fee-for-service model.[216] He agreed that it was possible that block and activity based funding was potentially an appropriate option, but that other types of funding, such as outcomes-based funding, could be used. In his view, outcomes-based models should continue to be explored to find out 'whether they can, indeed, induce some form of improved quality'.[217] Dr Panter also encouraged the examination of output-based funding models.[218]

Dr Hartland expressed some scepticism in relation to having block granted funding as a part of aged care services in workably competitive markets. He suggested that it would be better to think 'about them in terms of the people who need one or two service events rather than the product lines'.[219]

Services funded through individualised bundles

Counsel Assisting tested with witnesses a proposition that funding for services could be provided in an individualised bundle if the services were predictable and ongoing, provided in workably competitive markets, and where casemix classifications would be difficult to apply.[220] Under this approach, 'people would receive an entitlement to support and care based on their assessed need across a range of domains'.[221] This could apply to some services currently delivered through the Home Care Packages Program.[222]

Mr Warner said that he agreed with the proposition in principle, but that the qualification of workably competitive markets was important.[223] Professor Cutler also agreed with the proposition.[224]

Dr Panter described this proposition as 'a step in the right direction'. He thought the ability for funding to fluctuate up and down would result in a more appropriate and equitable service.[225] Mr Mersiades said that an individualised funding model based on a 'reasonable and necessary' criterion, such that individualised care plans could be used to generate individual budgets, should not be favoured for aged care.[226] Dr Mellors had similar concerns to Mr Mersiades.[227] But Professor Swerissen was in favour of funding classification levels flowing from an individualised care plan.[228] Similarly, Professor Ergas supported home care being funded through individualised plans costed on the basis of the efficient costs of services.[229]

Mr Gavshon supported a future funding model that would provide individualised support for residents and their families. However, he said that there were a number of lessons to be learned from the experience of the National Disability Insurance Scheme, including in relation to inflexibility, funding delays, inconsistency and uncertainty, amongst other issues.[230]

Mr Downie said that there were home-based environments where casemix funding was not possible at present, but that with 'significant work' the Australian National Aged Care Classification casemix system could be adapted for home care.[231]

Dr Hartland described this proposition as 'really close' to HealthConsult's proposal for episode-based care and what Professor Eager proposed in relation to secondary aged care. He stated that 'the idea that there is a group of people that need a bundle of services that you contemplate as a whole is absolutely agreed'.[232] Dr Hartland raised concerns about whether the absence of a casemix system was a prerequisite for funding in this model, cautioning that 'you actually need a classification system to sit underneath it so you can understand whether you got the funding right'.[233]

Maximum amounts of funding for care provided at home

Counsel Assisting tested with witnesses a proposition that the maximum amount of aged care funding available to a person living at home should be the same as the maximum amount available for care in a residential aged care facility.[234]

Dr Panter described an exercise undertaken by ECH Incorporated where they applied additional funding to Home Care Package clients so that their total funding was equivalent to what a person would have received in residential aged care.[235] He said that ECH Incorporated was able to assist these people in living 'at home, with higher degrees of complexity, much longer, and indeed in some cases, until the point of death in their home, which was their choice'.[236]

Dr Murphy said that in principle the Australian Department of Health 'strongly support the idea that Home Care Packages should be able to be much more generous and should enable people to stay in their home with increasing levels of frailty'.[237] However, Dr Murphy raised some concern about the prospect of requiring a residential aged care assessment process for someone in home care to determine a dollar amount for funding, and the technical complexity of such a process.[238]

Mr Gavshon supported the provision of funding to people regardless of the setting in which they live.[239] He considered a significant issue in the current system is that:

> residents that were to move into a residential aged care facility, and let's say that they're at an equivalent high, high/medium or an ACFI [Aged Care Funding Instrument] of roughly $200 a day, the equivalent funding for them under the Home Care Package program is only around $150 a day at the Level 4 level without any means test applied, and so what you can see is that depending on their choice of setting, they get inferior funding from the Government.[240]

Mr Mersiades considered the issue of whether to fund agnostic of setting a 'pivotal policy consideration' in developing a funding model for home-based care. However, he also made the point that services delivered in a person's home will rarely, if ever, match those that can be provided in a congregate living setting such as residential aged care'.[241]

Ms Chadwick expressed some concern about the proposition, telling us that 'if we're going to be agnostic of location, then I think we need to be very careful that it's like-for-like service'.[242]

Professor Cutler said that there was a potentially perverse incentive in this proposition, if the provider was responsible for determining whether an individual receives care at home or in residential care.[243] He supported independent assessments.[244]

Funding arrangements for congregate care

Witnesses were asked to consider a proposition for the funding of people living in congregate care settings, such as residential aged care and potentially other group living environments, involving the introduction of casemix adjusted activity based funding arrangements.[245]

In his statement, Mr Callaghan said that the Aged Care Funding Instrument was an inappropriate funding tool. He said the Australian National Aged Care Classification, being a casemix adjusted funding model of the type suggested by this proposition, would be better placed to deal with variables such as provider location and the specific populations they serve.[246] Professor Henry Ergas, a consultant economist, also agreed that casemix funding for residential care was preferable.[247]

Dr Murphy commented positively on this proposition, considering it 'good' and consistent with how the Australian Department of Health was approaching the Australian National Aged Care Classification.[248] Similarly, while also focusing on the possibility of a National Efficient Price via an independent pricing authority, Mr Downie commented positively on an Australian National Aged Care Classification-type funding model. He described it as a 'huge opportunity for more coordination and substitution of care'.[249]

Dr Murphy said that the way out for the current funding and financing issues in residential care was 'to get a proper independent transparent pricing system and a new case mix funding model'.[250]

Not all of the witnesses in the hearing were as supportive of introducing a casemix approach.

Mr Corderoy of StewartBrown proposed retaining the Aged Care Funding Instrument with some modifications, and not making major changes to the funding of residential care.[251] Professor Cutler also cautioned that due to the complexity of aged care, there was likely 'no perfect funding model for residential aged care'.[252]

Mr Downie said that the Independent Hospital Pricing Authority had not undertaken a review of the underlying statistical model, but had not observed any issues which would suggest that the Australian National Aged Care Classification is not fit for purpose. He raised alternative funding models to casemix-based systems, including a capitation model or block funding allocations based on historic activity and costs.[253]

Mr Darrell Price, the Principal & National Head of Health & Aged Care at Grant Thornton, doubted the correct future approach to robustly funding the aged care sector was a single model of funding. He said a single model would be unable to address the different funding needs of the wide variety of providers and market situations for all providers in Australia.[254]

However, Mr Thorley of Estia and Dr Mellors commented positively on this proposition. Dr Thorley described it as 'sound'. Dr Mellors confirmed Regis supported the proposition, and that it would be effective in an aged care setting.[255] Mr Mersiades of Catholic Health Australia described the proposition as 'basically sound'.[256]

Ms Chadwick also agreed that ongoing funding could be provided on a casemix model such as the Australian National Aged Care Classification.[257] However, she was also concerned that whatever funding model was used, that it left space for the funding of innovation within the aged care sector.[258]

Supplements for certain services in congregate care settings

Counsel Assisting tested with witnesses a proposition to retain certain residential aged care funding supplements until reviewed by the Aged Care Pricing Authority to determine the actual cost of providing the care in question. These supplements were the enteral feeding supplement, oxygen supplement and veterans' supplement.[259]

Dr Mellors stated that Regis supported the proposition, Mr Thorley stated he agreed with what was described in the proposition and Mr Mersiades's earlier commentary of propositions being 'basically sound' was also made in reference to this proposition.[260] Dr Murphy stated the Australian Government supported this proposition 'in general'.[261]

No witness commented adversely on this proposition.

Transitioning to new funding arrangements

We heard evidence about matters that should be considered during the process of transitioning to a new funding model. Professor Cutler said that he generally agreed with the Framework for Transition and Implementation document prepared by staff of the Royal Commission. However, he suggested a 'more explicit' reference to monitoring, because large reform can increase the potential for 'perverse behaviours' or 'outcomes that were unanticipated'.[262] He said any reform process should have a 'good quality monitoring framework around it: in particular, monitoring the quality of care being delivered, monitoring prices, and also, monitoring access to services', which he suggested could mitigate the risk from rapid reform of access to good quality care. Professor Cutler said that there has to be a clear understanding of how changes implemented through reform will occur and affect other parts of the aged care system.[263]

Dr Mellors identified defining aged care quality as a key, initial step of future funding reforms. She also listed proper costing of staffing models that would deliver that a defined level of quality as a critical step during transition.[264] Dr Panter suggested an interim arrangement for independent pricing during the period of transition to a new funding system. He noted that the current funding amounts for the Commonwealth Home Support Programme and Home Care Package Program offer less quantum of funding than was available when the programs were introduced.[265]

23.2.4 Principles for assessment of care need

Witnesses responded to a proposition from Counsel Assisting that the Australian Government should ensure universal access to timely assessment of needs for support and care, and reassessment as required. The proposition included a requirement that the assessment process would identify the required supports and care and the funding required to meet each person's needs, and sets out the principles that should apply to assessment of all aged care funding mechanisms for different aged care services.[266]

Professor Eagar raised several concerns about the proposition, in particular that it is not sufficiently broad or detailed and that it fails to identify the necessary skill set for the assessors.[267] She explained her view on this lack of specificity by pointing out there are two broad conflicting views on how assessment should be implemented which are not addressed or selected in the proposition:

> You can have a low-skilled, low-paid workforce and they're just assessing whether you're eligible for this, that or the other thing.
>
> There's another approach that says what we need to do is see assessment as a real opportunity to engage with a person and develop a wraparound that goes beyond aged care.[268]

Professor Eagar stated she believed the latter approach also had its issues, with the assessment and aged care system likely to 'start again' with the aged care assessment and not take into account an individual's history. In her view, this approach was not holistic enough.[269]

The principles set out in the proposition include that a resident of a residential aged care facility should not be required to undergo a reassessment if their condition improves under the care of an aged care provider. This principle was supported by Professor McCallum, who described it as 'a great positive' for 'improving people's health and wellbeing'.[270]

Paul Sutton, the Victorian Operations Manager for Ryman Healthcare, described the current assessment for residential aged care as complex and the claiming process as time-consuming, with regular new applications required as residents' needs change.[271] Professor Swerissen made the same observations of the current assessment system, and said the process is unrelated to individual care planning, subject to significant delays, with no integration of assessments of level of dependency and means. He said that an eligibility assessment does not lead to a care plan and the organisation of services, and that it is difficult for people receiving care to transfer between the different home care programs and the residential aged care program as their needs change.[272]

The Australian Department of Health indicated its support for funding assessments for residential aged care being conducted separately from the aged care provider. This is reflected in the Australian National Aged Care Classification and Assessment, Classification and Funding models to 'help ensure that care assessments are not influenced by funding considerations'. In its statement, the Department explained that assessments under the Australian National Aged Care Classification funding model would be carried out by independent assessors with professional health qualifications and specific training to undertake those assessments.[273]

In addition to mitigating the impact of funding considerations, the Australian Department of Health suggested that this approach could improve the quality of assessment data, as 'the independent assessment process would remove the incentives within the current provider assessment Aged Care Funding Instrument system to complete assessments to maximise funding'. The Department also suggested that the Government could more reliably predict its aged care spending.[274]

Dr Panter supported a single assessment process for funding for home and residential aged care, and said that the key features to determine are 'the trigger for reassessment and the evidence required for that'.[275] He agreed that aged care providers should not be undertaking assessments for funding levels of people receiving aged care, but suggested they have the opportunity to provide evidence for consideration during the assessment process on account of their ongoing relationship with the person receiving care.[276]

Mr Warner also described the importance of a single assessment process and more frequent reassessment. He said that while there needed to be further consideration of how to fund a person's specific needs, he completely supported the principles listed in Counsel Assisting's proposition. Mr Warner also considered the role of approved providers in care assessments, and said that the authority to assess a person for access to aged care services should rest with an independent authority, but that the provider who 'intimately knows the client' should be able to contribute to the assessment process. He said that although approved providers are often required to assist older people to register with My Aged Care and to continue to support them through the system, there is no funding to support that aspect of a provider's role. He suggested that each person should be allocated a dedicated Care Recipient Advocate, and that approved providers could be funded to carry out that role.[277]

Conversely, Dr Mellors told us that approved providers should continue to carry out assessments for aged care funding. She considered assessments conducted by an external agency 'inferior' to assessments conducted by an assessor employed by the aged care service provider.[278]

Dr Mellors compared the Australian National Aged Care Classification assessment process, which takes approximately 15 minutes to complete, to the longer assessment process of new residents that approved providers undertake upon entry to identify their care needs.[279] She suggested that the requirement to undertake two assessments would be an additional cost to the sector. Dr Mellors also suggested that the 15-minute 'point in time' assessment will not adequately capture the complex needs of residents due to behaviour and frailty changing throughout the day. She said that an assessor within an approved provider would observe a new resident over the course of the day and be more sensitive to changing needs, and should therefore be responsible for documenting each resident's needs and claiming the funding required.[280]

23.2.5 Payment in arrears and acquittal

Counsel Assisting tested a proposition to introduce processes for ensuring that funding provided to meet the costs of providing high quality care is spent on providing such care. The implementation of this proposition would result in the Australian Government requiring approved providers to acquit their overall expenditure on care or care staffing hours, and the payment of care subsidies to aged care providers to be made in 'arrears', or on an accrual basis.[281]

Professor Woods expressed strong support for this proposition, and said that it would allow for more accountability in care delivery. He described payment of government funding on accrual—expenditure incurred, but not paid—as 'by far the most appropriate mechanism', and said that an ongoing process of acquittal of accrued funds and spent funds could be achieved easily.[282]

Similarly, Mr Versteege described acquittal and payment in arrears as 'a good idea' and suggested that the requirement for acquittal of funds could be 'the key' to 'funding aged care services efficiently and effectively', even if not all acquittals are audited.[283] He said that acquittal is necessary to prevent funding models being 'gamed' by aged care providers.[284]

Dr Murphy accepted that 'the system manager has a right to know that funds have been spent appropriately', but expressed concern about an 'overly burdensome acquittal process as a supposed means to improve quality of care'.[285] Mr Thorley described transparency as 'absolutely critical' and said that the public and the Australian Government have 'an appropriate expectation of the transparency'.[286] Dr Mellors also expressed strong support for transparency in the way that aged care providers spend aged care subsidies funded by the Government, but stressed the importance of flexibility for aged care providers, particularly for larger organisations with centralised internal oversight.[287]

Mr Jason Ward, Principal Analyst at the Centre for International Corporate Tax Accountability and Research, described this proposition as a 'clawback mechanism'. He said that if funding is not spent on providing the services for which it is intended, the Australian Government should be able to retrieve it. He said that expenditure should be continuously reviewed, including the amount of expenditure on direct care staff.[288]

Professor Cutler expressed hesitation with the approach of measuring aged care by inputs. He understood the desire for an acquittal process, but stressed that it should be balanced with the additional administrative costs it could impose on aged care providers, and that it may reduce the flexibility aged care providers have with respect to their staffing arrangements. He accepted that an acquittal process might be introduced as a temporary measure until there can be better measurement of the quality of aged care services.[289] Mr Fielding suggested that more granular data of aged care provider expenditure on labour and accommodation should be collected through the process of acquittal, as currently there is insufficient data to determine indicators of appropriate aged care expenditure.[290]

However, Mr Corderoy said that he would not expect a requirement for providers to acquit their aged care expenditure to place an additional burden on aged care providers, as providers already collect the data on which acquittal would be based. He also expressed support for home care subsidy payments to be made in arrears, and said that this should be done 'as soon as practicable'. He said that despite some short-term cash flow implications, more appropriate business management and levels of equity and working capital will reduce the level of unspent funds in the home care system.[291]

Mr Mersiades agreed that payments of aged care subsidies should be made in arrears, as is the case in ordinary business practice. He described greater disclosure as 'fundamental' and said that this would 'avoid the administrative costs and prudential risks of providers holding unspent funds'.[292] He noted that this should be gradually implemented, and referred to the recommendations of the Aged Care Financing Authority with respect to transition and implementation arrangements. He raised concerns about the use of the word 'acquittal', due to its association with grant-funded programs in the public sector.[293]

Mr Mamarelis expressed concern about the potential cash flow implications for providers of aged care subsidy payments being made in arrears, and suggested this could 'create additional challenges in a highly competitive environment which is already financially constrained and change fatigued'.[294]

Dr Panter suggested that cash flow could be facilitated by providers receiving 80% of funding in advance to enable service provision, with the 20% balance of funding to be paid in arrears and dependent on the aged care provider achieving agreed outcomes.[295] He said that while he supports the acquittal process, he is concerned about the 'speed and efficiency' with which funding in arrears will be paid, and that some smaller and more specialised providers may 'fall foul' of the acquittal process unless those payments are made quickly.[296]

Mr Warner largely agreed with Dr Panter, and described payment in arrears as 'a sensible step forward', while noting that working capital is required for providers to fund the arrears payments and cover the significant costs of initial enquiries about home care services and 'onboarding' new care recipients through My Aged Care.[297] Similarly to Mr Mersiades, Mr Warner described this system as a 'normal' business arrangement that 'would enable providers to account for their transactions in a regular accounting manner'.[298] He suggested that this would allow aged care providers to use standard financial software to administer their aged care funding, saving them significant time and resources required to manually create large numbers of statements.

