



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

**INQUIRY INTO INTRODUCING INFORMED USER CHOICE AND
COMPETITION INTO HUMAN SERVICES**

DR S KING, Presiding Commissioner
MR R SPENCER, Commissioner
MR S INNIS, Special Adviser

TRANSCRIPT OF PROCEEDINGS

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DR KING: Good morning, and welcome to the public hearings for the Productivity Commission Inquiry into Introducing Informed User Choice and Competition into Human Services. My name is Stephen King, and I'm one of the commissioners on this inquiry. My fellow Commissioner is Richard Spencer and Special Adviser is Sean Innis.

I'd like to begin by acknowledging the Traditional Custodians of the land on which we meet today. I would also like to pay my respects to Elders past and present.

The Commission was requested by the Australian government to undertake this inquiry in April 2016. The inquiry was to be undertaken in two stages, the first stage a study report and the second stage an inquiry report.

The purpose of this study report was to identify the services best suited to reform and the final study report was released in December 2016 and identified six services as best suited to reform: end-of-life care, social housing, family and community services, services in remote Indigenous communities, public hospitals, and public dental services.

Following the release of the study report, the Commission commenced its inquiry report to identify and assess reform options in each of these priority services. A draft inquiry report was released in June which printed the Commission's draft recommendations for each of the services. We've talked to representatives from the Australian state and territory governments, service providers, peak bodies, unions, academics, researchers and individuals with an interest in the issues and held roundtables throughout the inquiry. We've received over 500 submissions over the course of the inquiry. We are grateful to all organisations and individuals that have taken the time to prepare submissions and to appear at these hearings.

This is the first public hearing for this inquiry. Following this hearing, hearings will also be held in Canberra, Melbourne and Perth. We will then be working towards completing the final report having considered all the evidence presented at the hearings and in submissions as well as others informal discussions.

The final report will be submitted to the Australian government in October. Participants and those who have registered their interest in the inquiry will be advised of the final report's release by the government, which may be up to 25 parliamentary sitting days after completion.

5 The purpose of these hearings is to facilitate public scrutiny of the Commission's work and to get feedback on the draft report. Now, we'd like to conduct these hearings in a reasonably informal manner, but I do remind participants that a full transcript is being taken, and that is what the microphones are for. It's a fairly small room; hopefully we can all hear each other. Because of this, however, comments from the floor cannot be taken, but, at the end of the day's proceedings, I will provide an opportunity for anyone who wishes to do so to make a brief presentation.

10 Participants are not required to take an oath but are required under the Productivity Commission Act to be truthful in their remarks. Participants are welcome to comment on the issues raised in other submissions.

15 The transcript will be made available to participants and will be available from the Commission's website following the hearings. Submissions are also available on the website.

20 For any media representatives attending today, some general rules apply: please see one of our staff for a handout which explains those rules. We've got Brad and Anna if anyone needs those.

25 To comply with the requirements of the Commonwealth occupational health and safety legislation you are advised that in the unlikely event of an emergency requiring the evacuation of this building, you should follow the exit signs to the nearest stairwell. Lifts are not to be used. Last time I looked, we were on the ground floor. Please follow the instructions of floor wardens at all times. If you believe you are unable to walk down the stairs that you don't have to walk down, it is important that you advise the wardens, who will make alternative arrangements for you.

30 Participants are invited to make some opening remarks of no more than five minutes. Keeping the opening remarks brief will allow us the opportunity to discuss matters in participants' submissions with more detail. Now, we are trying to keep to a pretty tight schedule, so if you're able to keep to the five minutes in opening comments, that would be fantastic.

40 I'd like to welcome our first person appearing at these hearings: Yvonne McMaster from Push for Palliative. Before starting, if you could just formally state your name and the organisation for the transcript.

DR McMASTER: I am Dr Yvonne McMaster and I'm with Push for Palliative. I've been a palliative care doctor for 40 years. Now retired, I'm a full-time advocate for more palliative care and better aged care. For its first 30 years palliative care was not a specialty, but there were some doctors like me who worked full time looking after people who needed what we

now call palliative care. It took those 30 years to build up enough knowledge to call palliative care a specialty, which, since 1997, requires specialist academic training.

5 Palliative specialists now have both the knowledge and the means to control most pain and other symptoms and to relieve much of the suffering that attends the end of life for both patients and their loved ones. It was in my retirement when I was leading a weekly support group for people with advanced cancer that I began to realise that instead of government's enhancing and supporting palliative care services, they were treating them as cash cows, a convenient place to take money when your bottom line needs propping up. I think, sadly, this can happen because nobody is in a position to complain about palliative care when it is under resourced. The dead can't speak; the weak are too sick to speak; the family want peace after the distress; and the employed professionals are forbidden to speak about the suffering they see but are sometimes too stretched to relieve. So palliative care is seen across Australia as a "quiet cut".

20 But I can speak now, and I'm very, very grateful for this opportunity to comment on the draft report. I want to congratulate the Commission on its research and on the draft, yet it fills me with apprehension. First, I want to stress that palliative care is not just needed for the last year of life. Both cancer and chronic conditions can progress slowly and their course can play out over years, not just months. Personally, I've been involved in the care of many people in the last five years of life. Time lines are not set in stone, so there can't be a time limit for when specialist palliative care is needed and can be brought in to provide pain, symptom relief and to give support.

30 My second concern is the Commission's desire to "use competitive processes to select providers or a single provider to deliver additional community-based palliative care services." I agree that the palliative care services do require enhancement, but the model we currently have of having specialist physicians, nurses and allied health employed by the state governments is not a failed one of itself. The only thing that's failed is that governments and health bureaucrats in state health departments and local health districts haven't grown the workforce, instead, in some places, they've reduced it. This is a failure of politics, not practice.

40 The draft acknowledges that palliative care services are stretched. I see that across New South Wales. Much more is needed, but why bring in another level of organisation needing more bureaucracy and increased difficulties of integration? That's the thing that gets me.

45 When we should be doubling down on the system that works, it seems that we are going all out on an outdated model, ignoring all that was learned

over the last 50 years. In what other branch of medicine would this be tolerated? It's like asking the cabin crew to fly your airplane:- it might have worked 100 years ago, but planes - and palliative medicine - are a bit more sophisticated today.

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What we are seeing playing out in western Sydney right now is a non-government organisation contracted to provide end-of-life care services for only the last three months of life based mainly on GPs, RNs and care assistants at an annual cost of \$1.72 million. That would have paid for two additional palliative specialists and 10 additional palliative care nurses or allied health. That would have brought their existing service up to gold standard, providing much better care than anything the new service could possibly provide and without the problems of how to deal with handing over dying people and their families from one service to another.

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What I fear is the introduction of an outdated model of generalist-based community palliative care services using GPs, non-specialist nurses and assistants in nursing for personal care. This does risk turning the clock back 50 years to the time when there was no expert training in palliative medicine or nursing and when each clinician had to learn on the job at the expense of patients and their families. This model is outdated and not as good as is claimed by those promoting it. It's failed in Queensland and has been rejected in much of New South Wales.

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If governments must use a variety of services to supplement the struggling specialist palliative care service, it will be vitally important to give contracts to services that offer adequate numbers of specialist palliative physicians, nurses and allied health to meet the community's needs. And please don't expect families and patients in their last year of life to be in a position to make a choice between a range of services; it's hard enough for governments to choose.

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The care available in aged-care facilities is of particular concern in this regard, and this is my last point: the fact that the Commonwealth doesn't mandate that there must be registered nurses 24-7 is a shame and a disgrace. For dying people not to have access to as-required medications is unacceptable. How can we mandate staffing in child care and not in aged care? There also needs to be, as your excellent draft states, much more access to and integration with specialist palliative care. At this time in New South Wales some LHDs have employed specialist palliative care nurses to attend aged-care facilities when asked, advising and training staff. They are thin on the ground, but they are a start.

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I thought you'd like to know about one outstanding approach in New South Wales. It's delivered by something called the palliative care aged

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care consultative service in southern New South Wales. They contract to aged-care facilities which are visited by specialist palliative care nurses at least once a week. She spends up to eight hours in each facility seeing patients, meeting relatives, having discussions, making clinical recommendations, upskilling staff in capacity and confidence, liaising with GPs and ensuring that the necessary medications are on hand. Advice is available 24-7. This service reduced transfers to hospital by two-thirds in its first year of operation. It has changed the culture in all the facilities it covers.

Payment for these services is directly from the facilities, but the service also saves the state government squillions. Adjusting the ACFI funding rules to allow palliative care to be funded for a longer period, as you recommend, will help more facilities to be able to afford such an excellent service.

We have a tried and tested palliative care system. We know it works. It just needs more workforce in the community, visiting nursing homes and in acute hospitals. All this with a net saving to the public purse, which can be demonstrated. I ask the Commission to consider these points, and I thank you very much.

DR KING: Thank you, Dr McMaster. Can I just the first question by following up on that last point, which is the palliative care aged-care consultancy service that you point out is an excellent service. You mentioned that funding is one of the barriers to this service being used more widely by aged-care facilities.

DR McMASTER: Yes.