Mr Warner further proposed a four week deposit for aged care services to ensure that providers have access to working capital. This deposit would be offset after six months or when the person ceased using services, whichever occurs sooner.[299] He also proposed that the Government be responsible for issuing the monthly statements for aged care services to the person receiving aged care, to reduce the administrative burden and costs on home care providers, and to allow the Government to 'better manage, report and reallocate' unspent funds.[300]

23.2.6 Prudential regulation of aged care

Witnesses were asked to respond to a series of propositions about the prudential oversight and financial management arrangements for the aged care system.[301]

The propositions outlined a new framework for prudential regulation and financial oversight to be managed by an appropriately resourced and empowered prudential regulatory body. In summary, the framework to be managed by the prudential regulatory body would encompass:

- more regular and better tailored financial reporting by aged care providers
- continuous disclosure requirements in relation to information that affects providers' ability to pay their debts or to continue to provide safe and high quality care
- reporting by aged care providers about the outsourcing of care management—that is, the general management of care for people receiving care from a particular residential or home care service
- more stringent liquidity and capital adequacy requirements.[302]

The Australian Government expressed broad support for the prudential regulation propositions as a whole.[303]

Current regulatory framework and need for reform

According to the Australian Department of Health and the Aged Care Quality and Safety Commission, the primary purpose of the existing prudential legislation is to protect and ensure that residential aged care providers return Refundable Accommodation Deposits to deposit paying residents on their departure or death.[304]

Both the Australian Department of Health and the Aged Care Quality and Safety Commission have responsibility for prudential and financial oversight functions. In broad terms, the Aged Care Quality and Safety Commission 'is responsible for the regulation of approved providers in relation to their prudential responsibilities' and the Department 'is responsible for collecting and assessing the financial and prudential information' that aged care providers are required to provide to the Secretary of the Department.[305]

The Department also conducts various risk assessment processes based on financial and prudential data and includes, among other assessment processes:

- 'First Pass Risk Assessments', which involve ranking providers of residential aged care in relation to risk of financial viability from 'low' to 'severe'
- 'Detailed Risk Assessments', which involve a more detailed analysis of providers ranked 'severe'.[306]

Mr Jaye Smith, First Assistant Secretary at the Australian Department of Health, said:

> the Australian Government and then the Department has absolutely accepted that the prudential framework is not currently fit for purpose, that it requires fundamental reform to make sure that it can meet contemporary needs in the system.[307]

The Department and the Aged Care Quality and Safety Commission agreed in principle about the need to strengthen the prudential oversight and financial management arrangements for the aged care sector.[308]

A number of the propositions tested at this hearing concerned financial management and prudential recommendations made in the *Inquiry into Events at Earle Haven* report, authored by Ms Kate Carnell AO. At the time of the hearing, the Australian Department of Health and the Aged Care Quality and Safety Commission had taken various steps towards implementing those recommendations.[309]

The Australian Department of Health also referred us to recent measures to improve its prudential and financial capabilities, including the commissioning of a project led by Mr Gary Barnier of the Aged Care Financing Authority.[310] In January 2020, the Department commissioned Mr Barnier to review its financial analysis processes and activities, including the monitoring and understanding of the causes of financial and prudential risks.[311]

In February 2020, Mr Barnier provided an update to the Australian Department of Health about the project which included his initial findings and recommendations.[312] He stated that 'identifying and working closely with high risk [approved] Providers well before they fail is the best way to minimise resident and community disruption and minimise RAD [Refundable Accommodation Deposit] losses', but that the Australian Government is 'not currently set up to do this'.[313] Further, Mr Barnier advised that:

- approximately a third of approved providers were experiencing or would soon experience 'severe financial stress'[314]
- 67 of the approved providers experiencing immediate or imminent financial stress required close scrutiny[315]
- 46 of the approved providers experiencing immediate or imminent financial stress required immediate intervention[316]

Given the timing of Mr Barnier's update to the Australian Department of Health, these matters were clearly known to the Department before the effects of the COVID-19 pandemic. The Australian Department of Health advised us that since Mr Barnier's update, it had established a dedicated team to engage with 'at risk' approved providers and had engaged external consultants to assist with the financial analysis of these approved providers.[317]

Reporting requirements on providers

Witnesses responded to a proposition that the prudential regulatory body should be able to require aged care providers to submit regular financial reports and to prescribe the frequency and form of reporting.[318]

Under the current framework, approved providers of residential aged care provide financial and prudential information to the Australian Department of Health through their obligation to submit an Aged Care Financial Report to the Department on an annual basis.[319] The Annual Prudential Compliance Statement is a component of the Aged Care Financial Report and requires approved providers to disclose a range of information about accommodation payments.[320]

Non-government approved providers of residential aged care must also submit an independently audited General Purpose Financial Statement which provides 'a true and fair view of the financial position and performance of the approved provider'.[321]

Approved providers of home care are also required to submit an Aged Care Financial Report, but are only required to complete the Home Care Income and Expenses Statement section of that report.[322]

Other than the approved providers which are listed entities, and the State, Territory and local government approved providers, residential aged providers are Tier Two reporting entities. Tier Two reporting entities are able to comply with reduced disclosure requirements under the Australian Accounting Standards.[323]

At the hearing, Mr Murray said that the Australian Department of Health would support, in principle, a tailored aged care reporting regime and 'getting better and more regular financial reporting'.[324] The Aged Care Quality and Safety Commissioner, Ms Anderson, also supported the principle of the prudential regulator specifying the material information for financial reports of providers.[325]

The Australian Government submitted that it supports empowering a prudential regulatory body to determine the frequency and form of financial reporting by aged care providers to:

- ascertain providers' financial viability risks
- manage orderly exits from the sector
- ensure that providers holding consumer assets such as Refundable Accommodation Deposit are able to meet their prudential obligations.[326]

The Australian Government stated that reporting requirements should be targeted to achieve specific outcomes, account for the size and complexity of the provider, and align with broader reporting frameworks.[327]

Mr Warner, Chief Executive Officer and co-founder of Home Instead Senior Care, said that he did not resist the proposition but cautioned that the information which is sought from aged care providers must be 'relevant and appropriate'.[328]

Dr Panter said he was comfortable with the proposition and referred to the need for 'greater transparency across the sector as a whole'.[329] He explained that the financial health of an organisation may impact the quality of the service delivered to clients and for that reason, it is appropriate to have greater transparency around the financial health of home care providers.[330]

Mr Thorley also supported the proposition.[331] He said that requiring higher level reporting from all approved providers is crucial to the overall performance of the sector and ensuring confidence in the sector.[332]

Mr Ward agreed that there should be a tailored standard for aged care financial reporting.[333] He said that in the for-profit sector there are many substantial aged care providers that do not file any financial statements with the Australian Securities and Investments Commission.[334] Mr Ward referred to a lack of uniformity in financial reports and to a lack of transparency in relation to expenditure on direct, frontline care workers and related party transactions.[335] He noted a recommendation of the Centre for International Corporate Tax Accountability and Research to require aged care providers to submit Tier One or Tier Two financial reports, subject to the level of funding that they receive from the Australian Government.[336]

Mr Corderoy confirmed that StewartBrown did not support a requirement to move all providers to Tier One or Tier Two reporting requirements.[337] StewartBrown considered that enhancements could be made to General Purpose Financial Statements, which may include additional disclosures or information that could be provided in accordance with Tier One reporting.[338]

We also heard evidence from a number of witnesses about deficiencies in the current prudential oversight and financial management arrangements for the aged care system, particularly the transparency of a provider's dealings with related parties.[339]

Continuous disclosure requirements

Witnesses responded to a proposition from Counsel Assisting that aged care providers be required to comply with continuous disclosure requirements. Under the proposed requirement, a provider must, if it becomes aware of the following material information, immediately disclose that information to the prudential regulatory body if that information:

- affects the provider's ability to pay its debts as and when they become due and payable, or
- affects the ability of the provider or any contractor providing services on its behalf to continue to provide aged care that is safe and of high quality.[340]

Mr Murray said that 'the question to be resolved is what is that level of materiality and how would that actually operate in practice'.[341] Ms Anderson agreed that a continuous reporting obligation would assist the Aged Care Quality and Safety Commission in its regulatory responsibilities, but cautioned against asking for or receiving information which the Commission would not use.[342] She also shared concerns about the need for clarity around the reporting obligation.[343]

The Australian Government submitted that 'any continuous disclosure reporting thresholds will need to be adjusted to the care setting and the scale of the perceived risk to the care recipient and Commonwealth funds'.[344]

Ms Chadwick cautioned against the potential additional costs associated with continuous reporting obligations for providers such as NewDirection Care Bellmere Pty Ltd.[345] Mr Warner said he would 'completely support' the reform to the extent it is needed to improve quality, but said that it needs to be agreed as to 'what's appropriate and what's relevant' to report.[346]

The reporting trigger

An issue explored in some detail was the event or 'trigger' that should compel an aged care provider to notify the prudential regulatory body in accordance with a continuous disclosure obligation.

The proposition was explored with a panel of representatives from the major Australian banks. Witnesses on this panel described how aged care providers reveal their liquidity to banks and the role of reporting to lenders against financial covenants.[347] In response to a question from Counsel Assisting about the 'lead indicators' for continuous disclosure obligations, Mr McCarthy referred to 'occupancy' and described the mix of Refundable Accommodation Deposits and daily accommodation deposits held by the aged care providers as a 'lead indicator towards liquidity'.[348]

Mr Williams said that it would be rare for a provider not to have an annual forecast of its expected future position, and said that the Commonwealth Bank would expect the forecast to be 'two or three years out'.[349] According to Mr Williams, it 'would be an expectation of borrowers in the sector, that they would have a functioning financial model that would be able to be updated on a regular basis'.[350] Mr Williams said that a requirement to the effect that a provider must notify the regulatory body if in any three-month period, their projections were 15% or 20% different, was reasonable.[351]

Ms Hordern said that the key consideration was if outflows were outweighing inflows. She said the Westpac Banking Corporation very carefully monitors both the Refundable Accommodation Deposit / Daily Accommodation Payment mix, because that can have a significant impact on a provider as well as key occupancy levels.[352] Mr Morris said where the operator is forecasting 'that cash outflows don't meet incoming cash flow' it would usually be expressed on an operator's cash flow statement through the change in Refundable Accommodation Deposits and Daily Accommodation Payment elections and value.[353] He said a forward forecast cash flow can provide an early warning sign and this 'really goes to the heart of liquidity'.[354]

Mr Thorley expressed the view that the ultimate test is one of solvency.[355] He said that if there was a requirement for more frequent reporting, and for reports to be accompanied by an auditor's opinion about the provider's capacity to meet ongoing obligations, then reporting would be an important benchmark in terms of any continuous disclosure requirement.[356] Dr Mellors of Regis Healthcare Limited agreed with these observations by Mr Thorley.[357] She added that cash flow forecasting would be another good metric.[358]

Mr Mamarelis identified a decline in the net inflow of Refundable Accommodation Deposits and a decline in occupancy as the 'first trigger' for compulsory disclosure, and then the need for those projections to be tied back to overall cash flow.[359] He suggested that

changes in occupancy and cash flow could be measured easily, but that the cash reserves of an organisation must also be taken into account.[360]

Mr Bennett of Ryman Healthcare Limited said that a 'bright-line marker' around occupancy or cash outflows is very hard because every organisation is different.[361] He said:

> if you're going to have a bright-line test, it's your liquidity requirements under the prudential reporting, and a trigger that if you breach any of those, then you are required to report that immediately.[362]

Mr Cameron Ansell, Managing Director at Ansell Strategic, gave evidence about the need for providers to have visibility of capital flows from accommodation payments and operating deficits.[363] According to Mr Ansell:

> if you have visibility over your capital flows from resident accommodation payments as well as you're operating deficits, then I think that would put you in a position to be able to raise concerns. Not all providers, as in any business, will have the capacity to be able to provide that much notice.[364]

The Australian Government submitted that the nature of any changes that would trigger the requirements for immediate disclosure requires further careful consideration, particularly on matters affecting the ability of an aged care provider to provide safe and high quality care.[365]

Reporting on outsourcing of care management

Witnesses were asked to consider a proposition that aged care providers should be required under statute to notify the prudential regulatory body of any proposed subcontracting of care management before the arrangement takes effect.

Mr Smith said that since March 2020, the Australian Department of Health had clarified the requirement for providers to advise of such changes and had implemented changes to the relevant notification form.[366]

Ms Anderson said she could not make an observation about trends, but said outsourcing does happen to different extents. She said it was her understanding that outsourcing management of a service was 'less often the case'. Ms Anderson said there were specific risks that may attach to an arrangement where an aged care provider brought in a labour hire management team from a separate corporate entity. She said each circumstance should be 'carefully considered for their potential risk'.[367]

The Australian Government submitted that particular consideration should be given to home care providers, noting that subcontracting plays a significant role in home care providers' care management and business structures.[368]

Both Mr Thorley and Mr Ward supported the proposition but considered that it could go further. Mr Ward suggested that if the entity receiving the contract is not an approved provider then there should be some process to vet the suitability of that entity.[369] Mr Thorley said the outsourced manager should be required to be an approved provider.[370]

Powers of the prudential regulator

Information gathering powers

Witnesses responded to a proposition that the prudential regulatory body should be able to compel the production of information and documents and the giving of evidence, by any person involved in the provision of aged care services. It was also proposed that the prudential regulatory body or an authorised individual have certain other powers, including powers to enter aged care work premises without consent and access documents.[371]

Ms Anderson told us that the existing powers that enable officials from the Aged Care Quality and Safety Commission to go on to the premises of an aged care providers are 'conditional on the consent of the provider'.[372] She said that it was rare that a provider would deny consent, but in that event, if 'judiciously used', the power of entry would serve a useful purpose.[373]

Mr Smith of the Australian Department of Health agreed with Ms Anderson.[374] He added that on the basis of the Department's experience with 'providers at risk', providers are generally 'very willing to…have us in and show us the information we need to be able to make those more detailed assessments about viability' but having the power 'could be a useful thing'.[375]

The Australian Government submitted that it supports powers of the prudential regulatory body being 'commensurate and proportionate to the sector and the matters under investigation'.[376] However, the Australian Government cautioned that the proposal to allow '"full and free access at all reasonable times to any document, goods or other property" may be viewed as a significant extension of current provisions' of the aged care legislation, and that any introduction of 'expanded powers should be consistent with other regulators'.[377]

Tools for enforcing the prudential requirements

Witnesses responded to a proposition from Counsel Assisting that the prudential regulatory body be empowered to impose certain outcomes if an aged care provider breaches prudential regulatory requirements. Broadly, the proposed outcomes included:

- informal methods, such as increased regulatory scrutiny or additional reporting requirements
- certain directions to a provider
- court enforceable undertakings
- the imposition of civil or administrative penalties.

The proposition also recommended that the prudential regulatory body have the power to make recommendations to the quality and safety regulator, including recommendations about the imposition of sanctions.[378]

Mr Nigel Murray of the Australian Department of Health supported the proposition, noting that 'the regulator would need the appropriate tools and…range of different response options' to manage and oversee the prudential requirements.[379]

Ms Anderson agreed that the proposition would assist but said that it did not give any weight to 'education, guidance and encouragement of best practice'.[380] Ms Anderson said that this was important because she believed the Aged Care Quality and Safety Commission does 'some of our best work…in raising awareness of what the regulations are, and through behavioural insights activities, nudging providers towards compliance without needing to wield more heavy duty reference'.[381]

Building the capability of the regulator

Witnesses responded to a proposition from Counsel Assisting that the Australian Government ensure its prudential capability in the aged care sector by including:

- a program to recruit and retain senior forensic accountants and specialists with prudential regulatory experience, and sufficient numbers of employees with either accounting qualifications or other financial skills
- systems and processes for regulatory intelligence to build a risk profile of aged care providers
- a system and processes to monitor and respond to indicators of risk revealed by providers' financial reporting
- an electronic forms and lodgement platform
- appropriate resourcing of the above systems and processes.[382]

Ms Anderson told us the staff allocated to the prudential compliance role at the Aged Care Quality and Safety Commission are 'highly competent, but there aren't enough of them'. However, she did also note that the Commission was recruiting across most of its operational areas over the coming months.[383]

Ms Anderson raised a particular concern about the reference in the proposition to building a risk profile of aged care providers:

> The question which came to my mind, if the prudential regulator is to be separate from the quality and safety regulator then there would need to be far greater clarity about the way in which those two entities would work together in order that they didn't cross each other unhelpfully, and they weren't doing each other's work with inadequate information available to them to draw conclusions.[384]

Ms Anderson said that if a prudential regulator were to build a risk profile that is entirely separate from the risk profile developed by the body responsible for quality and safety that 'would introduce more problems than it solves'.[385] Mr Smith shared these concerns, noting that the Australian Department of Health has responsibilities 'outside of the prudential compliance framework relating to provider viability, risk assessment…that would have a lot of relevance to prudential compliance arrangements' and for that reason, communication and the sharing of tools between all parties would be important.[386]

Mr Smith otherwise observed that the 'fundamental principle of increasing capacity, having the right skill sets available to undertake risk assessments and to undertake audits and financial analysis is very important'.[387]

The Australian Government submitted that enhanced capability information systems and processes will be essential across the regulatory spectrum to support the prudential regulation propositions.[388] The Australian Government said that to achieve this, it would be necessary to build capability in areas including 'prudential regulation, financial reporting analytics and care and safety analysis along a continuum'.[389]

Mr Callaghan told us that investment in prudential functions should occur immediately and could not wait for the development of a new prudential regulatory body.[390]

A further issue which was explored with some witnesses was the location of the prudential regulatory body within the Australian Government.

Mr Callaghan told us that the responsibility for financial oversight and prudential regulation should rest with the Department or a specialised agency and should not be the responsibility of the agency that is responsible for quality and safety.[391] Mr Smith of the Australian Department of Health said he did not disagree with Mr Callaghan. He told us that the option of centralising prudential functions in one organisation was considered at the time the prudential compliance functions moved from the Department to the Aged Care Quality and Safety Commission.[392]

Ms Anderson said the Aged Care Quality and Safety Advisory Council considered that the prudential functions would be better addressed if they were integrated into a single entity, being the Aged Care Quality and Safety Commission.[393]

The Australian Government submitted that it 'supports empowering a single body responsible for both prudential regulation and enhanced financial risk management' and that there were 'advantages in having a single regulator responsible for both quality and prudential regulation'.[394] The Australian Government submitted that regardless of the body or bodies responsible for the respective functions, 'effective and efficient communication between persons performing prudential regulation and quality regulation is also essential and should be clearly delineated'.[395]

Prudential regulation standards, including liquidity and capital adequacy requirements

Liquidity requirements

Witnesses responded to a proposition from Counsel Assisting that the prudential regulatory body should be empowered to impose liquidity requirements on residential aged care providers which hold Refundable Accommodation Deposits. The purpose of this approach is to ensure that these providers would be able to repay such deposits when required and without jeopardising their financial viability.

The proposition proposed certain requirements, including that providers submit annual certification by an independent auditor regarding financial liabilities, maintain a particular ratio of liquid assets to financial liabilities in excess of a specified ratio (known as a 'liquidity threshold') and notify the prudential regulatory body if the liquidity threshold is infringed. Counsel Assisting proposed that the prudential regulatory body should have the capacity to take a varied approach to setting appropriate liquidity thresholds for different providers.[396]

The Australian Department of Health and the Aged Care Quality and Safety Commission acknowledged that one of the key deficiencies in the current prudential regulation arrangements for approved providers is that the Liquidity Standard does not provide for specific provider liquidity requirements.[397] The Department and the Commission argued that implementing minimum requirements for key financial metrics, such as a provider's liquidity, would improve the viability and sustainability of the sector.[398]

The Australian Department of Health stated that it had adopted a new methodology to analyse the liquidity of individual providers, and that this methodology would be used to analyse the financial position of all residential aged care providers for the financial year ended 30 June 2020.[399]

Mr Murray told us that the Australian Department of Health supports the general principle of having a prescribed liquidity level, and that it would be appropriate for the regulator to have discretion to adjust the liquidity requirements according to the particular circumstances of providers.[400] He acknowledged that when the Department undertakes the first pass risk assessment process, it applies an objective liquidity measure to identify risk.[401] Mr Murray said that in future, a liquidity standard would be an additional benefit to the system and would be easier to assess compliance.[402]

The Australian Government stated that it 'supports strengthening liquidity requirements'.[403] It submitted that:

> it would be desirable to allow the Government to set general requirements where considered appropriate, and to give the prudential regulatory body flexibility to vary requirements as required.[404]

Regarding any transitional arrangements, the Australian Government stated that it supports flexible liquidity thresholds during any transition and that such arrangements should be carefully managed to ensure continuity of care.[405]

Mr Corderoy addressed a report prepared by StewartBrown in October 2019 for the Australian Department of Health. The report recommended, among other things, that a single minimum liquidity threshold across all providers be set at 15%.[406] The report also developed a risk assessment model for the Department to assess which providers are at risk in relation to financial viability.[407] The risk model includes several aspects including 'liquidity levels' as the primary risk factor and 'capital adequacy ratio' as a secondary risk factor.[408] Mr Corderoy explained that following a review of failed providers, StewartBrown felt that 'the major prudential risk, is a provider not having the liquidity to meet their debts'.[409]

Ms Chadwick said:

> I would hate to see the capacity for growth be stifled as well if, you know, we had to hold a large number of capital, if you like, just sitting there for liquidity purposes.

She asked that we consider other measures.[410]

Capital adequacy requirements

Witnesses also responded to a proposition from Counsel Assisting that the prudential regulatory body be empowered to impose capital adequacy requirements for the purpose of ensuring that providers maintain adequate net assets above the liabilities they owe.

Similar to the proposition regarding liquidity requirements, Counsel Assisting proposed that the prudential regulatory body may require providers to:

- obtain annual certification by an independent auditor as to the adequacy of their capital
- maintain a particular ratio of net assets to liabilities in excess of a specified ratio (known as a 'capital adequacy threshold')
- notify the prudential regulatory body if that capital adequacy threshold is infringed.[411]

Further, Counsel Assisting proposed that the prudential regulatory body be empowered to take a varied approach to setting capital adequacy thresholds and determine a transition pathway if capital adequacy thresholds were introduced.[412]

Mr Murray suggested that the liquidity ratio would be the primary measure to implement but cautioned that the capital adequacy requirement is 'something that possibly needs… further reflection'.[413] He explained that the Australian Department of Health already considers net asset requirements in its risk ratings.[414] Mr Murray told us that the question is whether there will be benefit from expanding that to some prescriptive ratio which would have to vary between different providers.[415]

Ms Anderson stated that:

> the liquidity ratio is more valuable than the capital adequacy ratio because the liquidity ratio goes to performance against the financial obligation that the refundable accommodation deposit requires.[416]

However, Ms Anderson clarified that she was not suggesting that capital adequacy is irrelevant.[417]

Mr Corderoy described capital adequacy as a 'secondary measure' because it 'depends on the structure of the entity'.[418] He noted that a not-for-profit entity has a different equity structure than a for-profit.[419] Mr Corderoy noted that capital adequacy does not give a full measure for determining viability of a provider, and does not allow comparison between for-profits and not-for-profits.[420]

23.2.7 Capital financing of residential aged care services

Counsel Assisting asked several witnesses to consider current capital financing arrangements for residential aged care and their strengths and weaknesses, as well as the requisite features of any alternative capital financing arrangements.

23.2.8 The current capital financing mechanisms in residential aged care

Currently, residential aged care businesses raise capital through equity investments, loans from financial institutions and accumulated profits, as well as through deposits from residential aged care facility residents, called Refundable Accommodation Deposits, which act effectively as interest free loans. Providers can also raise revenue for their capital investment from residents through:

- Daily Accommodation Payments made by residents
- capital grants paid by the Australian Government to approved providers
- an Accommodation Supplement paid by the Australian Government for residents, known as 'supported residents', who do not have the means to pay for their own accommodation costs.[421]

A Refundable Accommodation Deposit is a lump sum payment made by a resident of a residential aged care facility to the approved provider operating that facility. These deposits are refunded to the resident when the resident leaves the facility, or to their estate when the resident dies. The deposits are interest free and enable residential aged care providers to avoid attracting significant interest costs on their capital expenditure.[422]

A Daily Accommodation Payment is a daily payment from a resident of a residential aged care facility to the approved provider operating that facility. A resident can choose to pay a Daily Accommodation Payment as an alternative to a Refundable Accommodation Deposit, or pay a combination of the two. The Daily Accommodation Payment amount is derived from the price of the equivalent Refundable Accommodation Deposit and a prescribed conversion rate, known as the Maximum permissible interest rate.[423]

For supported residents, the amount that may be charged for their accommodation is limited to the amount of the Accommodation Supplement.[424] For residents who are not supported by the Australian Government, approved providers may ask for an accommodation payment in excess of the amount of the Accommodation Supplement, but there are some consumer protections in place.[425] If an approved provider wishes to obtain a Refundable Accommodation Deposit (or corresponding Daily Accommodation Payment) above a prescribed ceiling or threshold (currently $550,000), application for a higher limit to be set must be made to the Aged Care Pricing Commissioner.[426]

Importance of Refundable Accommodation Deposits

Mr Costello explained that it in his opinion it was never going to be possible 'to run residential aged care with the ageing of the population off the taxpayer alone', adding that the Refundable Accommodation Deposit mechanism was introduced to enable the aged care system to gain access to private financing.[427] He said that residents should be contributing to the cost of capital for their aged care accommodation, subject to 'proper assets and income tests, and proper regulation as to prudential controls'.[428]

The Australia and New Zealand Banking Group described Refundable Accommodation Deposits as 'fundamental to aged care development lending' and stated that any changes to the financing mechanism would impact on the current and future balance sheets of approved providers and their liquidity.[429]

The Commonwealth Bank of Australia commented on the stability of Refundable Accommodation Deposits as a source of capital financing, and described the mechanism as an important component of the sector's 'bankability'.[430] In addition to being the primary source of money for the repayment of development loans, the Commonwealth Bank stated that Refundable Accommodation Deposits give financial institutions certainty that debt incurred for development of residential aged care will be repaid.[431]

The Commonwealth Bank also said that due to the significance of Refundable Accommodation Deposits as a funding source, stability in the prices of these deposits and consumer preferences in choosing these (or a Daily Accommodation Payment) are required to ensure that approved providers do not need to fund significant outflows of Refundable Accommodation Deposits.[432]

The National Australia Bank also identified the role of Refundable Accommodation Deposits in its assessment of an approved provider's ability to repay debt.[433] The bank stated that there is a strong reliance on Refundable Accommodation Deposits in the assessment of applications for capital financing, and that, typically, it will require the total amount of new Refundable Accommodation Deposits and any uplift in existing these deposits to be directed to repayment of outstanding debts.[434]

Westpac Banking Corporation made similar observations about Refundable Accommodation Deposits, linking an approved provider's ability to collect new Refundable Accommodation Deposits to its ability to borrow for capital development, and identifying deposit collection as a basis for the size of debt that the bank will give to an approved provider.[435] It stated that Refundable Accommodation Deposits enable the bank to lend greater amounts to an approved provider than the approved provider's operational cash flow would generally allow, particularly for smaller providers.[436]

Refundable Accommodation Deposits enable approved providers to repay capital loans within four years.[437] For reasons such as liquidity concerns, the immaturity of transaction activity markets, and the ways in which approved providers and residential aged care facilities are valued, Westpac Banking Corporation considers that without Refundable Accommodation Deposits and Daily Accommodation Payments (or alternative equivalent sources of funding), its ability to lend to approved providers would be seriously impacted.[438]

The evidence of the four major banking institutions about the importance of Refundable Accommodation Deposits was consistent with that given by Mr Ansell, who told us that 'the banks generally expect to have most of their development funding repaid through those deposits'. Mr Ansell described this as the 'normal process through which the majority of nursing homes are built'.[439] He said that the majority of property assets in the aged care sector are funded by Refundable Accommodation Deposits.[440]

We also heard from approved providers about how the use of Refundable Accommodation Deposits affects their aged care businesses. Mr Bennett told us that Refundable Accommodation Deposits fund almost all of the costs of acquiring land and developing a residential aged care facility.[441] Mr Mamarelis described Refundable Accommodation Deposits as 'extremely important' for funding current and future development projects.[442] He agreed with Commissioner Pagone that approved providers 'substitute' Refundable Accommodation Deposits they receive from people living in residential aged care with capital they borrow from a bank to fund the construction of a new facility. He went on to say that the anticipation that funds borrowed for development will be substituted in this way may be determinative in whether a bank is willing to lend money to support a development.[443]

Mr Mamarelis also agreed with Commissioner Pagone's suggestion that a bank will effectively provide an approved provider advanced funding for the construction of new residential aged care facilities on the basis of the Refundable Accommodation Deposits the provider expects to receive once the residential aged care facility begins accepting residents. He said that the bank will expect the approved provider to collect the required Refundable Accommodation Deposits to repay the debt within 18 to 24 months.[444]

From the perspective of people living in residential aged care, Mr Versteege observed that the current arrangements regarding Refundable Accommodation Deposits enable a person to pay their accommodation costs while retaining the value of the Refundable Accommodation Deposit, which can then be passed on to family when it is refunded. He told us that this is a positive thing.[445]

Issues concerning Refundable Accommodation Deposits

Witnesses identified a range of issues concerning Refundable Accommodation Deposits and their pivotal role in the capital financing of residential aged care. Ms Julie-Anne Mizzi, Global Head of Social Care at AMP Capital, described the aged care sector as a 'property industry' rather than a care and services industry, due to Refundable Accommodation Deposits being the main source of return for providers, and higher Refundable Accommodation Deposits lowering the cost of capital for approved providers.[446] She said that Refundable Accommodation Deposit prices are heavily dependent on high property values in the areas where residential aged care facilities are developed, and higher Refundable Accommodation Deposits are used by approved providers to cross-subsidise the shortfall in care revenue.[447] She proposed that aged care funding mechanisms should recognise and incorporate the capital costs of developing and improving residential aged care facilities, and encourage continued development of new residential aged care facilities, and upgrading of existing ones.[448]

The Australian Treasury explained that people living in residential aged care facilities are increasingly choosing to pay their accommodation costs through Daily Accommodation Payments instead of Refundable Accommodation Deposits. They said this will cause approved providers to 'increasingly require new sources of capital' and 'adjust their business models in response to this change in preferences'.[449] This was consistent with the response from the Australian Department of Health, which observed the trend in consumer preferences from Refundable Accommodation Deposits towards Daily Accommodation Payments. The Department noted that the potential consequences of this trend include cash flow uncertainty and financing and liquidity challenges.[450]

Mr Callaghan said that despite the current shift away from Refundable Accommodation Deposits being modest, approved providers are concerned about the cash flow implications of this and may delay their investment plans.[451] He added that consultations with approved providers suggested that 'weakness in the housing market and the decline in house prices influenced consumer preference towards Daily Accommodation Payments'.[452] Quantifying the trend, Mr Brown said that the proportion of people living in residential aged care choosing to pay for their aged care accommodation through Refundable Accommodation Deposits only had declined between September 2014 and September 2017 from 90% to 60%, with people increasingly choosing to pay Daily Accommodation Payments, or a combination of both.[453]

Mr Ansell explained concerns that the shift in preferences towards Daily Accommodation Payments could place strain on the liquidity of the sector, particularly given that a lot of the Refundable Accommodation Deposits were 'invested in bricks and mortar, and not a huge amount was necessarily held in cash'.[454] He said there was concern that the COVID-19 pandemic might make it more difficult for people to pay for their accommodation in lump sums, sell their homes, be unwilling to divest or liquidate their assets, further encouraging Daily Accommodation Payments instead of Refundable Accommodation Deposits. He said that, ultimately, the concern is that the sector will face a 'cash flow crisis' while responding to infections in residential aged care facilities.[455] Mr Ansell suggested that the COVID-19 pandemic is 'revealing structural problems with the deposit model' that could otherwise be managed better. He said that the combination of people opting to pay for their accommodation with periodic payments rather than in a lump sum, along with a deteriorating property market and a low maximum permissible interest rate, will result in serious liquidity strains for approved providers in the near future.[456] Mr Ansell then recommended that the Australian Government create and promote a mechanism to repay Refundable Accommodation Deposits to the families of people living in residential aged care to alleviate the liquidity strain on approved providers.[457]

National Australia Bank told us that this shift will impact on the bank's assessment of lending applications from approved providers.[458] Westpac Banking Corporation concurred, and described the shift as a relevant consideration for lending decisions, with approved providers often giving undertakings with respect to Refundable Accommodation Deposit collection in the course of negotiating a loan with the bank.[459] Westpac also said that should the trend in preferences towards Daily Accommodation Payments continue,

it expects to see approved providers as a whole be less able to repay capital loans.[460] Ms Hordern identified the key benefit of Refundable Accommodation Deposits from a lender's perspective is that they enable the bank to lend significantly more than would be possible relying only on an approved provider's operating cash flow.[461]

In its statement, Australia and New Zealand Banking Group presented modelling demonstrating the trend of increasing consumer preferences to pay Daily Accommodation Payments. It stated that the higher proportion of Daily Accommodation Payments will decrease the amount of debt available to approved providers.[462] Mr Morris explained that the intention was to demonstrate that Australia and New Zealand Banking Group would not have the appetite to lend to approved providers to fund construction projects, where people contribute to their accommodation costs through Daily Accommodation Payments only, as the bank expects aged care capital financing debt to be repaid within about three years through incoming Refundable Accommodation Deposits.[463] Australia and New Zealand Banking Group also highlighted that the shift away from Refundable Accommodation Deposits decreases the reach of the Australian Government's Refundable Accommodation Deposit repayment guarantee.[464] Mr Morris noted that while the current change of preferences from Refundable Accommodation Deposits to Daily Accommodation Payments appears very slight, the bank has concerns with falling occupancy and continued changes in Refundable Accommodation Deposits and Daily Accommodation Payments preferences, that liquidity will be more of an issue for operators.[465]

Mr Morris also told us that the significant amount of Refundable Accommodation Deposit liability existing on the balance sheets of approved providers can be risky as consumer preferences shift towards Daily Accommodation Payments. That is because in these cases there is less liquidity available to approved providers, and there is a decrease in lending appetite from the bank when Refundable Accommodation Deposits are not as readily available to approved providers as they have previously been.[466]

The Commonwealth Bank of Australia also identified the ratio of Refundable Accommodation Deposits to Daily Accommodation Payments as a relevant consideration in lending decisions, due to the longer period of time taken to service debts when an approved provider collects Daily Accommodation Payments. As a result, the ratio will impact the way in which a prospective residential aged care facility is valued for lending purposes.[467] The bank also said that due to the declining occupancy rate in residential aged care, outgoing Refundable Accommodation Deposits may not be replaced with incoming Refundable Accommodation Deposits, which will reduce an approved provider's liquidity. The Commonwealth Bank of Australia noted that lower preferences for Refundable Accommodation Deposits had been offset by overall increases in Refundable Accommodation Deposit prices over this period.[468]

Mr McCarthy observed that without Refundable Accommodation Deposits as the primary source of repayment for debts, National Australia Bank 'would rely on the future cash flows and the profitability of the operator to be able to repay the debt'. He suggested that this would require a longer tenure of the debt, and a higher repayment rate, which would in turn slow the capital financing of residential aged care facilities.[469] National Australia

Bank also stated that it considers approved providers operating residential aged care facilities in regional, rural and remote areas to be higher risk for lending purposes than those operating residential aged care facilities in metropolitan areas. In metropolitan areas, approved providers are more likely to attract people who are paying higher Refundable Accommodation Deposits and Daily Accommodation Payments, in line with higher median house prices.[470]

Refundable Accommodation Deposits are dependent on median housing prices, and are therefore significantly influenced by housing market trends.[471] Westpac said the volatility of residential housing pricing is a lending risk due to the impact of market changes on the price of Refundable Accommodation Deposits.[472] It also referred to a correlation it has observed between housing market trends and the decision by people living in residential aged care to pay Refundable Accommodation Deposits or Daily Accommodation Payments.[473]

Mr Mamarelis described approved providers' reliance on Refundable Accommodation Deposits as a source of capital as 'extremely difficult to undo' and instead stressed the necessity for 'mechanisms to reinforce it and support it and build more confidence into it'.[474] He said this was particularly important when approved providers are 'facing economic shock', and that the priority should be protecting residents' Refundable Accommodation Deposits 'in these times of uncertainty'.[475]

Ms Mizzi from AMP Capital said that the level of recurrent funding for approved providers would need to 'materially increase' without funding through Refundable Accommodation Deposits to encourage continued development and upgrade of residential aged care facilities. She described the retention of Refundable Accommodation Deposits or an equivalent as 'critical to sustainability' of the aged care sector, describing the current cap on Refundable Accommodation Deposits as 'prohibitive'. Ms Mizzi suggested that Daily Accommodation Payments be determined by a higher interest rate than the maximum permissible interest rate.[476] Mr Callaghan told us that for as long as the supply of residential aged care places is constrained, he would not support any move away from the Pricing Commissioner having a role in approving increases to Refundable Accommodation Deposits and Daily Accommodation Payments.[477]

Mr Thorley cautioned that a sector-wide event, such as a drop in the housing market, recession, or otherwise change to accommodation payment preferences:

> could result in a material reduction in the number and value of RADs [Refundable Accommodation Deposits] being provided to the sector as more incoming residents opt to pay a DAP [Daily Accommodation Payment].[478]

He noted that if a shift of this nature occurred across the whole of the sector to a degree of 10%, it could cause a capital shortfall of approximately $3 billion across the sector.[479]

Dr Mellors told us that lower occupancy rates were being used as leverage by aged care advisors to bargain for lower Refundable Accommodation Deposit and Daily Accommodation Payment rates with approved providers, adding to the financial pressure currently facing approved providers.[480] This is consistent with Mr Versteege's view, who suggested that 'stating what the occupancy rate in a particular facility when people are looking would help a great deal in prompting people to question an asking price'.[481] He likened the process to a real estate transaction, and suggested that an approved provider will advertise a higher rate than what they are prepared for a person to pay.[482]

Dr Mellors also identified the lowering of the maximum permissible interest rate as an incentive for people living in residential aged care facilities to choose to pay for accommodation with Daily Accommodation Payments as a further financial pressure on approved providers, describing this as a 'capital risk'. He explained that Refundable Accommodation Deposits play a 'critical role in supporting the financial viability of the aged care sector'.[483] Dr Mellors cautioned that over time, the trend of preferences towards Daily Accommodation Payments over Refundable Accommodation Deposits may render 'building, rebuilding or refurbishing projects financially unviable'.[484]

Mr Mersiades also identified the decrease of the maximum permissible interest rate as a cause for concern, noting that the value of Daily Accommodation Payments paid by a person living in residential aged care decreases with the maximum permissible interest rate.[485] He said that the lowering of the rate is occurring at the same time as people entering residential aged care are increasingly choosing to pay for their accommodation with Daily Accommodation Payments.[486] Mr Mersiades also said that there is a risk of a 'liquidity squeeze' if there is a sudden further increase in the proportion of people entering residential aged care and choosing to pay Daily Accommodation Payments, or a significant decrease in the level of occupancy of residential aged care facilities.[487] He said that in the absence of Refundable Accommodation Deposits, approved providers would become increasingly reliant on sourcing debt financing from lending institutions, and noted the benefit to the Australian Government of approved providers relying less on Government funding and the Refundable Accommodation Deposit guarantee.[488]

There were also concerns raised about the efficiency of the prices that may be charged for accommodation for residents who are not supported by the Australian Government. Professor Ergas's statement noted that Refundable Accommodation Deposits have partially enabled approved providers to avoid price regulation, as well as being a means by which approved providers have been able to use both short- and long-term market power.[489] He explained that short-term market power arises when there are 'transient supply shortages in a particular area, allowing suppliers to extract higher RADs [Refundable Accommodation Deposits] from consumers with an urgent need for service' and that long-term market power arises when 'demand in an area durably exceeds the places that can be made available, or when an area has natural monopoly characteristics'.[490] He suggested that Refundable Accommodation Deposits have likely enabled inefficient price discrimination to occur in the aged care sector.[491]

Professor Ergas stressed that despite Refundable Accommodation Deposits reducing the cost of capital for approved providers, it should not be assumed that Refundable Accommodation Deposits are an efficient way to raise capital. He explained that the opportunity cost to the person funding their accommodation may exceed the opportunity cost of the approved provider obtaining capital financing from alternative sources.[492]

However, there was consensus between Professor Menezes and Professor Cutler that the current form of light-handed economic regulation of Refundable Accommodation Deposits is reasonably appropriate to protect the interests of unsupported residents from approved providers' market power, and that heavier forms of regulation such as price caps would not be justified.[493] This was a widely accepted position amongst the other witnesses. Dr Mellors and Mr Thorley echoed Professor Cutler's views about the current system for the regulation of accommodation prices working well.[494] However, Dr Mellors said that there should be regular review of the threshold for accommodation prices above which recourse to the Pricing Commissioner should be required.[495]

Alternative approach to capital financing

Witnesses discussed alternative approaches to capital financing that do not involve Refundable Accommodation Deposits. Several of these approaches relied on a 'weighted average cost of capital' model for residential aged care.