DR KING: Is it the only barrier, or what other barriers do you see to rolling out this sort of model more broadly through the aged-care services?

DR McMASTER: I'm really not aware of any other problem. The service is itself expanding; it is based in Bowral in the Southern Highlands, but it has now expanded down to Goulburn and to other parts of south-west Sydney. So it's only a matter of getting aged-care facilities to cough up. It might also have been a little bit hampered by the fact that the ACFI funding started to be a bit more tenuous. Facilities were charged and there was an inquiry into facilities which used the palliative care grading that gave them 12 points, I think, which allowed them to get additional funds from the Commonwealth. Those investigations have frightened facilities and have prevented them from saying that they were using palliative care.

DR KING: I see. But the one that are using the service, essentially it's being funded by the aged-care facilities themselves?

DR McMASTER: Yes, and through the ACFI funding, really.

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DR KING: Yes. I guess the question is: why have some aged-care facilities taken it on and why haven't others taken it on? Is it just that a small group of them have seen the light and say this is the way to go, or what?

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DR McMASTER: I think it's partly that and it's partly how much funding each facility receives. Certainly there are some areas where aged-care providers employ palliative care nurses. For instance, Uniting Care has one palliative care nurse for about 60 or 70 facilities, which is ridiculous. Anglicare, the Anglican care one, has two nurses for numerous facilities, but it's not enough investment by any means. I think they don't appreciate how much benefit they can receive. But I guess there are also a lot of facilities that are struggling.

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DR KING: And, again, this is for my own clarification: the palliative care aged-care consultancy service, that type of service, you would see that as an alternative to a full-time RN or as a complement to a full-time RN?

DR McMASTER: I think a full-time RN is essential, everywhere.

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DR KING: Again, just on the clarification from your opening remarks area, I just wanted to follow up a little bit more about the current system, because you mentioned in your opening remarks, and you mentioned in your submission, that the current model community palliative care in New South Wales where specialists doctors, nurses and allied health are employed by LHDs or NGOs contracted to the LHDs works fairly well. Do you mind just expanding on what bits of the current system work well, what bits need work, which bits work better than others, just to understand why you think this current system works pretty well and that approach?

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DR McMASTER: Of course metropolitan services are better resourced than rural services. Metropolitan has been able to attract more funding to palliative care services than rural services have. Rural services are very significantly neglected – very significantly neglected. They work well. For example, a rural service that works really well is Coffs Harbour, which has now for five years had a palliative specialist physician. You probably know that very few rural centres have palliative physicians. Since they've got their palliative physician in Coffs Harbour, home death rates went from 18 per cent to 70 per cent, so that's been a really wonderful achievement.

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I just have to tell you, there's something very nasty that happens: it's frequently quoted that 14 per cent of people in Australia die at home and 70 per cent would like to. Then services quote figures which don't relate to the Australian population; they relate to people who agree that they want to be at home who are within the palliative care service and want to be cared for at home, so a very select population. That's also the population that I'm talking about in Coffs Harbour, although the 18 per cent before the physician arrived was of the patients enlisted with their service. So they were palliative care patients; it wasn't everyone in the community that was aged care or whatever. That's a genuine increase, but there are many other comparisons made in quite a lot of papers saying that 70 or 80 per cent is achieved. Well, it's not 80 per cent of the Australian population.

DR KING: You mentioned Coffs Harbour. So can I take it from your comments that there are big differences in rural areas?

DR McMASTER: Yes.

DR KING: That some people miss out in rural areas.

DR McMASTER: Yes.

DR KING: Coffs Harbour is an area - - -

DR McMASTER: It was an exceptional area. I'd love to tell you about it terrible miss-out job.

DR KING: Please.

DR McMASTER: Tamworth, which is a town of 60,000 people with a surrounding area of 100,000, has one specialist palliative care nurse – actually now two, just arrived. At one time they had a palliative physician who used to cover had whole district right up to the New South Wales border. He would go visiting rural towns and treating people. For at least five years that's not been the case and they've made no effort to replace that doctor, although there are doctors who'd like to go there. So there's a distinct problem with some local health districts who can't see the point. After all, the dead can't speak.

DR KING: So do you see the individual local health districts as being the main barrier to scaling up this system, that some get it and some don't?

DR McMASTER: Yes.

DR KING: Or are there other barriers?

DR McMASTER: That's a pretty big barrier. The New South Wales government has got the message now, I'm pleased to say. It's taken a while to get it to them. But, yes, I think local health districts are struggling. They have a tough time. They're not given as much funding as they'd like to have, and from time to time they're told they've suddenly got to take up mental health or some other area and they're not given additional funding generally for that. But it has been shown that having specialist palliative care can actually reduce costs, and it's been hard to get that through to them. It's their costs that they're looking at: the costs of running their hospitals.