Professor Stephen Gray of the University of Queensland's School of Business and Director and Chairman of Frontier Economics, explained that the weighted average cost of capital model is 'a simple weighted average of the returns that are required by equity investors and debt investors' and is observable.[496] He told us that debt investors require a return in the form of an interest rate that is observable in the market and that the model developed by Frontier Economics is a 'building block model' which involves the application of the weighted-average cost of capital to the service provider's capital base. He stated that the building block model ensures investors providing capital over the course of an investment 'are just made whole'.[497]

Professor Gray said that this economic model can be relied on by potential investors in the aged care system to estimate 'a fair and reasonable return' and to consider the risk of an investment in an aged care provider, and then recover the capital they invest with a 'just, fair and reasonable return on the capital' for the investment period.[498] He noted that once the weighted-average cost of capital is determined, benchmarking valuations need to be conducted to understand the capital bases of residential aged care facilities that will be subject to capital investment.[499] He said that using this method, it would be possible to achieve a mechanism to understand the appropriate return on capital investment in a residential aged care facility and use this to develop tailored accommodation subsidies for residential aged care.[500]

Mr Ansell proposed an alternative approach to Refundable Accommodation Deposits for aged care capital financing that relies on a weighted-average cost of care model:

> If we were to accept that refundable accommodation deposits are not going to be the major instrument in the future then the model for the DAP [Daily Accommodation Payments] or an alternative annuity needs to work. Part of the reason that it's hard to make it work at the moment is because it's based on the MPIR [maximum permissible interest rate], as we discussed earlier, which just goes up and down all the time. It's very difficult to make a decision about an investment in property even if you are an independent party looking at a passive investment, if that rent is going to be going up and down all the time. So having an annuity number based on a reasonable amount, perhaps reflecting the weighted average cost of capital for provision of aged care services or for the delivery of services in a nursing home, is possibly the first step. And most in the rest of the world, a lot of nursing homes are built through RE [real estate] investment trusts where the owner of the property is not necessarily the operator.
>
> The second component of that then to make it work is that you can't keep having a situation, as we have in Australia, where the cost of care is exceeding the amount of support subsidies either through residents or through the Government to meet those costs. Because what happens is if the provider is unable to maintain a surplus or break even, they will eat into the accommodation revenues.[501]

In response to Mr Ansell's proposal, Mr Mamarelis said he agreed with some of the concepts but saw challenges in its application.[502] Mr Mamarelis told us that he thought a base-level weighted-average cost of capital model could work generally across most locations, but noted that an average or standardised model may not be appropriate for all of the 'varying profiles of organisations'. He noted that not-for-profit organisations with large cash reserves will source finance differently to for-profit organisations that are heavily leveraged with significant debt financing.[503] He also described the maximum permissible interest rate as a 'broken model' because it is 'regressing at a time where prices are rising, and it's going totally against the grain right now'. He said that it is also incentivising a shift away from Refundable Accommodation Deposits.[504] He noted that at Whiddon Group, there would be 'some tolerance' of the cost of capital that would not occur in a for-profit organisation—for example, because there is a 'benevolent or social dividend' factored into building a residential aged care facility in a regional location which may require some compromise on viability.[505]

Mr Bennett agreed that the maximum permissible interest rate is a 'broken model' that does not provide the level of funding that an approved provider can source through debt financing or Refundable Accommodation Deposits. He accepted that the model proposed by Mr Ansell would be preferable to the current Daily Accommodation Payments model.[506]

Frontier Economics submitted that the maximum permissible interest rate 'does not properly equate' Refundable Accommodation Deposits and Daily Accommodation Payments.[507] It suggested that if the purpose of reforming capital financing is to equate the two methods of paying for aged care accommodation from the perspective of an approved provider, the interest rate should be based on the approved provider's 'commercial borrowing rate'.[508] It further proposed that a weighted-average cost of capital model could be used as an alternative to Refundable Accommodation Deposits. This would determine the annual price per aged care place that an approved provider would need to charge to receive the required revenue to cover the costs of providing residential aged care services,

including a 'reasonable return on capital'.[509] Frontier Economics suggested that this could be used to understand the amount paid for a supported residential aged care place, and the maximum amount that could be charged for a non-supported aged care place, allowing a reliable figure to be published to assist people to make decisions about their care.[510]

Professor Cutler suggested that the use of an interest approach is probably the more appropriate approach rate to convert the value of a Refundable Accommodation Deposit to a corresponding Daily Accommodation Payment, However, he said that the interest rate has to be set in a way that ensures equivalence for a person entering residential aged care, whether they pay a Refundable Accommodation Deposit or a Daily Accommodation Payment. He also cautioned that similar to the current volatility of the maximum permissible interest rate, there will be some volatility with a weighted-average cost of capital approach, as it is a 'composition of equity and debt' and those rates also change. Professor Cutler concluded that approved providers can mitigate volatility by adjusting their accommodation prices as interest rates decrease and lower the portion of Daily Accommodation Payments.[511]

Mr Thorley proposed a different reform to the capital financing model for aged care. He suggested that financial derivative instruments, managed by financial institutions, could enable an approved provider to effectively convert a Refundable Accommodation Deposit to Daily Accommodation Payment or vice versa. He said this could be possible through the creation of a pool of Refundable Accommodation Deposit / Daily Accommodation Payment funds, which would enable approved providers to draw Refundable Accommodation Deposits or Daily Accommodation Payments to better suit their own capital needs or strategies.[512] He stated that a centrally managed pool of this nature would allow the approved provider to better manage risk affecting the sector. He added that it could be used as a tool by the regulator, whereby an approved provider that is not strong enough financially, does not have a strong balance sheet, and does not meet its prudential compliance and management requirements, would only able to receive accommodation payments in the form of Daily Accommodation Payments.[513]

Australia and New Zealand Banking Group cautioned that any alternative capital financing mechanism for aged care must be developed in consultation with the sector, and with generous time for transition.[514]

23.2.9 The financing of aged care into the future

Introduction

Counsel Assisting explored various options for the financing of aged care, including general revenue financing, an aged care levy, and various forms of social insurance and private insurance products, but did not test any specific propositions in relation to them.

Principles for the assessment of financing options

Several witnesses were examined on their views about underlying principles for aged care financing and foundations for a new financing model. These principles have assisted us to assess and consider the financing options for the aged care system that were tested in this hearing.

Mr Keating suggested that with a deteriorating dependency ratio and fewer people in the tax system, it is reasonable for older people to use some of their accumulated funds and assets to meet the costs of their aged care. He said that despite the inheritance issues arising from using the family home to fund aged care, it is a more significant burden to rely on the smaller number of people paying taxes to support the care of all people aged over 65 years. He suggested it was reasonable to create a 'post-funded model' through which older people with assets and accumulations can support their own aged care.[515]

Mr Keating also told us that superannuation has a role in relieving the public financing of the provision of aged care services, and that the aim of superannuation policy was to have more people living independently at home with a capital sum or income stream beyond the age pension. He said that superannuation was designed to be available to people on top of the age pension, rather than instead of it, and that the retirement financing system should 'morph' into a longer-term aged care financing system.[516]

Professor John McCallum, Chief Executive Officer and Research Director at National Seniors Australia, observed that older people have indicated that they are willing to pay more for their aged care, but noted that they are not actively planning to do so. He suggested that it is important for older people to be directing their finances to the care they consider most important, which he considers to be aged care services delivered in their homes.[517] Mr Ian Yates AM, Chief Executive of COTA Australia, agreed, adding that 'if we want older Australians to pay more we have to give them the system they want and overwhelmingly they want care at home'.[518]

Irrespective of the particular financing model to be adopted, Professor Piggott stressed the importance of equity in public financing, including the financing of aged care. He explained the different types of equity that must be considered in implementing an aged care financing model. In the context of a taxation-based financing model, he described 'horizontal equity' as meaning that those with equal resources should be taxed in an equivalent way. He called this 'a very fundamental principle of public finance'.[519] This includes guaranteeing against 'capricious taxation' and taking into account only relevant considerations that are treated equally.[520] He noted that there may be some 'difficulties of interpretation', using the example of two people having equal wealth, but having that wealth in different forms, such as in a principal place of residence and in a taxable asset respectively.[521]

Professor Piggott then explained the principle of 'vertical equity', where each person pays proportionately to the amount of wealth they have. He described this as 'much simpler' to understand and apply than the notion of horizontal equity. Professor Piggott noted that vertical equity exists in the current Australian taxation system, which he described as progressive.[522] He accepted the possibility that vertical inequity will arise from a public

financing approach that relies solely on taxation, as compared to a social insurance model, but noted that it would depend on the nature of taxation chosen to finance the aged care system and the rates applied. He said that vertical inequity can usually be counteracted.[523]

Professor Piggott also explained the principle of 'intergenerational equity'. He told us that public financing can burden future generations with costs incurred to care for the generation currently receiving services. He described the responsibility for achieving intergenerational equity as very important, and noted that it is particularly relevant in the context of retirement incomes and aged care. He noted the relevance of this concept to a hypothecated levy as a public financing option for aged care, where the levy would be paid by younger generations for the benefit of older people accessing aged care.[524]

Considering a public financing model that relies solely on general taxation, without additional, special design features, Professor Piggott accepted that a taxation financing option will be weaker on vertical and intergenerational equity than other financing options. He referred to a lack of built-up reserves as a weakness of ordinary taxation, noting that a hypothecated levy would achieve the preservation of funding for the future. He explained that many tax economists would disagree with the premise of keeping reserves and idea of a hypothecated levy 'because of all the trouble of keeping the reserve'.[525]

A special purpose 'aged care' levy

Several witnesses gave evidence about the capacity to finance aged care services through a special purpose aged care levy and whether such a levy should be hypothecated or non-hypothecated. That is, whether the special levy should be created where the funds raised should be directed solely to the aged care sector and whether the rate of the levy should be adjusted depending upon hypothetical actuarial forecasts or set at a fixed rate.

A non-hypothecated levy

The Australian Treasury stated that 'levies can be a useful funding tool in circumstances where benefits provided by the revenue raised from the levy flow exclusively to those who pay the levy, rather than the broader society'.[526] They may be used to 'respond to a demonstrable market failure', 'provide a price signal or indicate the risk of an activity' or 'operate as an increase in marginal personal tax rates' such as in the case of the Medicare levy. Treasury argued that 'levies can be designed to cover a portion of the costs of a Government program' and subject to 'top up funding' where spending is greater than the amount raised by the levy.[527]

The Australian Treasury also identified certain consequences associated with levies which raised less than or more than the Government spending on the particular policy area. For example, where spending exceeds the amount raised by the levy there is the potential for public misconceptions about the cost of the program and the contribution of the public to the cost. Conversely, when funding for the levy is higher than the costs of the program, the Australian Government may not be able to use the funds for other essential purposes due to public commitments.[528]

Further, the Australian Treasury stated that it was 'important to consider the relative economic cost of a levy compared to other arrangements'.[529] According to Treasury, levies can 'increase complexity and reduce the efficiency of the personal income tax system', 'lead to high effective marginal tax rates' and 'tax planning activities as individuals seek to reduce their tax burden'.[530]

Dr Kennedy, Secretary to the Australian Treasury, identified that there are ways to achieve transparency or show the Australian Government's commitment to funding a particular area on an ongoing basis without necessarily raising a levy.[531]

Professor Woods said that a 'non-hypothecated levy paid into the Consolidated Revenue Fund is no more than an increase in taxation (for a limited or indefinite period) with a separate label'.[532] He considered that this should be taken into account in any further exploration of levies.[533]

Mr Hayes of the Health Services Union gave evidence about modelling from Equity Economics which he said suggests 'the quantum of additional funding required to deliver high-quality care in line with community expectations, is between $2 billion and $20 billion over four years'.[534] Mr Hayes expressed support for an increase to the Medicare levy from 2% to 2.5% to deliver this additional funding.[535] He also said that 'earmarking the tax' and transparency measures 'would provide the public assurance that has been missing on aged care funding and its relationship to high-quality care'.[536]

A hypothecated levy

The Australian Treasury stated that it 'is usually not supportive of the hypothecation of funding for particular purposes'.[537] Treasury cited a range of public policy considerations which underlie this view, including that hypothecation limits spending flexibility, inhibits the ability of the Australian Government to efficiently manage its cash flows, and may not result in the intended public policy outcomes being delivered.[538]

Dr Kennedy said that the question with respect to hypothecation was not the Australian Treasury's position on hypothecation, rather the circumstances in which hypothecation would work well.[539] He queried the utility of hypothecation in the context of 'wide and complex' systems such as aged care.[540]

The Australian Treasury stated that 'funding can be publicly committed for specific purposes without requiring hypothecation'.[541] In that context, Treasury cited the Government's spending on the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme as examples.[542]

Further, the Australian Treasury gave evidence that it does not support the establishment of an investment fund to fund the aged care sector given 'the ongoing nature of the program' and 'the costs and financial risks that would be associated with the establishment and operation of such a fund'.[543] Treasury identified a number of specific concerns in relation to investments funds, such as the exposure to variations in economic conditions.[544]

Mr Costello also gave evidence about hypothecated levies. He explained that a difficulty with hypothecated funds is that demand may change and there is the possibility that the funds may be underfunded or overfunded.[545] He added that hypothecation 'inhibits flexibility and overall budget policy'.[546] He agreed that hypothecation might be used to 'protect a body of money from being interfered with by the…government of the day acting under the motivations of the fiscal imperatives of the day'.[547]

In relation to investment funds in particular, Mr Costello said that 'more hypothecated funds have failed than have succeeded'. He cautioned that 'hypothecation can easily be undone by subsequent governments' and that the funds are 'only creatures of statute and the statute can be changed'.[548]

In response to a question from Counsel Assisting about whether there are examples of successful hypothecated funds overseas, Mr Costello said that funds existed around the world but that they are 'massively underfunded' due to the ageing of the population.[549] Mr Costello went on to say:

> And so all around the Western world you've got this problem that the ageing of the population and longevity is undermining these funding mechanisms, and at the end of the day you're either going to require much greater taxes or levies to fund them, or you're going to have to go to benefits and I think in most countries the experience is going to be the cutting of benefits.[550]

In response to the suggestion that a levy may be reviewed, Mr Costello said that this could occur but that changes would need to be legislated.[551] He said that adjusting a levy may solve one problem in a particular policy area, but cause difficulties for the funding of other areas of expenditure because taxpayers may expect a reduction in general income tax in return.[552]

We also heard evidence from Dr Kenneth Henry AC, former Secretary to the Australian Treasury. Dr Henry said that in his view, aged care 'would be best funded by a special purpose hypothecated levy'.[553] According to Dr Henry, 'there are very few heads of Government expenditure that satisfy the conditions for having a hypothecated levy, but aged care certainly does'.[554]

Dr Henry identified that the general problem with hypothecated levies is that once the revenue has been raised for a particular purpose, there is an incentive for the money to be spent even if there is no good case for the expenditure, or there is a more worthy need for expenditure in an unrelated area of government activity.[555] He said that in the case of aged care, Government expenditure will increase faster than the tax base.[556] Dr Henry explained that in those circumstances, 'there's a lot of rigour around the construction of the levy' and the risks of hypothecation are quite small. He said this was because the levy is 'going to have to be increased in the future and the Government will have to come to Parliament with a Bill to increase the rate of the levy and to explain why the rate of the levy has to be increased'.[557] In Dr Henry's view, there is also a positive aspect to this process:

> So the positive is that because the Government would have to come to Parliament and explain the reason why the levy has to be increased, the Government would, on an ongoing basis, be explaining to the population the connection between the levy and the benefit that society is getting from the levy. And this is rare. It's rare for the public to see the social benefit from their

> taxes. But here's a case where the Government could demonstrate very clearly the connection between what people are providing by way of tax revenue and the enormous social benefit that comes from the aged care system that they're supporting.[558]

Dr Henry agreed that any disadvantages with hypothecation are counterbalanced by advantages in this instance.[559] He said that 'without hypothecation, the proportion of government outlays going to aged care would be increasing over time' and 'there would be a reallocation of spending in favour of aged care'.[560] According to Dr Henry, 'having a hypothecated levy does mean that you understand that that's the case' and there is a requirement to identify to the Parliament and the public the amount being spent on aged care and how the funds will be raised.[561]

Dr Henry explained that the rate of the levy would increase over time and the risk of 'allocating too much to one head of expenditure at the cost of other more worthy heads of expenditure' does not arise.[562] He said that this would arise in the case of a hypothecated levy for an area of Australian Government spending that was not going to increase each year, but that is not the case for aged care.[563]

Professor Piggott told us that a hypothecated tax or levy on a taxable income base would be the best option to finance aged care.[564] He proposed that an aged care levy could be at a constant rate or progressive across income range and/or set at differentiated rates by age. He explained that the proposed aged care levy 'would meet current and projected aged care outlays on a pay-as-you-go basis'. He suggested that the accumulated reserves from the aged care levy could be managed by the Future Fund.[565]

Professor Piggott gave an illustrative example of how his proposed aged care levy might work in practice. He proposed that every individual over the age of 40 years may have a 1% increment applied to their personal income tax. Professor Piggott said it would also be possible to consider imposing an increment of 1.5% on those aged 60 years and older and then reserving a portion of the funds immediately.[566]

Professor Piggott suggested a hypothecated levy would need a reasonably comprehensive review every three or four years.[567]

Social insurance

We heard evidence from a number of witnesses about the potential merits or otherwise of introducing a social insurance financing model for aged care in Australia. A range of views were heard on this subject.

Mr Keating told us that only the Australian Government can insure across generations.[568] He suggested that at around 85 years, the Australian Government should take responsibility for every aged person, and provide a direct calibrated product looking after health, accommodation and income, assisted and supported by a care coordinator.[569] He continued:

> a commercial insurer can't insure across generations. They don't have the flexibility or the capital adequacy to do it. But the Commonwealth can do it, and the Commonwealth is a default insurer anyway through the age pension. So as the Commonwealth is the default insurer through the

> age pension and can insure across generations, it's the natural candidate to offer longevity insurance. So we pay a levy, some people might die at 56 or 60, and their contribution funds the person who lives to 95 or 100. A classic insurance system.[570]

Professor McCallum stated that while Australia had 'a long history of political resistance to increases in user contributions for long-term age care', there are:

> good social policy grounds for incorporating a social insurance pillar into this mix including to stabilise funding, reduce late life anxiety and reduce the constant political and financial pressures on government revenue.[571]

Professor McCallum was involved in the drafting of the *Ensuring Quality of Later Life* report in 1998 which proposed a social insurance scheme for Australia.[572] In broad terms, this report proposed:

> to start with 10 years of a contribution 2000–2011 of 1.1% of taxable income from every Australian aged over 25 and earning more than $15,000 in four possible options:
>
> (1) paying the EQOLL [Ensuring Quality of Later Life] levy in similar fashion to the Medicare Levy;
>
> (2) buying it through an approved life insurance fund offered through and Australian Superannuation Fund;
>
> (3) similarly, through a Private Health Insurer, and;
>
> (4) an investment in a continuing care retirement community with approved care package.
>
> The contribution rates and options were to be reviewed at the end of the 10 years.[573]

The recommendations of the report were not implemented.

Professor Michael Sherris, Professor of Actuarial Studies at the University of New South Wales and Chief Investigator at the Australian Research Council Centre of Excellence in Population Ageing Research, commented on the possibility of introducing a social insurance scheme in Australia. He described aged care risks as in principle suitable for risk pooling through insurance.[574] He explained the benefit of Australian Government involvement in a social insurance scheme over a private insurance scheme because it limits issues of adverse selection, allows pooling of a larger group of individuals, and could provide for more flexibility in the financing of the costs.[575] He also argued that the implementation of social insurance would amount to the formalisation of an important role the Australian Government already has, but within a clearer structure.[576]

Other witnesses were more cautious. Dr Henry was more supportive of the idea of financing aged care through a levy, but acknowledged social insurance could be a possibility alongside a tax levy.[577]

Professor Piggott also indicated broad support for a social insurance model for aged care, but noted it would be a significant policy departure.[578] However, he stated that social insurance 'carries with it an administrative load that we can probably do without'.[579]

Professor Henry Cutler of Macquarie University said 'there is currently no strong argument to suggest a social insurance model would deliver better outcomes than current tax arrangements for aged care'.[580]

The Australian Treasury was also cautious on social insurance and told us that the Treasury doubted there were significant gains in introducing a social insurance scheme in parallel to existing arrangements.[581] Treasury considered it was unclear that compulsory social insurance would provide more certainty for the future of financing in the aged care sector.[582] Treasury also contended that social insurance works best in schemes where there is low probability of a participant needing to access the scheme, but when that access is needed the losses to be compensated are large, which is not the case for aged care.[583]

Mr Versteege stated his belief that a social insurance scheme could work, but considered that politicians have an aversion to the earmarking of funds for a specific purpose.[584]

A number of witnesses also raised the issue of intergenerational equity. Professor Piggott described this issue as follows:

> Intergenerational equity is the idea that perhaps we are burdening future generations with costs that we ourselves incur. And so if you look at increases in debt, right, that debt will eventually be paid off by future generations and not by my generation. And so responsibility with regard to that is very important.[585]

The Australian Treasury also raised this issue, noting that the establishment of social insurance today 'would do little to fund aged care costs for the current generation of older Australians' and that working age people would have to fund their own care needs and those of current retirees.[586]

Dr Henry also urged caution. He stated that perhaps 10 or 20 years ago it may have been different, but that:

> I think it's too late to be developing such a scheme now. I think it would be intergenerationally unfair, because it would be saying to those who follow the baby boomer generation that 'You're going to have to pay for the costs of your parents and grandparents in aged care and you're also going to have to pre-fund your own aged care'. I think it's enough that we ask of them that they, as workers, fund the aged care of their parents and grandparents. I think that's enough for society to expect of them. And they might even think that's too much, given the size of the baby boomer population bulge relative to the size of the subsequent generations.[587]

International models of social insurance were also examined. The evidence of Dr Pieter Bakx, of Erasmus University, and Professor Naoki Ikegami, of St Luke's University, described in-force social insurance models for long-term and aged care in the Netherlands and Japan respectively, which are discussed later in this chapter.

Pay-as-you-go social insurance and pre-funded insurance model

We considered two alternative means of setting up a social insurance system, pay-as-you-go and pre-funded. The former relates to a system where during a given period the incoming revenue from premiums is calculated to be roughly the same as the outgoing expenditure on payouts by the insurance scheme. The latter is a system which requires an initial build-up of monetary reserves in order to have a pool of funds reserved and earmarked to pay out to participants in the scheme.

The pre-funded model was less popular with the witnesses in the hearing. Dr Henry agreed that his concerns about intergenerational equity expressed in his written statement arose from a conception of social insurance as being pre-funded.[588] Dr Kennedy, alongside Ms Jenny Wilkinson, Deputy Secretary of the Fiscal Group of the Australian Treasury, acknowledged that their stated objections to social insurance had largely been based on the idea of a pre-funded model.[589]

Ms Wilkinson of the Australian Treasury stated 'issues we had in a pre-funded scheme which obviously don't apply like a pay-as-you-go scheme, like the issues around intergenerational equity'.[590] Similarly, Dr Henry said his objections would be less emphatic to a pay-as-you-go social insurance scheme.[591] Despite acknowledging that some of the objections to social insurance fell away when considering this latter type of model, Treasury's representatives remained ambivalent to the overall concept. Dr Kennedy stated:

> why would you introduce this insurance system, it's to get some benefit from the risk pooling, and I'm not sure how the risk pooling benefit helps here, because in design terms you would want a system where people are drawing on the system for need that's paid for, you're looking for a way of risk pooling somehow or other that I guess the whole population has contributed on some basis for this premium. That—in some ways that's no different from depending on how you apply the premiums from using general revenue.[592]

Ms Wilkinson stated that she was unsure why that approach would be taken or how it substantively differed from a hypothecated levy.[593] Similarly, Professor Woods believed that there was 'no net gain' to establishing social insurance, stating that 'another principle of public policy is that you should only make change if there is a material net benefit and this doesn't pass that test'.[594]

In addition to these two broad methods of funding, Mr Keating advocated for what he described as a post-paid system, similar to the Higher Education Contribution Scheme, which he described as removing the fiscal bar on the adequacy of funding that is necessary to provide the care that is needed.[595] He acknowledged such a system would have a weakness, in that people may intentionally divest themselves of assets before accessing the system in order to not contribute as much towards the costs of the system.[596]

Fund governance

A smaller number of witnesses also commented on how any social insurance fund or scheme should be governed. Mr Costello drew our attention to the 'robust governance' of the Future Fund, which was given a 'very clear mandate' and by way of statute its resources were ring-fenced until 2020.[597] He went on to say when there is money to be used for a given purpose, whoever is governing that system not only is guarding against fraud, loss and risk but also against the government of the day.[598]

Professor Piggott suggested that the Future Fund could be an appropriate body to govern the use of any aged care funds, noting the Future Fund's reputation for governance.[599] He also suggested this task could also be taken on by the proposed Independent Aged Care Pricing Authority.[600]

International comparative models

Netherlands

Dr Bakx and Professor Ikegami described the social insurance schemes that exist in the Netherlands and in Japan, respectively. We note Professor Cutler's opinion that international comparisons should be treated with a degree of caution because 'we have different systems, and often, studies have different methodology, different assumptions, different data availability'.[601] Nonetheless, the experience of both the Netherlands and Japan in deploying their models of social insurance provide useful in-practice examples of social insurance.

Dr Bakx described the social insurance of aged care as a system that creates value, enabling individuals to access care that they may otherwise be unable to afford, which in turn allows future financial certainty.[602] He also described the existence of the insurance scheme in the Netherlands as reducing the demands on informal carers, allowing them to remain more active in the workforce.[603] In Dr Bakx's view, if social insurance is funded 'incompletely', requiring co-payments or other contributions, this reduces its value because it re-introduces financial uncertainty and requires means testing to ensure the scheme remains valuable for more marginalised subgroups.[604]

Dr Bakx summarised the Dutch system, administered under three different pieces of legislation related to institutional care, home care, and social supports. The legislation for institutional and home care establish social insurance schemes and mandatory enrolment for everyone. These schemes are used to pay for the long-term care of the population. Under the legislation, social supports are to be funded through general taxation.[605]

For home care in the Netherlands, the 'social insurance' is administered by private entities. They act as the insurers, competing on price and services.[606] There is a means-tested insurance premium and a 'nominal premium' in home care. The latter, which must be the same for everyone, is set by and paid directly to insurers.[607] This is not the case for institutional care, which is administered by the relevant regional municipal authority. Institutional care has no private involvement and no competition.[608]

Despite home care insurers being private entities, they are required to accept everyone who wishes to be insured. Risk is equalised to ensure proper incentives are in place to provide proper coverage and care for everyone being insured.[609] In a further departure from how private insurance usually acts, Dr Bakx said that the scheme remains pay-as-you-go and that insurers do not build up a fund to generate returns and draw upon in the future.[610]

The role of private insurers in long-term home care in the Netherlands was established in 2015. Dr Bakx was unable to give a definitive reason for the change, but suggested that it may been thought that regional governmental offices, which previously had oversight of the home care insurance scheme, had little incentive to organise care effectively and efficiently, and that private health insurers, with the correct incentives, would be better placed to provide care.[611]

In relation to the scheme of social insurance for institutional care, there is a means tested co-payment that people accessing institutional care must pay; and the maximum amount payable by someone is capped annually.[612] There is also only a single insurer—a central social insurance fund operated by the Government.[613]

Dr Bakx agreed that the existence of the social insurance scheme in the Netherlands conferred an intangible community benefit: a sense of a social contract for sustainable long-term care for older people.[614]

Japan

The system in Japan has some similarities to the Dutch system, in that it operates as a 'pay-as-you-go' social insurance scheme and does not build a pool of funds. Professor Ikegami gave us a detailed explanation of this system.

Professor Ikegami explained that Japan's Long-Term Care Insurance (LTCI) was implemented because of Japan's ageing demographic profile and perceived weaknesses in the existing supports. Tax-funded social services were targeted at poorer elderly people, and therefore those on middle income had difficulty accessing services. Additionally, health services in Japan which offered free in-patient care to elders led to poor financial results.[615]

LCTI is half-paid by compulsory long-term care premiums and half from taxes. The premiums are levied on those aged 40 years and over.[616] For those aged 40–64 years, premiums are deducted alongside health insurance premiums and are allocated to a national fund. The Japanese Government allocates money in the fund to local municipalities on an as-needed basis.[617]

For those aged 65 years and above, the LTCI premium is deducted from the public pension. The deduction is means tested to income, with different rates for low, medium, and high income earners.[618]

The concept of the younger generation being required to contribute was an issue in Japan at the outset of the scheme. The initial plan had been for those from 20 years of age to pay premiums, but the program did not pass the Japanese parliament in this form.[619]

Professor Ikegami also explained how the scheme is managed on a three-year basis by the Japanese government, including revising the premiums every three years to balance expenditures.[620] Differences in income from LTCI and expenditure in a local municipality are equalised by the national government from the premiums gathered from those 40–64 years.[621] Similarly, the national government controls the price of LTCI service items by setting the cost of these services in a fee schedule.[622] During this three-year period, the insurance premiums that may be charged by a local municipality are frozen.[623]

However, Professor Ikegami told us that the fiscal cost of LTCI in Japan has been the greatest concern regarding its sustainability.[624] He confirmed that expenditures on LTCI had tripled since its inception.[625] He also indicated that there is an argument that when the scheme was set up, the entitlements under the scheme were set too generously, and have proven to be hard to balance fiscally.[626]

An attempt to control costs was made in 2005 by introducing co-payments for those in institutional care settings, that they must pay the 'hotel' costs of bed and board—although those on low incomes had these costs waived.[627]

When asked by Counsel Assisting whether an advantage of a social insurance scheme is that it does insulate, to a degree, the long-term funding of aged care from day-to-day fiscally-driven decisions made by the government of the day, Professor Ikegami replied:

> The fiscal situation still has considerable impact, but it is cushioned by the fact that half of the revenue comes from insurance premiums which are more cushioned from wage decreases and unemployment. …the premiums are earmarked [and] designated for long-term care so if they pay premiums they have a right, an entitlement to those services.[628]

As with Dr Bakx, Professor Ikegami agreed that social insurance of this type established a form of social contract between the Government and the premium payers, entitling premium payers to services in the future. He went on to contrast this with the prior tax-funded system in Japan:

> Well, as I said, before Long-Term Care Insurance social services were provided by tax-paid local government services. That led to perceived ad hoc decisions by the Government official in charge and also greater variation across disparity. Under social insurance the eligibility gives you a right to purchase services up to the entitled amount. So you can say the tax model was tried out but did not meet—was perceived not to meet the situation. So a new Long-Term Care Insurance was thus implemented.[629]

According to Professor Ikegami, the Japanese model of social insurance could be a useful precedent for the introduction of a similar LTCI model in Australia.[630] Professor Sherris also said that he believed much could be learned from the Japanese system.[631]

Private insurance

We heard from a number of witnesses about private insurance in aged care. Professor Sherris gave evidence that long-term care and longevity risks are the major risks faced by retirees and 'are currently financed by government, private retirement income, superannuation savings and personal savings including housing equity'.[632] Professor Sherris said 'longevity insurance for superannuation savings, through well designed

insurance products, can enhance the financing for aged care from government by ensuring more individual financial resources are available in older ages'.[633]

Professor Sherris gave evidence about insurance in the aged care system currently and said that the Australian Government is the primary insurer of long-term care risks and provides longevity insurance through the age pension.[634] He explained the benefits of private insurance in aged care:

> Aged care risks can be pre-financed using insurance and other retirement income products. Insurance reduces uncertainty about future risks and replaces self-insurance, which requires significant precautionary savings resources, with an average cost through risk-pooling. This improves individual welfare as well as societal welfare more generally.[635]

We also heard evidence about the disadvantages of private insurance. Professor Sherris explained that the costs of organising insurance reduce the benefits of risk pooling, and that these costs can increase insurance premiums.[636]

Professor Sherris said that private product markets for insuring and financing long-term care will only appeal to individuals with sufficient savings, superannuation and certain health status.[637] He said that individuals with less wealth will not be able to afford insurance premiums and individuals with significant wealth will be able to self-insure.[638] Therefore, individuals with middle levels of wealth are most likely to benefit from private insurance.[639]

Professor Swerissen gave the example of private health insurance in Australia and how it 'has demonstrated the difficulties in combining public financing and voluntary private insurance'.[640] Professor Swerissen said 'despite a range of inefficient subsidies, tax incentives and regulation, private health insurance is unpopular and continues to spiral downward. It has also led to inequitable and advantaged access to necessary services for those with private insurance'.[641] Professor Cutler also referred to the private health insurance system in Australia, stating that the system has 'significant administration costs' and limited competition.[642]

Mr Versteege did not support private insurance, stating that the Australian Government would be required to subsidise individuals who cannot afford insurance premiums and that the Australian Government has historically 'rewarded the self-sufficient…leaving people on low incomes dependent on the public health system and subject to waiting lists'.[643] Mr Versteege also referred to the private health insurance system in Australia, stating that it 'has been an unmitigated horror show for older Australians on low incomes' and that 'there would be little appetite among people on low incomes to embrace private aged care insurance'.[644]

Professor Woods did not express an opinion on the introduction of private insurance. However, he cautioned against the Australian Government providing incentives, including subsidies or tax waivers, to prop up a private insurance market.[645]

Professor Piggott generally did not support private insurance for aged care and referred to the difficulty in estimating future aged care costs, the lack of a functioning market, and consumer behaviour in not choosing private insurance.[646] Professor Piggott said that private insurance may have a role in covering additional and extra service fees for individuals who want residential care services above a basic threshold.[647]

Dr Henry supported private insurance for individuals who want to pay for a higher standard of care than is funded by government.[648]

We also heard evidence about the private insurance market. Professor Sherris said that taxation, means testing and regulatory requirements need to be conducive to a private insurance market for this to occur.[649] Professor Swerissen agreed, stating that 'appropriate market conditions' and 'favourable regulatory arrangements and government incentives' are required for private insurance schemes.[650] Professor Sherris explained that the Australian Government has a role to play in developing private markets for long-term care products and that 'there are significant potential welfare gains' from the Australian Government doing so.[651]

The Australian Treasury explained the requirements for developing a market for private insurance. Treasury said that 'the viability of a private aged care insurance market would depend on having sufficient numbers of people taking up the product to allow pooling and risk sharing. There are both demand and supply side constraints to forming a market'.[652] Treasury explained that the willingness of insurers to offer aged care insurance products would depend on a reasonable rate of return and 'regulatory certainty'.[653] Treasury indicated that the availability of reinsurance, where some of the risks are transferred to another entity, affects the existence of the private market for insurance and that 'insurance products would need to be designed in such a way that reinsurers would be willing to provide coverage'.[654] Treasury did not support mandatory private insurance.[655]

Professor Sherris recommended that the Australian Government 'provide support or ways to encourage the private markets for individuals who are providing their contribution… for their own longevity and their own aged care risks'.[656] He said that the Australian Government could drive the market, as was done for Medicare and health insurance, and that this could be done with the Australian Government as the insurer or reinsurer.[657] Insurance would need to be provided through a 'regulated insurer subject to relevant insurer prudential regulatory requirements', including premium rating and solvency, and actuarial assessment.[658]

Professor Sherris gave evidence about how longevity insurance could function. Individuals with superannuation could self-insure by drawing down on their superannuation to meet their needs until their savings are exhausted, and then they could move to the age pension. Alternatively, individuals who purchase longevity insurance where their risks are pooled with other people could generate a higher income from their savings instead of self-insuring. This would leave these individuals in a better position because of the benefits of pooling.[659]

Annuities are a type of longevity insurance product that provide 'regular, secure payments guaranteed for life'.[660] Professor Sherris discussed products that combine life annuities and long-term care insurance, which 'have the potential as a private insurance product to insure aged care costs and risks'.[661] These combination products, also called life care annuities, are more affordable for people with disabilty and older individuals, and require less solvency capital 'per dollar premium compared to stand-alone long-term care insurance'.[662] Life annuities generate a 'constant income during retirement until you die' and are most likely to be purchased by people who will live a long life.[663] The market for life annuities in Australia is very small, with only one major provider of annuities.[664] Australians generally have not had the savings to purchase annuities and instead rely on the age pension, which causes a 'crowded-out' private market.[665]

Dr Henry discussed the report and recommendations of a review that he chaired, *Australia's future tax system* report, which was presented to the then Australian Treasurer in 2009. He said that the Australian Government could support the development of immediate and deferred annuity products by issuing long-term securities, making data available to maintain the longevity index, and removing prescriptive rules regarding income streams and product innovation.[666] Dr Henry said the report recommended that the Australian Government should offer a product that allows individuals to purchase a lifetime income and that the Australian Government, or the private sector with Australian Government support, could 'invest in the provision of these products to address longevity risk'.[667] Dr Henry agreed that he was suggesting that controls on the ability to purchase additional care should be loosened to be similar to the health system, where individuals can purchase private health. He added that the loosening must not disadvantage individuals who cannot purchase additional care.[668]

We also heard evidence about the role of superannuation in private insurance. Professor Sherris said 'individuals are increasingly accumulating savings through the superannuation guarantee, but they are yet to really convert that into products that will give them longevity protection, and there's a move in that direction in Australia'.[669] When asked by Counsel Assisting if the intention of superannuation was to ease the pressure on public financing of aged care, Mr Keating agreed. He said 'the aim of the policy was to have more people at home and having them more independent by having a capital sum or an income stream available to them beyond that of simply the age pension'.[670]

Dr Kennedy gave evidence that the current policy arrangements have not 'fully exploited the opportunity for our superannuation system…to be providing a set of products that could make that contribution on an ongoing basis'.[671] Dr Kennedy explained that 'we see people holding substantial superannuation assets at death' and that the system needs to move towards getting 'the superannuation system and the aged care system working more effectively such that there are simple, straightforward products that allow people with the means to make a reasonable contribution to their aged care'.[672]

Personal contributions to the costs of aged care

Counsel Assisting tested with witnesses propositions relating to the personal financial contributions that older people could be required to make in relation to aged care services. Broadly, these propositions could be divided into two categories. The first was fees payable for aged care services available in the community or on an intermittent basis, such as social supports, enabling services and ongoing care at home. The second related to residential aged care.