DR KING: Do you think the \$100 million in the state budget this year is going to make a big difference to that?

DR McMASTER: If it goes in the right direction. The first tranche is to go out to rural areas, which is excellent. They've announced six additional physicians for rural areas. If we can fill them, that will make an enormous difference. They've announced additional nurses for rural areas and training for nurses. Some \$41 million has been set aside, in fact, to be used after the roundtables which the minister organised, the findings are released. Hopefully it will mean that there'll be more specialist palliative physicians throughout New South Wales and nurses and allied health to do the job.

DR KING: Sorry, I'm still clarifying from your opening comments.

DR McMASTER: I like you clarifying.

DR KING: You have put this emphasis on the palliative care specialists. I guess there are two questions there: one is on workforce training. Are there appropriate training pathways for specialists in palliative care at the moment? If not, what needs to be done? If there are, great. To what degree do you see a gap between what's needed and what isn't? Then I also just want to come back to you about the generalist care. The first question is training: do you see a gap there?

DR McMASTER: There are appropriate pathways, both for physicians and nurses – and allied health. The problem is getting people in rural areas to take it up. They have a slightly separate pathway. They're developing gradually an idea that the nurses, if they have a specialist nurse in the area, can train up another nurse, so a buddy sort of system. And then there are online training courses or a course can be attended. The last budget – the \$100 million over four years – that gave some money for scholarships, because that was a barrier, and that will help.

5 It's going to be tricky, though, to get New South Wales Health to actually aim that at specialist palliative care. Unfortunately, it seemed at the moment that New South Wales Health has a mindset that pretty well anyone could do palliative care. In fact, a deputy director-general said to me once, "Well, I think I could train a monkey to do palliative care." So it's not very encouraging, I have to say.

10 **DR KING:** Do you see more needing to be done in the formal VET, university space?

15 **DR McMASTER:** I think more is about to be done. In this announcement there was funding for 300 nurses to have training. What I have to do is convince New South Wales Health that that should be specialist training for nurses for which there'll be funded positions. Because there's no point training in something and not having a funded position. And the problem is I think Health thinks that what they can do is train just generalist nurses a little bit so maybe they understand a little bit about holding someone's hand or maybe giving them a shot of morphine when they need it. But generalist nurses have duties to do a lot of other things apart from palliative care, so the general community nurses spend most of their time doing wound dressings and so forth. They would be lucky to spend five per cent of their time doing palliative care.

25 The thing that we've learned over the years is that you need to develop clinical acumen about seeing someone approaching the end of life, seeing what their level of pain is, assessing issues, knowing how to manage delirium which occurs in a third of people at the end of life and is very hard to manage and lives on in the memories of the people that are left behind when they see their loved ones ending their life delirious.

30 So there is a lot to learn, and I don't think that training up the whole mass of community nurses that have got all these other things to do is economic for one thing. I think we need specialist nurses to do those things, people who really can spend all of their time seeing people in their last years of life and assessing symptoms and seeing what happens when you give a dose of morphine to one or a dose of morphine to another – it's different – or what the other new wonderful medications are, and then having the experience and the confidence to be able to advise the GPs that maybe have to write the prescriptions. Those sorts of things all needs experience. As I said, it took us 30 years before we could be a specialty.

DR KING: Thank you very much for that.

45 **DR McMASTER:** Sorry, you were going to go on.

5 **DR KING:** Let me ask a final general question and then I'll pass over to my colleagues. I guess at a general level we've run through a number of issues and you've really pointed out the key issues that you see affecting end-of-life care in Australia. Do you think our draft recommendations are on the right track?

DR McMASTER: Yes.

10 **DR KING:** Do you think if our draft recommendations were implemented in full it would make a big difference? Where do you see the holes being specifically in our draft recommendations? If you were able to get out the red pen, I guess, what would you put it through? Where would you add?

15 **DR McMASTER:** The first thing is my worry about the first model I've seen of additional services. We've had two additional services now in New South Wales: the New South Wales government about three years ago brought in end-of-life care packages for people in the last few days of life. And they were quite good, but they were limited in their scope because the last few days of life is pretty short and people are actually in serious decline
20 for much longer than that. And that was quite good in being able to interact. It managed to integrate with the palliative care services that were operating. And it wasn't really called for that they have particular expertise; they were mainly giving personal assistance. So that worked quite well.

25 But what we're seeing in western Sydney is an actually takeover of the palliative care community service with a much lesser service. So it would be very alarming for that to be the model that would be taken up. It would be alarming if any model is taken up which doesn't have enough expertise.