A number of witnesses gave evidence about their support for co-contributions and other forms of individual contributions to the cost of their own aged care services where they have the means to do so. Mr Callaghan said that having wealthy individuals contribute to the costs of care is an aspect of 'intergenerational equity' and part of 'sustainability'.[673] He said that his view was that:

> across the board, that we should have a situation where those who have the capacity and the income to contribute and afford the services that they need as they age, they should be making a contribution and we should have a fair and equitable safety net for those who do not have the financial means to be able to do so.[674]

Mr Costello said that he thought it was 'fair to have an assets and an income test'.[675] Professor Ergas also generally supported the imposition of co-payments across all aged care fees.[676]

Dr Kennedy said that the 'community has an expectation that those of us who are in a position to contribute more should contribute more to the full range of services we get'.[677]

Fees for aged care services

Fees for social supports, enabling services, respite services and ongoing care at home

Counsel Assisting explored with witnesses a proposition that in relation to social supports and enabling services, nominal fees should be payable by people accessing those services. In relation to respite services, Counsel Assisting tested whether older people should be required to contribute to the costs of the services that they receive that are associated with ordinary costs of living and additional services, but not the costs of care or accommodation. For ongoing care at home, Counsel Assisting tested that people receiving care at home should not be required to contribute to the costs of any care services that they receive. They should, however, be required to make nominal co-payments for any domestic assistance services they receive.[678]

In relation to the fees for social supports, Professor Woods gave evidence that:

> I agree with the proposition that if you have free goods that there's a risk of over-consumption and by introducing a fee you get much more critical evaluation of your achieving value as a consumer for your contribution. So in principle, that's quite sound but there are a number of sort of perverse potential outcomes...It's great in principle, but I would strongly recommend a workshop of relevant parties to work through those issues because the danger is that you're creating a whole layer of process and opportunities for different applications that may not be worth it.[679]

On the topic of fees for ongoing care at home, Professor Woods advocated for changes to the structure of personal contributions for Home Care Packages from being an 'incomes test' to a 'means test'.[680] He otherwise did not agree to the propositions in relation to ongoing care at home.[681]

Mr Yates said that in relation to enabling services, COTA Australia considered 'that there shouldn't be co-payments for assistive technology and home modifications' because these services should be 'part of a restorative approach, which is in the Government's interest to promote'.[682] He indicated that COTA Australia is 'generally supportive' of the propositions in relation to social supports, respite services and ongoing care at home.[683]

Mr Versteege gave evidence that the Combined Pensioners and Superannuants Association does not support the current income-tested care fee which is currently charged in relation to Home Care Packages.[684] He told us that:

> We accept that there must be a limit to what home care can cost the Government, but the idea that once you reach that maximum, that people should then pay for their own care, out of their own pocket if they have enough money, or through home equity. I think that is wrong when up to that point you have not levied any fees, any personal contributions to fees at all. I think that's inconsistent and it's unfair.[685]

Mr Warner said that people should, if they are able to, make a contribution.[686] He noted that the current Home Care Package means testing system is 'quite complicated'. Sean Rooney, Chief Executive Officer, Leading Age Services Australia, supported fees for ongoing care at home.[687]

Fees for residential aged care

Counsel Assisting tested a series of propositions in relation to user contributions towards the costs of residential aged care. Under these propositions, people using residential aged care services would be required to contribute to the costs of services they receive associated with ordinary costs of living, to meet the costs of any additional services they choose to receive and pay any relevant accommodation costs. For older people receiving the pension, their contribution would be capped at 85% of the pension.[688] The propositions did not say whether any annual or lifetime caps on individual contributions would be applied.

Counsel Assisting also tested two alternative propositions relevant to individual contributions to the cost of aged care. Under one, older people would not be required to pay individual contributions towards the cost of care services.[689] Under the other, means testing arrangements for accommodation charges and daily care fees in residential care would be recalibrated to achieve progressively greater contributions from people who have greater levels of assets and income.[690] Where an older person cannot meet the required fees, they would be assisted with these costs.[691]

Mr Yates, Professor McCallum and Mr Versteege each supported the principles underlying Counsel Assisting's propositions on fees for residential aged care.[692] Similarly, Professor Cutler said at a general level he supported the propositions on means testing for residential aged care.[693]

Professor McCallum noted fees for residential aged care can leave self-funded retirees feeling 'worse-off' than pensioners, but this was 'typical' of most systems with means testing.[694] He noted that despite these feelings it is important to 'keep people with the motivation to self-fund'.[695]

Professor Piggott said that fees 'may introduce some form of discipline, and you introduce a sense of consumer engagement' which may increase the value that people attach to the subsidised services.[696] He told us that 'the idea of having co-pays and maybe differential co-pays for different kinds of services is an important one'.[697]

Ms Chadwick said that means testing in aged care should be similar to other sectors, such as childcare wherein a base line of funding would be provided by the Australian Government and anything above that amount would be paid for by the consumer.[698]

Ms Mizzi said that means testing should be simplified and more closely aligned with the means test for the pension.[699] She gave evidence that current means testing provides too much support to wealthier individuals.[700]

In relation to the level at which the fees might be set, Mr Corderoy told us that for residential aged care, the contributions, either by the Government or an individual, 'have to be commensurate to provide a return for the provider to provide that accommodation and maintain that accommodation to the right standard'.[701]

Dr Mellors said it would be important to set 'minimum level' standards for living expenses and that there would 'always be a need for consumer protections in terms of price gouging', noting that this could be done with 'existing infrastructure'.[702] Dr Mellors told us that she supported changes to means testing to ensure that those with means contributed more to the cost of their own care.[703]

Professor Piggott indicated his support for caps on the total amounts that a person could pay each year and over the course of their lifetime on fees 'to insure against catastrophic loss' for as long as there is not an effective aged market for aged care services.[704] He considered that the current lifetime cap is 'quite low' and can be substantially increased.[705]

Mr Mamarelis told us that where providers were 'struggling for viability, I don't think it makes sense to cap contributions on those who can afford to pay'.[706] He supported propositions where older people would not be charged any fees for the cost of care.[707] Mr Bennett gave evidence that in New Zealand there were no lifetime caps on means tested contributions.[708]

Mr Mersiades said that an independent pricing authority could have a role in setting the fees payable by people living in residential aged care.[709] He told us he would have a concern if the independent pricing authority would, in principle, set a cap for such fees because he thought that 'older people should have the capacity to be able to exercise some choice as to the standard of living they want in their older age'.[710] He supported an approach where a basic level, which applied to all older people, could be set, and then for providers to have capacity 'within a regulatory framework to negotiate additional services for a fee'.[711]

Mr Brown said that co-contributions by people living in residential aged care should be increased and providers should be allowed to charge more for additional services.[712]

Mr Thorley told us that the costs of providing care were greater compared to the fees that older people pay at present in the form of the Basic Daily Fee. In his view, if there remained a gap between fees paid by older people and the cost of delivering aged care, that gap should be 'supported by government'.[713] Ms Sparrow gave similar evidence, that aged care service providers are unable to recoup costs from consumers, where costs of care delivery and everyday living services are greater than consumer contributions and Aged Care Funding Instrument funding.[714]

Equity release to fund aged care services

We heard from a number of witnesses about using equity release schemes, including reverse mortgages and the Pension Loans Scheme, to fund aged care services.

Professor McCallum told us about the views of consumers on their personal wealth being used to fund aged care, stating that consumers 'don't see their house as a source of income in the future' and that people will maintain their assets 'even at the cost of not providing quality care for themselves'.[715] However, Professor McCallum supported equity release and said that releasing some of the equity in homes is important for the economy.[716] Mr Versteege disagreed, stating 'home equity release schemes have no structural place in the financing and funding of aged care services'.[717] Mr Versteege said 'any new proposal involving equity release and the family home will fail' due to 'the financial risk associated with becoming the reverse mortgagee'.[718]

Professor Woods supported equity release schemes, stating 'there is clearly scope for the wealth that is embedded in somebody's home to be available to supplement their income to contribute to paying for aged care services'.[719]

We received evidence that the home is excluded from means testing when it is occupied by a protected person, such as a spouse or dependent child.[720] We heard about the need to consider the interests of spouses or dependent children when implementing equity release schemes.

The Australian Treasury said 'it is appropriate that the family home should be excluded from the means test when a partner or a dependent child is occupying the residence' and 'equity in the home could still be incorporated in the means test through the use of the pension loan scheme' when a spouse or dependent child remains living in the home.[721]

When asked by Counsel Assisting if it would be possible to design a scheme that appropriately caters to the interests of a person who lives in or also has an interest in the home, Professor Piggott said it would be possible and it 'depends how far you go with this' as to who is protected.[722] Professor Piggott was hesitant about a child being protected from eviction, but said a spouse could be.[723] Professor Piggott discussed a scenario where one person enters an aged care facility and their partner remains at home, so 'value in the home is being chewed up. And so if the protected person subsequently requires expensive aged care then there is a depleted resource'.[724] Professor Piggott did not have a solution for this challenging issue.[725]

Dr Kennedy agreed with Counsel Assisting's proposal that a reverse mortgage could be designed so that the property would only be sold for a security interest when the partner dies. If that design feature was implemented, a share of the equity could be imputed to the person receiving aged care services and a debt would be accrued in a way that would not jeopardise the partner's residence.[726]

Mr Versteege raised concerns about including the owner-occupied home 'in any means testing', stating that 'any attempts to access the wealth in the owner-occupied house… should not happen before people are in secure housing, that is, in housing where, if they develop mobility issues, they can stay until it really becomes untenable'.[727]

We also heard evidence about releasing equity in the home through reverse mortgages. Professor Piggott supported reverse mortgages and explained their operation:

> And the essential contract is that either as a lump sum or as a string of payments the home is put up as collateral but no repayment occurs until some triggering event takes place. The triggering event could be vacating the home or selling it or could be death. And then the lender recoups with compound interest on that loan at that point.
>
> So that kind of mechanism could operate in this context, I think, and perhaps should operate in this context.[728]

Professor Sherris explained that reverse mortgages could be used to unlock equity in the home to purchase private insurance products.[729] Reverse mortgages have the 'potential to provide higher consumption while individuals are healthy and to finance longevity or aged care risks through financing the purchase of life annuities or long-term care insurance'.[730] This would allow individuals to cover their long-term care risks with insurance rather than using the house to 'hedge' the risk of moving into residential aged care.[731] Professor Sherris explained that individuals could use the house to offset residential aged care accommodation costs as a form of long-term care insurance or they 'could unlock some of the equity earlier to buy that insurance and have in place…insurance to cover other costs'.[732]

The banks gave evidence about why they do not offer reverse mortgage products. Mr Morris said that Australia and New Zealand Banking Group does not offer a reverse mortgage product 'as it falls outside of our risk appetite'.[733] The Commonwealth Bank of Australia also does not offer reverse mortgages, and withdrew the product from the market because disputation arose in situations where the reverse mortgage was taken out for the purpose other than benefiting the homeowner. Mr Williams said that the Commonwealth Bank of Australia was concerned that older people might be in vulnerable situations when participating in reverse mortgages taken out 'other than for the benefit of the homeowner', such as an 'investment in a business' of a 'son or daughter'.[734] Mr Williams made the point that 'there is generally a societal expectation upon the passing of elderly family members that the home is part of the inheritance and arrives in an un-mortgaged fashion'.[735] Westpac Banking Corporation does not offer reverse mortgages. Ms Hordern stated that 'you are dealing with individuals at a very vulnerable time in their life, and I think that historically has played into the bank's reluctance to consider reverse mortgages'.[736] National Australia Bank also does not offer reverse mortgages as these products fall outside their risk framework.[737]

In relation to the aversion of banks to provide reverse mortgages, Professor Sherris said 'I can understand the kinds of reservations that the banks have around these reverse mortgage products' and explained that banks can be accused 'of taking advantage of older people with these products—because they are priced above a standard loan'.[738]

Mr Keating said a benefit of reverse mortgages is that 'the assets of the person maintain them in their later life'. Mr Keating expressed the view that the Australian Government 'could establish a funding capability for reverse mortgages easily enough'. However, Mr Keating also said 'I don't think politically you will get away with a mortgage on the home'.[739]

Counsel Assisting questioned Dr Kennedy about previous reviews which have raised mechanisms such as reverse mortgages as an adjunct to compulsory user contributions in aged care and the possible aversion on the part of government regarding reverse mortgages. In response, Dr Kennedy said 'my observation would be that successive governments have found it very difficult to ask for these types of contributions and change these income tests or assets tests'.[740]

We also heard evidence about the Pension Loans Scheme, which is a reverse mortgage scheme offered by the Australian Government.[741] Witnesses were generally supportive of the Pension Loans Scheme. Professor McCallum said the current issues with it is that the interest rates are 'too high to be attractive' and that people are not aware of the Pension Loans Scheme. However, Professor McCallum supported the Pension Loans Scheme, stating 'I think, if we can get that moving, we have some factors that are really important for the economies going forward, which is to, you know, release some of the savings we have in houses'.[742]

Mr Yates agreed with Professor McCallum, stating that the Pension Loans Scheme 'needs to be much more widely promoted' and the interest rate needs to be 'more attractive'. However, Mr Yates cautioned that 'if the Government were to do it at a very low interest rate, then you would remove the opportunity for any other products out there in the market'.[743]

Professor Sherris supported the Pension Loans Scheme:

> I think it's a great idea. It's the sorts of things that governments should be doing to support different ways of financing these risks in retirement. And certainly we know that individuals have high levels of equity in their home, lower levels of liquidity to cover their living costs and to perhaps buy other kinds of products. So it's a very valuable means of unlocking equity and enhancing welfare in older age.[744]

Mr Costello supported the reverse mortgages and the Pension Loans Scheme, stating that 'financial products that can allow people to raise accommodation bonds against the family home, which is generally their greatest asset, I think there's a much more scope for them, and I think the Government could assist there'. Mr Costello said 'this is a classic area where those people that do use residential care and do have assets should be asked to make a contribution'.[745]

Combinations of financing mechanisms

Professor Piggott suggested that it would be prudent to obtain financing for aged care through multiple sources and approaches. He said that any decision about financing aged care must 'begin with the idea that aged care has to be predominantly publicly funded, it's a predominantly public responsibility'. According to Professor Piggott, it is then important to understand how to fund aged care with economic efficiency, and how to do so equitably, in terms of funding delivery and financing. He suggested that the financing could be obtained from two sources, a taxation source and the contributions made by people receiving aged care services. Based on this, he concluded that a hypothecated levy 'would best meet the requirements of efficiency and equity with regard to public general finance sources'.[746] Revenue would be sourced from a hypothecated levy, with a significant role given to co-contributions by people receiving aged care services. Reliance on the two sources in this way will support the notion that people receiving aged care services should value the care they are provided, and the taxation element will help to ensure that there is equity in the way that finances are raised.[747] Professor Piggott also suggested that social insurance could serve as a 'back up' for people who cannot make contributions to their aged care, and to make contributions on the behalf of those people.[748]

Endnotes

1 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9414.5–9.
2 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9135.17–39.
3 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9490.44–9491.1.
4 Transcript, Sydney Hearing 5, John McCarthy, 21 September 2020 at T9490.35–38.
5 Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9491.16–20.
6 Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9492.10–15.
7 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9421.43–9422.1.
8 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9318.14–9319.6.
9 Transcript, Sydney Hearing 5, Fahim Khondaker, 14 September 2020 at T9163.23–25.
10 Transcript, Sydney Hearing 5, Fahim Khondaker, 14 September 2020 at T9163.34–38.
11 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9569.1–10. See also Transcript, Sydney Hearing 5, David Bennett, 21 September 2020 at T9573.12; Transcript, Sydney Hearing 5, Natasha Chadwick, 21 September 2020 at T9550.25–26; Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9522.28–33.
12 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9521.44–45
13 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9520.27–34; Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9521.44.
14 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9522.29–33.
15 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9137.13–16.
16 Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9495.37–42.
17 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9491.8–11.
18 Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9471.17–24.
19 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9505.6–19.
20 Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9474.43–9475.2.
21 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 127, ANS.0001.0007.0001 at 0005.
22 Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0007.
23 Transcript, Sydney Hearing 5, Martin Warner, 22 September 2020 at T9601.15–16.
24 Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0007.
25 Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9124.19–22.
26 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [98]–[99].
27 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 90, CTH.9999.0001.0001; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 92, RCD.9999.0519.0001; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 114, RCD.9999.0522.0001; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 115, RCD.9999.0522.0018.
28 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9214 [90].
29 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9215 [94].
30 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9215 [95].
31 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 114, RCD.9999.0522.0001 at 0008.
32 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193 [16]; 9202 [45b]; 9218 [103].
33 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9218 [103].
34 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9429.21–22.
35 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9429.30–33.
36 Transcript, Sydney Hearing 5, Brendan Murphy and Nicholas Hartland, 18 September 2020 at T9429.27–37. For evidence of the increase in adverse regulatory actions and outcomes in 2017-18, see for example Exhibit 1-10, Adelaide Hearing 1, Department of Health Aged Care Regulation in Quality – Activity & Actions, RCD.9999.0005.0001.
37 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9429.46–9430.8.
38 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193 [17].
39 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193 [17].
40 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193–9194 [18]; Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0014 [45a]; Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9428.30–37.
41 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193–9194 [18a]; 9194 [20b].
42 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9429-9–13; T9424.10–15.
43 Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9427.8–15; T9426.10–15.
44 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [98].
45 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [99].
46 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [99].
47 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9218 [104].
48 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9218 [106].
49 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9428.32–35.
50 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0014–0015 [45b].
51 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9448.35–38; Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0015 [45c].

52 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9449.17–23.
53 Exhibit 21-10, Sydney Hearing 5, Statement of Michael Callaghan, WIT.0748.0001.0001 at 0004 [18].
54 Exhibit 21-10, Sydney Hearing 5, Statement of Michael Callaghan, WIT.0748.0001.0001 at 0005 [18d].
55 Exhibit 21-10, Sydney Hearing 5, Statement of Michael Callaghan, WIT.0748.0001.0001 at 0006 [19a].
56 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9320.30–35.
57 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9320.38–42.
58 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9434.36–38.
59 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.2–4.
60 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.3–6.
61 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.6–9.
62 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.9–12.
63 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 69, RCD.9999.0347.0001 at 0003 [10]; Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9599.3–12.
64 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9599.3–12; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 69, RCD.9999.0347.0001 at 0003 [10].
65 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9181.4–6.
66 Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0009; Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9140.41–9141.7.
67 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9145.18–37; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 114, RCD.9999.0522.0001 at 0002.
68 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9141.36–40.
69 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9142.14–26.
70 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0003–0006.
71 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0007–0008.
72 Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0007.
73 Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0010.
74 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9144.29–9145.12.
75 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0009 [61].
76 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0008 [49], [51].
77 Exhibit 21-20, Sydney Hearing 5, Statement of Ian Thorley, WIT.0776.0001.0001 at 0012 [81].
78 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9635.13–17.
79 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9531.15–18.
80 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9533.3–7.
81 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9531.23–24.
82 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9532.1–9; Transcript, Sydney Hearing 5, Natasha Chadwick, 21 September 2020 at T9563.35–36.
83 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9532.7–9.
84 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9532.12–17.
85 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9521.27–31.
86 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9580.16–20.
87 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9447.10–11; Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0007 [26].
88 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0003, Proposition FF 1: Aged care pricing authority. See also at 0004–0006, Proposition FF 2: Funding for indirect costs, Proposition FF 3: Economic regulation of the aged care sector, Proposition FF 7: Aged care services to be funded through casemix adjusted activity based funding arrangements.
89 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9442.10–11.
90 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9414.5–9.
91 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9573.41–9574.6.
92 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9598.25–28.
93 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9523.40–46; Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9628.46–9629.1; Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9146.45–57; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 78, RCD.9999.0331.0001 at 0026 [72].
94 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9390.30–42.
95 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9180.3–5; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 78, RCD.9999.0331.0001 at 0026 [72].
96 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9327.16–17.
97 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0006 [22].
98 Submissions of Regis Healthcare, Sydney Hearing 5, 5 October 2020, RCD.0012.0076.0001 at 0004 [1].
99 Transcript, Sydney Hearing 5, Kathleen Eagar, 17 September 2020 at T9362.18–25.
100 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9524.22–27.
101 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9327.13–28.
102 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9327.27–28; T9326.36–40.
103 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9324.16–20.
104 Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9509.10–14.
105 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9442.4–8.

106 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9442.4–6.
107 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9181.1–2; T9180.9–11; T9180.37–42.
108 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9186.3–5.
109 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0006 [23].
110 Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9379.15–23.
111 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9234.14–15.
112 Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0011 [64].
113 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0010 [65].
114 Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9385.45–9386.12.
115 Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9385.46–47; T9386.18.
116 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0003 [15].
117 Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9379.6–13.
118 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9522.35–39; Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9534.36–40; Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9535.5–7.
119 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9534.38–39.
120 Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9378.46–47.
121 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 69, RCD.9999.0347.0001 at 0002–0003 [10].
122 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0001–0002 [6].
123 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0002 [6].
124 Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9382.30–31.
125 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9629.26–31.
126 Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9382.30–31.
127 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9424.4–9.
128 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0006 [34].
129 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0006 [31].
130 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0006 [32]; 0003 [14].
131 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0006 [33].
132 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9210 [77c].
133 Exhibit 21-3, Sydney Hearing 5, Statement of Michael Woods, RCD.9999.0465.0001 at 0011 [45].
134 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0015–0016 [94].
135 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0015 [94].
136 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0003–0004, Proposition FF 2: Funding for indirect costs.
137 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0009, Proposition FF 12: Payment in arrears and acquittal.
138 Exhibit 21-10, Sydney Hearing 5, Statement of Michael Callaghan, WIT.0748.0001.0001 at 0013 [32]; Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9132.39–41; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 78, RCD.9999.0331.0001 at 0012 [29].
139 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9327.42–46.
140 Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9431.18–26.
141 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9530.10–14.
142 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9523.9–11.
143 Submissions of COTA Australia, Sydney Hearing 5, undated, RCD.0012.0077.0001 at 0004.
144 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9629.7–11.
145 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9181.44–47.
146 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9182.1–4.
147 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9529.37–38; T9530.3–4; Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9530.18–19.
148 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9530.20–23.
149 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9329.32–33.
150 Transcript, Sydney Hearing 5, David Bennett, 21 September 2020 at T9574.45–47; Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9575.29–36.
151 Transcript, Sydney Hearing 5, Natasha Chadwick, 21 September 2020 at T9556.28–30.
152 Transcript, Sydney Hearing 5, Jonathan Gavshon, 21 September 2020 at T9555.8–10; T9555.13–16.
153 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0004, Proposition FF 3: Economic regulation of the aged care sector.
154 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9178.35–41.
155 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 83, RCD.9999.0383.0001 at 0003 [16].
156 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.0079.
157 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9282.42–45.
158 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9283.41–43.
159 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9286.28–30.
160 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9283.35–43.
161 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.0079 at 0082.

162 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.0079 at 0082.
163 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9284.5–8.
164 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.0079 at 0083; 0133.
165 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9297.35–39.
166 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9290.30–34.
167 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.0079 at 0083.
168 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9294.17–19.
169 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9626.47–9627.2.
170 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9625.36–40.
171 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9330.24–30; T9331.22–27.
172 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9330.34–37.
173 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9330.43–46.
174 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9331.1–20.
175 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9624.45–9625.11.
176 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9627.2–5.
177 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9442.39–43.
178 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9543.12–13; Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9542.16.
179 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9543.13–15.
180 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9543.16–18.
181 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0004, Proposition FF 4: Funding arrangements in 'thin markets'.
182 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0004, Proposition FF 4: Funding arrangements in 'thin markets'.
183 Exhibit 21-15, Sydney Hearing 5, Statement of Australia and New Zealand Banking Group Limited, RCD.9999.0393.0001 at 0009–0010.
184 Exhibit 21-16, Sydney Hearing 5, Statement of Westpac Banking Corporation, WPC.9999.0002.0001 at 0020.
185 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 78, RCD.9999.0331.0001 at 0023 [57].
186 Exhibit 21-23, Sydney Hearing 5, Statement of Chris Mamarelis, RCD.9999.0335.0001 at 0005 [27]; 0007 [41].
187 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9576.21–27.
188 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9569.42–9570.5.
189 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0019 [108].
190 Transcript, Sydney Hearing 5, David Bennett, 21 September 2020 at T9577.40–47.
191 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0043 [84].
192 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9578.10–33.
193 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9443.9–10.
194 Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9443.15.
195 Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9443.15; T9443.46–9444.3.
196 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9631.33.
197 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9137.22–39; Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0012.
198 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0004–0006, Proposition FF 5: Aged care services to be funded through a combination of block and activity based funding, Proposition FF 6: Aged care services to be funded through individualised bundles, Proposition FF 7: Aged care services to be funded through casemix adjusted activity based funding arrangements.
199 Transcript, Sydney Hearing 5, Kathleen Eagar, 17 September 2020 at T9342.36–39.
200 Transcript, Sydney Hearing 5, Kathleen Eagar, 17 September 2020 at T9342.44–45.
201 Transcript, Sydney Hearing 5, Kathleen Eagar, 17 September 2020 at T9355.43–9356.7.
202 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0009 [47]–[48].
203 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0009 [49]–[50], [55].
204 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0011 [64]; 0012 [71]–[73].
205 Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0013 [78]; 0015.
206 Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9444.26–30.
207 Transcript, Sydney Hearing 5, Kathleen Eagar, 17 September 2020 at T9356.37–9357.5.
208 Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9436.47–9437.1.
209 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0004, Proposition FF 5: Aged care services to be funded through a combination of block and activity based funding.
210 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 69, RCD.9999.0347.0001 at 0002 [9].
211 Transcript, Sydney Hearing 5, Jonathan Gavshon, 21 September 2020 at T9552.36.
212 Transcript, Sydney Hearing 5, Jonathan Gavshon, 21 September 2020 at T9552.37–8.
213 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0011 [73].
214 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0011–0012 [73].
215 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0045 [98.1]–0046 [98.4].
216 Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0022 [112]–[113].
217 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9639.48–9640.3.

218 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9615.41–46.
219 Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9444.30–35.
220 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0005, Proposition FF 6: Aged care services to be funded through individualised bundles.
221 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0005, Proposition FF 6: Aged care services to be funded through individualised bundles.
222 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111 RCD.9999.0523.0001 at 0005, Proposition FF 6: Aged care services to be funded through individualised bundles.
223 Transcript, Sydney Hearing 5, Martin Warner, 22 September 2020 at T9606.6–9.
224 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9640.23–24.
225 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9605.38–9606.2.
226 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0031 [176].
227 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0046 [101].
228 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 83, RCD.9999.0383.0001 at 0006 [32].
229 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 82, RCD.9999.0338.0001 at 0010 [41]–0011 [45].
230 Exhibit 21-21, Sydney Hearing 5, Statement of Jonathan Gavshon, WIT.1357.0001.0001 at 0013 [83a–g].
231 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0012 [79]–[80].
232 Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9445.13–16.
233 Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9445.21–23.
234 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0006–0007, Proposition FF 8: Maximum funding amounts for care at home.
235 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 69, RCD.9999.0347.0001 at 0005 [12].
236 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9600.10–16.
237 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9446.40–42.
238 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9446.42–9447.2.
239 Transcript, Sydney Hearing 5, Jonathan Gavshon, 21 September 2020 at T9549.15–17.
240 Transcript, Sydney Hearing 5, Jonathan Gavshon, 21 September 2020 at T9548.42–47.
241 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0006 [40], [43].
242 Transcript, Sydney Hearing 5, Natasha Chadwick, 21 September 2020 at T9559.34–37.
243 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9640.24–29.
244 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9640.24–29.
245 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0005–0006, Proposition FF 7: Aged care services to be funded through casemix adjusted activity based funding arrangements.
246 Exhibit 21-10, Sydney Hearing 5, Statement of Michael Callaghan, WIT.0748.0001.0001 at 0006 [19]; 0018 [46].
247 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 82, RCD.9999.0338.0001 at 0010 [44].
248 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9446.23–24.
249 Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9385.20–24.
250 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9434.38–39.
251 Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0009–0011.
252 Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0021 [110].
253 Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0011 [68]–[70].
254 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 76, RCD.9999.0326.0001 at 0027.
255 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9531.37; Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9531.11–13.
256 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9533.18–19.
257 Exhibit 21-22, Sydney Hearing 5, Statement of Natasha Chadwick, WIT.1361.0001.0001 at 0028 [136b].
258 Transcript, Sydney Hearing 5, Natasha Chadwick, 21 September 2020 at T9556.2–7.
259 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0007, Proposition FF 9: Residential aged care supplements.
260 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9531.11–13; Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9533.18–19; Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9531.37; T9531.46.
261 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9447.10–11.
262 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 20 at T9641.26–36.
263 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9641.26–36; T9641.46–9642.7.
264 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9522.36–45.
265 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9598.47–9599.3.
266 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0008–0009, Proposition FF 11: Principles for the assessment of need.
267 Transcript, Sydney Hearing 5, Kathleen Eagar, 17 September 2020 at T9344.23–25.
268 Transcript, Sydney Hearing 5, Kathleen Eager, 17 September 2020 at T9344.24–35.
269 Transcript, Sydney Hearing 5, Kathleen Eager, 17 September 2020 at T9344.35-38.
270 Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9120.39–42.
271 Exhibit 21-24, Sydney Hearing 5, Statement of Paul Sutton, RCD.9999.0378.0001 at 0019 [147].
272 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 83, RCD.9999.0383.0001 at 0002 [12]–[13].

273 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9197 [31a]; 9209 [72]; 9210 [73]–[75].
274 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9197 [31a]; 9209 [72]; 9210 [73]–[75].
275 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9607.34–36; T9608.18–21.
276 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9607.34–36; T9608.18–21.
277 Transcript, Sydney Hearing 5, Martin Warner, 22 September 2020 at T9607.9–20; T9608.25–29; T9609.3–10; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 68, RCD.9999.0375.0001 at 0004 [23]–[29].
278 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0049 [121]–[123].
279 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0049 [121].
280 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0049 [121], [123].
281 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0009, Proposition FF 12: Payment in arrears and acquittal.
282 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9188.39–40; T9188.46–9189.1; T9189.40–43.
283 Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9132.5–6; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0017 [104].
284 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0017 [104]–[105]; Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9123.5–6.
285 Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9447.25–26; T9447.26–28.
286 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9537.46–T9538.1.
287 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9537.34–38.
288 Transcript, Sydney Hearing 5, Jason Ward, 16 September 2020 at T9310.34–42.
289 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9628.9–22; T9628.30–31.
290 Transcript, Sydney Hearing 5, Andrew Fielding, 14 September 2020 at T9165.23–31.
291 Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0017; Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9156.10–33.
292 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0028 [161].
293 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0028 [161]–[162]; Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9358.15–20.
294 Exhibit 21-23, Sydney Hearing 5, Statement of Chris Mamarelis, RCD.9999.0335.0001 at 0017 [102].
295 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 69, RCD.9999.0347.0001 at 0008–0009 [14].
296 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9613.44–9614.3.
297 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 68, RCD.9999.0375.0001 at 0003 [19]–[20].
298 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 68, RCD.9999.0375.0001 at 0003 [19].
299 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 68, RCD.9999.0375.0001 at 0013 [104].
300 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 68, RCD.9999.0375.0001 at 0003 [19]; 0005 [33]–[34]; Transcript, Sydney Hearing 5, Martin Warner, 22 September 2020 at T9612.34–38.
301 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0018–0025, Proposition PR 1: More stringent regular financial reporting requirements, Proposition PR 2: Information gathering powers, Proposition PR 3: Continuous disclosure requirements in relation to prudential reporting, Proposition PR 4: Requirement to report on outsourcing of care management, Proposition PR 5: Liquidity requirements, Proposition PR 6: Capital adequacy requirements, Proposition PR 7: Tools for enforcing the prudential requirements, Proposition PR 8: Building the capability of the regulator.
302 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0018–0025.
303 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0011 [42].
304 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3550 [4].
305 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3552 [7]–3553 [10].
306 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3555 [15a]–[15b].
307 Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9452.39–42.
308 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3551 [6]; Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0005 [16]; Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9451.12–18; Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9451.22–25.
309 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3572 [69]; 3576–3582.
310 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3561 [35]; 3570 [63h].
311 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3561 [35]; 3570 [63h].
312 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 104, CTH.1000.0006.3545 at 3546 [5]–[6]; tab 93, CTH.1000.0006.3499.
313 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 93, CTH.1000.0006.3499 at 3501.
314 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 93, CTH.1000.0006.3499 at 3506.
315 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 93, CTH.1000.0006.3499 at 3507.
316 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 93, CTH.1000.0006.3499 at 3507–3508.
317 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 104, CTH.1000.0006.3545 at 3546 [5]–3547 [9].
318 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0019–0020, Proposition PR 1: more stringent regular financial reporting requirements.
319 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3553 [12a].
320 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3553–3554 [12b].

321 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3553–3554 [12c].
322 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3554–3555 [13].
323 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 103, CTH.1038.0003.3433 at 3519–3520 [10.2].
324 Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9463.31–36.
325 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9463.44–46.
326 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0011 [43c].
327 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0011 [43c].
328 Transcript, Sydney Hearing 5, Martin Warner, 22 September 2020 at T9617.4–14.
329 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9617.32–33.
330 Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9617.36–41.
331 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9539.38–39; T9540.1–2.
332 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9539.38–45.
333 Transcript, Sydney Hearing 5, Jason Ward, 16 September 2020 at T9307.29.
334 Transcript, Sydney Hearing 5, Jason Ward, 16 September 2020 at T9305.41–43; T9306.24–26; Exhibit 21-9, Sydney Hearing 5, Letter from Centre for International Corporate Tax Accountability and Research, RCD.9999.0510.0001 at 0002.
335 Transcript, Sydney Hearing 5, Jason Ward, 16 September 2020 at T9307.31–36; T9306.34–9307.3.
336 Exhibit 21-9, Sydney Hearing 5, Letter from Centre for International Corporate Tax Accountability and Research, RCD.9999.0510.0001 at 0002; Transcript, Sydney Hearing 5, Jason Ward, 16 September 2020 at T9308.22–42.
337 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9155.8–36.
338 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9155.28–35.
339 Transcript, Sydney Hearing 5, Fahim Khondaker, 14 September 2020 at T9160.40–9161.15; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 10, RCD.9999.0388.0044 at 0117–0119; Transcript, Sydney Hearing 5, Andrew Fielding, 14 September 2020 at T1961.27–32; Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9154.27–40.
340 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0021, Proposition PR 3: Continuous disclosure requirements in relation to prudential reporting.
341 Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9463.23–24.
342 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9463.5–9.
343 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9462.9–13.
344 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0012 [43e].
345 Transcript, Sydney Hearing 5, Natasha Chadwick, 21 September 2020 at T9558.7–10.
346 Transcript, Sydney Hearing 5, Martin Warner, 22 September 2020 at T9617.19–28.
347 Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9500.22–37; Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9497.42–45; T9499.47–9500.20; Transcript, Sydney Hearing 5, John McCarthy, 21 September 2020 at T9500.42–9501.9.
348 Transcript, Sydney Hearing 5, John McCarthy, 21 September 2020 at T9501.18–24. See also Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9502.42–45.
349 Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9503.22–27.
350 Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9503.25–31.
351 Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9503.42–9504.1.
352 Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9502.40–44.
353 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9502.19–22.
354 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9502.1–4; T9502.11–14.
355 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9540.22.
356 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9540.40–43.
357 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9540.47; T9541.8–10; T9541.17.
358 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9541.12–13.
359 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9581.46–9582.1.
360 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9528.22–40.
361 Transcript, Sydney Hearing 5, David Bennett, 21 September 2020 at T9583.4–5.
362 Transcript, Sydney Hearing 5, David Bennett, 21 September 2020 at T9583.4–8.
363 Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9479.29–9480.37.
364 Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9480.22–28.
365 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0012 [43e].
366 Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9468.4–7.
367 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9468.33–37.
368 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0011 [43b] fn 27.
369 Transcript, Sydney Hearing 5, Jason Ward, 16 September 2020 at T9310.9–18; T9310.22–26.
370 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9539.32–36.
371 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0020, Proposition PR 2: Information gathering powers.
372 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9464.8–10.
373 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9464.22–23; T9464.10–12.
374 Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9464.25–27.
375 Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9464.25–32.

376 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0012 [43d].
377 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0012 [43d].
378 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0024, Proposition PR 7: Tools for enforcing the prudential requirements.
379 Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9467.12–15.
380 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9467.17–23.
381 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9467.423–27. See also: Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0012–0013 [43h].
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383 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9453.32–35.
384 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9469.9–14.
385 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9469.14–18.
386 Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9469.20–31.
387 Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9469.22; T9469.28–31.
388 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0013 [43j].
389 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0013 [43j].
390 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9335.34–38.
391 Exhibit 21-10, Sydney Hearing 5, Statement of Michael Callaghan, WIT.0748.0001.0001 at 0024 [65].
392 Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9456.11–34.
393 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9456.5–9.
394 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0005 [20]; 0011 [43a].
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397 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3566 [51b].
398 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 116, CTH.1038.0003.3550 at 3566 [52a].
399 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 104, CTH.1000.0006.3545 at 3548 [10a].
400 Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9465.18–21.
401 Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9458.28–31.
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404 Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0012 [43g].
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409 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9153.4–9.
410 Transcript, Sydney Hearing 5, Natasha Chadwick, 21 September 2020 at T9559.8–14.
411 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0023–0024, Proposition PR 6: Capital adequacy requirements.
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416 Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9466.38–9467.3.
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430 Exhibit 21-14, Sydney Hearing 5, Statement of Commonwealth Bank of Australia, CBA.9999.0003.0001 at 0002 [10].

431 Exhibit 21-14, Sydney Hearing 5, Statement of Commonwealth Bank of Australia, CBA.9999.0003.0001 at 0002 [10]; 0003 [13]; 0005 [26].
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433 Exhibit 21-17, Sydney Hearing 5, Voluntary Statement of National Australia Bank, RCD.9999.0386.0001 at 0003.
434 Exhibit 21-17, Sydney Hearing 5, Voluntary statement of National Australia Bank, RCD.9999.0386.0001 at 0003; 0004.
435 Exhibit 21-16, Sydney Hearing 5, Statement of Westpac Banking Corporation, WPC.9999.0002.0001 at 0011.
436 Exhibit 21-16, Sydney Hearing 5, Statement of Westpac Banking Corporation, WPC.9999.0002.0001 at 0002; 0009.
437 Exhibit 21-16, Sydney Hearing 5, Statement of Westpac Banking Corporation, WPC.9999.0002.0001 at 0011; 0012.
438 Exhibit 21-16, Sydney Hearing 5, Statement of Westpac Banking Corporation, WPC.9999.0002.0001 at 0017.
439 Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9471.23–24.
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441 Transcript, Sydney Hearing 5, David Bennett, 21 September 2020 at T9573.17–18.
442 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9581.1–3.
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445 Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9116.24–27.
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451 Exhibit 21-10, Sydney Hearing 5, Statement of Michael Callaghan, WIT.0748.0001.0001 at 0012 [30]–0013 [31].
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455 Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9472.33–45.
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461 Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9506.5–9.
462 Exhibit 21-15, Sydney Hearing 5, Statement of Australia and New Zealand Banking Group Limited, RCD.9999.0393.0001 at 0004–0005; 0010–0011.
463 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9505.6–14.
464 Exhibit 21-15, Sydney Hearing 5, Statement of Australia and New Zealand Banking Group Limited, RCD.9999.0393.0001 at 0011.
465 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9505.31–35.
466 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9505.15–19.
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469 Transcript, Sydney Hearing 5, John McCarthy, 21 September 2020 at T9505.41–47.
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472 Exhibit 21-16, Sydney Hearing 5, Statement of Westpac Banking Corporation, WPC.9999.0002.0001 at 0015.
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474 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 T9587.5–13.
475 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9586.47–9587.13.
476 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 84, WIT.0764.0001.0001 at 0024 [86]; 0041–0042 [149].
477 Exhibit 21-10, Sydney Hearing 5, Statement of Michael Callaghan, WIT.0748.0001.0001 at 0012 [29].
478 Exhibit 21-20, Sydney Hearing 5, Statement of Ian Thorley, WIT.0776.0001.0001 at 0016 [117].
479 Exhibit 21-20, Sydney Hearing 5, Statement of Ian Thorley, WIT.0776.0001.0001 at 0016 [117].
480 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0016.
481 Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9125.30–32.
482 Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9125.30–35.
483 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0030; 0058 [171]–[173].
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485 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0005 [34].
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487 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0010–0011 [67].
488 Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0034 [189]–[191].
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490 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 82, RCD.9999.0338.0001 at 0012 [50].
491 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 82, RCD.9999.0338.0001 at 0012 [49]–[50].

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493 Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9293.11–9294.19; Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9626.47–9627.2.
494 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9543.12–13; Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9542.16.
495 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9543.13–15.
496 Transcript, Sydney Hearing 5, Stephen Gray, 17 September 2020 at T9365.31–33.
497 Transcript, Sydney Hearing 5, Stephen Gray, 17 September 2020 at T9371.1–8.
498 Transcript, Sydney Hearing 5, Stephen Gray, 17 September 2020 at T9371.1–8.
499 Transcript Sydney Hearing 5, Stephen Gray, 17 September 2020 at T9371.23–30.
500 Transcript, Sydney Hearing 5, Stephen Gray, 17 September 2020 at T9365.22–43; T9366.3–5; T9371.2–30; T9372.9–29.
501 Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9478.43–9479.14.
502 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9585.26–27.
503 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9585.5–24.
504 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9585.20–22.
505 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9585.13–38.
506 Transcript, Sydney Hearing 5, David Bennett, 21 September 2020 at T9585.44–9586.1.
507 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 23, RCD.9999.0402.0002 at 0007 [8].
508 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 23, RCD.9999.0402.0002 at 0062 [310b].
509 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 23, RCD.9999.0402.0002 at 0043 [193].
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511 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9639.8–24.
512 Exhibit 21-20, Sydney Hearing 5, Statement of Ian Thorley, WIT.0776.0001.0001 at 0015 [111].
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514 Exhibit 21-15, Sydney Hearing 5, Statement of Australia and New Zealand Banking Group Limited, RCD.9999.0393.0001 at 0012.
515 Transcript, Sydney Hearing 5, Paul Keating, 14 September 2020 at T9107.19–31.
516 Transcript, Sydney Hearing 5, Paul Keating, 14 September 2020 at T9096.34–38; T9097.38–45; T9100.1–2.
517 Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9110.16–19.
518 Transcript, Sydney Hearing 5, Ian Yates, 14 September 2020 at T9126.45–46.
519 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9229.9–12.
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524 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9230.1–8.
525 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9231.14–23.
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529 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0009 [54].
530 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0008 [54].
531 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9392.13–15.
532 Exhibit 21-3, Sydney Hearing 5, Statement of Michael Woods, RCD.9999.0465.0001 at 0023 [83.2a].
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534 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 80, RCD.9999.0405.0001 at 0008 [43].
535 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 80, RCD.9999.0405.0001 at 0008 [44].
536 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 80, RCD.9999.0405.0001 at 0009 [48].
537 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0009 [57].
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539 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9391.28–31.
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543 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0010 [64].
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545 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9247.11–34.
546 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9247.40–41.
547 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9247.43–9248.5.
548 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9248.17–22.
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550 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9250.15–19.
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554 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9275.8–10.
555 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9274.26–31; Exhibit 21-7, Sydney Hearing 5, Precis of evidence of Kenneth Henry, RCD.9999.0501.0001 at 0003 [14]–[15].
556 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9274.38–39.
557 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9275.1–7; Exhibit 21-7, Sydney Hearing 5, Precis of evidence of Kenneth Henry, RCD.9999.0501.0001 at 0003 [16].
558 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9275.15–23.
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561 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9277.45–9278.1.
562 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9278.1–6.
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564 Exhibit 21-6, Sydney Hearing 5, Submission of the ARC Centre of Excellence in Population Ageing Research, RCD.9999.0508.0001 at 0002.
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567 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9236.35–39.
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569 Transcript, Sydney Hearing 5, Paul Keating, 14 September 2020 at T9099.26–39.
570 Transcript, Sydney Hearing 5, Paul Keating, 14 September 2020 at T9100.23–29.
571 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 28, AWF.680.00019.0001 at 0010.
572 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 20, RCD.9999.0373.0001.
573 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 28, AWF.680.00019.0001 at 0011.
574 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0003 [2]; 0011.
575 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9218.8–15.
576 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9220.1–5.
577 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9278.39–42.
578 Exhibit 21-6, Sydney Hearing 5, Submission of the ARC Centre of Excellence on Population Ageing Research, RCD.9999.0508.0001 at 0007–0010.
579 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9231.32–37.
580 Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0016 [88].
581 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0006 [34].
582 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0007 [42]–0008 [47].
583 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0006 [29].
584 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0021 [129].
585 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9230.2–5.
586 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0006 [33].
587 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9277.15–22.
588 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9278.14–32.
589 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9394.30–9395.43; Transcript, Sydney Hearing 5, Jenny Wilkinson, 18 September 2020 at T9396.35–37.
590 Transcript, Sydney Hearing 5, Jenny Wilkinson, 18 September 2020 at T9396.35–37.
591 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9278.34–42.
592 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9395.35–42.
593 Transcript, Sydney Hearing 5, Jenny Wilkinson, 18 September 2020 at T9396.1–9.
594 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9192.15–20.
595 Transcript, Sydney Hearing 5, Paul Keating, 14 September 2020 at T9102.29–9103.14.
596 Transcript, Sydney Hearing 5, Paul Keating, 14 September 2020 at T9104.3–10.
597 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9254.30–41.
598 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9255.18–20.
599 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9233.15–26.
600 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9233.32–9234.6.
601 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9623.28–32.
602 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 109, AWF.680.00032.0001 at 0001.
603 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 109, AWF.680.00032.0001 at 0002.
604 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 109, AWF.680.00032.0001 at 0002; Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9659.35–43.
605 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9656.28–37.
606 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9662.40–47.
607 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9658.3–9.
608 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9657.43–9658.22.

609 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9658.30–36.
610 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9667.26–35.
611 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9666.17–21.
612 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9659.3–11; T9660.6–15.
613 Transcript, Sydney Hearing 5, Pieter Bakx, 22 September 2020 at T9665.16–20.
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615 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9197.11–24.
616 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9197.44–46.
617 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9198.22–28.
618 Exhibit 21-4, Sydney Hearing 5, Statement of Naoki Ikegami, RCD.9999.0318.0001 at 0002 [13].
619 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9199.17–29.
620 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9207.31–42.
621 Exhibit 21-4, Sydney Hearing 5, Statement of Naoki Ikegami, RCD.9999.0318.0001 at 0002 [13].
622 Exhibit 21-4, Sydney Hearing 5, Statement of Naoki Ikegami, RCD.9999.0318.0001 at 0003 [14], [17].
623 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9199.31–47.
624 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9204.47–9205.5.
625 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9203.2–7.
626 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9204.47–9205.5; Exhibit 21-4, Sydney Hearing 5, Statement of Naoki Ikegami, RCD.9999.0318.0001 at 0006 [29].
627 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9205.14–30.
628 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9206.17–30.
629 Transcript, Sydney Hearing 5, Naoki Ikegami, 15 September 2020 at T9206.35–9207.3.
630 Exhibit 21-4, Sydney Hearing 5, Statement of Naoki Ikegami, RCD.9999.0318.0001 at 0005 [27].
631 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9220.12–18; T9222.23–24.
632 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0003 [2]; 0002 [1].
633 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0003 [2].
634 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9210.32–36.
635 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0003 [3].
636 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0003–0004 [6]; Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9214.41–44.
637 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0003 [5].
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639 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0005 [12]; Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9216.40–9217.1.
640 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 83, RCD.9999.0383.0001 at 0005 [23].
641 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 83, RCD.9999.0383.0001 at 0005 [23].
642 Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0016 [90].
643 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0020 [126].
644 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0021 [128].
645 Exhibit 21-3, Sydney Hearing 5, Statement of Michael Woods, RCD.9999.0465.0001 at 0021 [81.4].
646 Exhibit 21-6, Sydney Hearing 5, Submission of the ARC Centre of Excellence in Population Ageing Research, RCD.9999.0508.0001 at 0003; 0009.
647 Exhibit 21-6, Sydney Hearing 5, Submission of the ARC Centre of Excellence in Population Ageing Research, RCD.9999.0508.0001 at 0009.
648 Exhibit 21-7, Sydney Hearing 5, Precis of evidence of Kenneth Henry, RCD.9999.0501.0001 at 0004 [18].
649 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0004 [8].
650 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 83, RCD.9999.0383.0001 at 0005 [23].
651 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0005 [11].
652 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0007 [38].
653 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0007 [39].
654 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0007 [41].
655 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 118, CTH.9300.0001.0001 at 0007 [40].
656 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9222.25–27.
657 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9222.36–41.
658 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0012–0013.
659 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9210.45–9211.12.
660 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 32, RCD.9999.0490.0001 at 0005; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 28, AWF.680.00019.0001 at 0012 [3.2].
661 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0004 [7].
662 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0008 [9].
663 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9212.12–18.
664 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9211.38–40.
665 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9214.29–32.
666 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9269.32–9270.1.

667 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9270.3–11.
668 Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9279.9–22.
669 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9210.36–39.
670 Transcript, Sydney Hearing 5, Paul Keating, 14 September 2020 at T9097.43–45.
671 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9398.18–22.
672 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9398.29–36.
673 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9332.24–26.
674 Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020 at T9332.5–9.
675 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9259.4–5.
676 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 82, RCD.9999.0338.0001 at 0010 [41].
677 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9399.46–9400.1.
678 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0009–0010, Proposition FF 13: Fees for social supports, Proposition FF 14: Fees for assistive technology and home modifications, Proposition FF 15: Fees for respite care, Proposition FF 16: Fees for care at home.
679 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9190.16–28.
680 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9176.21–23.
681 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9191.1–2.
682 Transcript, Sydney Hearing 5, Ian Yates, 14 September 2020 at T9121.5–8.
683 Transcript, Sydney Hearing 5, Ian Yates, 14 September 2020 at T9121.1–3.
684 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0016 [94].
685 Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9120.27–31.
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688 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0010–011, Proposition FF 17: Fees for residential aged care, Proposition FF 18: Fees for residential aged care – ordinary costs of living.
689 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0010, Proposition FF 17: Fees for residential aged care.
690 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0012, Proposition 20: Alternative means testing arrangements.
691 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 111, RCD.9999.0523.0001 at 0010, Proposition FF 17: Fees for residential aged care.
692 Transcript, Sydney Hearing 5, Ian Yates, 14 September 2020 at T9115.25–27; Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9115.31–36; Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9115.40–43.
693 Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9640.46–9641.2.
694 Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9113.21–23.
695 Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9113.25–27.
696 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9227.1–4.
697 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9227.29–31.
698 Exhibit 21-22, Sydney Hearing 5, Statement of Natasha Chadwick, WIT.1361.0001.0001 at 0027 [127].
699 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 84, WIT.0764.0001.0001 at 0009 [31d].
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701 Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9148.15–17.
702 Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9527.37–42.
703 Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0013.
704 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9238.23–28.
705 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9238.46–9239.2.
706 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9584.21–23.
707 Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9584.36–41.
708 Transcript, Sydney Hearing 5, David Bennett, 21 September 2020 at T9583.13–41.
709 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9528.45–47.
710 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9528.45–9529.4.
711 Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9529.15–19.
712 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 78, RCD.9999.0331.0001 at 0029–0030.
713 Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9526.30–38.
714 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 79, RCD.9999.0330.0001 at 0005 [33]–0006 [34].
715 Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9111.30–33.
716 Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9117.27–30.
717 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0014 [79].
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719 Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9176.13–15.
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722 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9240.18–19.
723 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9240.19–21.

724 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9240.22–26.
725 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9240.21–26.
726 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9401.35–9402.6.
727 Transcript, Sydney Hearing 5, Paul Versteege, 14 September 2020 at T9116.29–36.
728 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9239.22–29.
729 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9218.38–42.
730 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 31, AWF.680.00004.0001 at 0009 [4].
731 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9218.42–44.
732 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9218.38–9219.2.
733 Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9511.14–15.
734 Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9510.35–9511.1.
735 Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9511.2–4.
736 Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9510.22–24.
737 Transcript, Sydney Hearing 5, John McCarthy, 21 September 2020 at T9511.19–20.
738 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9219.11–18.
739 Transcript, Sydney Hearing 5, Paul Keating, 14 September 2020 at T9103.27–28; T9103.21–22; T9106.40–41.
740 Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9403.4–12.
741 Transcript, Sydney Hearing 5, Jenny Wilkinson, 18 September 2020 at T9403.1; Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9258.20–21.
742 Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9117.27–29.
743 Transcript, Sydney Hearing 5, Ian Yates, 14 September 2020 at T9117.45–9118.3.
744 Transcript, Sydney Hearing 5, Michael Sherris, 15 September 2020 at T9219.26–31.
745 Transcript, Sydney Hearing 5, Peter Costello, 16 September 2020 at T9258.17–24.
746 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9225.25–26.
747 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9225.16–34.
748 Transcript, Sydney Hearing 5, John Piggott, 15 September 2020 at T9230.44–9231.3.

24. Counsel Assisting's final submissions

24.1 Hearing overview

We held our final public hearing in Melbourne, Victoria, on 22 and 23 October 2020. Senior Counsel Assisting the Royal Commission, Peter Gray QC and Peter Rozen QC, presented submissions on behalf of the Counsel Assisting team consisting of Peter Gray QC, Peter Rozen QC, Richard Knowles SC, Paul Bolster, Erin Hill, Brooke Hutchins and Eliza Bergin. Those submissions included 124 proposed recommendations for consideration by us and for the general public to comment on, as well as a timeline indicating when those recommendations should be implemented.[1] The submissions, timeline and recommendations were published on the Royal Commission's website on 22 October 2020 and were updated on 23 October 2020.

At the commencement of the hearing, Senior Counsel Assisting explained that:

> it is the responsibility of the aged care system to support and nurture our older people and the recommendations we are proposing to you today and tomorrow and in the written [submissions]…are our contribution to that endeavour.
>
> …
>
> Through these submissions we will set out the recommendations that we say are available for Commissioners to make, based on our analysis and examination of the evidence.
>
> The recommendations and the final report will form the basis of authoritative advice to government and to the aged care sector on how to ensure the aged care system of the future aligns with the expectations of the Australian people.[2]

The submissions began by addressing the nature, extent and systemic causes of substandard aged care, and then set out what Counsel Assisting described as a 'blueprint' for the future, which addressed the following topics:

1. principles of the new aged care system
2. design of the new aged care system
3. program design
4. quality and safety
5. aged care for Aboriginal and Torres Strait Islander people
6. the aged care workforce
7. informal carers
8. provider governance

9. research and aged care data
10. aged care accommodation
11. younger people in residential aged care
12. aged care for people with disability
13. better access to health care
14. aged care in regional, rural and remote areas
15. proposed funding arrangements and outline of financing options
16. prudential regulation and financial oversight
17. effective regulation
18. transition and implementation.

Counsel Assisting's submissions were informed by, but did not repeat, the submissions made on workforce in Adelaide Hearing 3 on 26 February 2020 and on program redesign in Adelaide Hearing 4 on 4 March 2020. The submissions drew upon post-hearing submissions received in relation to those hearings, and addressed aspects of workforce and program design that were not covered in those submissions. Counsel Assisting did not propose recommendations about long-term financing options or capital financing, as the consultation process in response to 'Consultation paper 2: Financing Aged Care' was in progress at the time.[3] However, Counsel Assisting's submissions canvassed the evidence and information received in relation to these topics, as well as potential options for reform.[4]

Counsel Assisting submitted that if fully implemented, the proposed recommendations should 'bring about significant, wide-ranging, long-lasting and beneficial changes'.[5] The submissions concluded by outlining the core components of a vision for aged care in 2030 and beyond.

We invited responses to Counsel Assisting's submissions and directed that they be provided by 12 November 2020. Responses were sought in relation to each of the 124 recommendations proposed by Counsel Assisting, as well as other matters that arose at the hearing.

Over 350 responses were received. We have taken those responses, together with Counsel Assisting's submissions, into account in preparing the recommendations contained in Volume 3 of our Final Report.

Endnotes

1 Submissions of Counsel Assisting the Royal Commission, Final Hearing, 22 October 2020, RCD.9999.0541.0001; Submissions of Counsel Assisting the Royal Commission: Annexure A, Final Hearing, 22 October 2020, RCD.9999.0542.0001; Submissions of Counsel Assisting the Royal Commission: Proposed Recommendations, Final Hearing, 22 October 2020, RCD.9999.0540.0001.

2 Transcript, Final Hearing, 22 October 2020 at T9678.4–7; T9678.18–25.

3 Submissions of Counsel Assisting the Royal Commission, Final Hearing, 22 October 2020, RCD.9999.0541.00001 at 0398 [1316]; Transcript, Final Hearing, 23 October 2020 at T9799.28–30.

4 Submissions of Counsel Assisting the Royal Commission, Final Hearing, 22 October 2020, RCD.9999.0541.00001 at 0398 [1316]–0407 [1345].

5 Submissions of Counsel Assisting the Royal Commission, Final Hearing, 22 October 2020, RCD.9999.0541.00001 at 0472 [1598].

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