30 I go to a rheumatologist for my arthritis because I know the rheumatologist understands the complicated medications, and if the first one doesn't work, she tries another one, and I'm confident in that. She knows what to do if things really don't work. But we can't expect GPs to know everything, and they don't, and they don't see enough of everything.
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DR KING: Thank you for that.

MR SPENCER: One issue I just wanted to explore a bit further – and you mentioned this a few times – is the fact that we as a society don't talk about
40 this. So people are normally confronted with this at a very stressful time of life.

DR McMASTER: Yes.

MR SPENCER: So the general level of literacy around palliative care is perhaps really lacking in the general public.

DR McMASTER: Yes.

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MR SPENCER: What thoughts do you have about that in terms of how that could be helpful for people to make better decisions, be more informed and make better choices about end of life?

10 **DR McMASTER:** I honestly think it's a little bit limited to be frank because if you think about it, actually being told you're going to die is a very, very threatening thing. And very few people want to face that discussion. Even if we go and we have – as you'll hear later today from GroundSwell, which is an excellent organisation – they have death cafes
15 and places where people start to talk about it. This is a movement throughout the world; it's happening. It still is very hard to conceive that you're going to reach the end of your life, that you're not going to be here anymore, and people one from that. I really don't know how much we can change the whole attitude.

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I know we changed the attitude to sex and – wow – look where that led us. So maybe it's possible, but it has been a concern for me that governments are looking perhaps a little too much at, "Let's all talk about it." What happens if we all do, as I do, and say in my advanced care
25 directive, "In these circumstances, I would prefer to have palliative care," and palliative care's not there?

MR SPENCER: You mentioned western Sydney a couple of times. Could you tell us a little bit more about that model?

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DR McMASTER: Yes.

MR SPENCER: Is that the local health district?

35 **DR McMASTER:** Well, yes, it was, although it was clearly initiated through the state government and through the social impact group within Treasury. There's a social impact investment group within Treasury. There's been a lot of talk that maybe social impact investment funding would be a good thing for palliative care, because we all know how much
40 money it would save. You've heard the stats for New South Wales: a billion dollars is spent every year on just admissions to hospital in the last year of life. What that means is 40 days, on average, in hospital in your last year of life spread out over an average of four admissions. That's distressing, actually, and that's distressing, because many of those
45 admissions could be handled by a properly resourced palliative care service

with proper 24-hour cover and where people were monitored, so that people know who they're ringing and they know that they can get the right, appropriate help so they don't have to ring 000 and go to hospital. Sorry, I've gone off the question.

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MR SPENCER: No, that is very helpful, thank you. Just going back to an earlier comment that you made about eligibility, we adopted what we understand to be a generally accepted definition of "end-of-life care for the last 12 months".

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DR McMASTER: Yes.

MR SPENCER: You mentioned in other situations up to five years. What thoughts do you have about that eligibility issue? How do we determine that?

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DR McMASTER: I was especially troubled by mention in the draft that it would be more expensive to extend it to a longer period, and I guess it would, but, again, the savings still remain. Once people start to have conversations with people, for instance, with advanced cancer, then the treatments are often modified, people start to be realistic. That kind of thing is very helpful. Sorry, I've forgotten now where you were.

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MR SPENCER: Just on the eligibility issue as to when does a government determine - - -

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DR McMASTER: Well, there's no doubt that palliative care has to start much earlier than the last year of life. People with cancer are living much longer now, but they're having symptoms on the way and they're needing supportive care, which palliative care services provide.

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The other conditions – kidney failure – where palliative care has become very useful and starting to be integrated earlier in some areas, respiratory disease, cardiac disease and dementia, all of those areas, they're not a one-year decline; they're really going on for years, and they're having problems and they need to have help. Having palliative care integrated, really, into each of those specialties would be very good.

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MR SPENCER: Thank you.

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MR INNIS: Yvonne, I just want to start by saying thank you for all the work that you've done and clearly in promoting a very important set of issues. I want to start by acknowledging something, which is clearly this is a system that's evolving over time. We're conscious that we're starting from a very unsophisticated system, and what you've described to us is

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quite a sophisticated system. The question that we will wrestle with in our recommendations is a pathway forward. I just want to confirm that what we've recommended so far is a step in the right direction, even if it's not perfect from your perspective.

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DR McMASTER: I'm not sure what you are envisaging, really, if you have supplementary services. I'd be much happier to support that suggestion if I knew that those supplementary services would incorporate specialist palliative care or if I knew that what you're suggesting is just personal care that people can have in their homes and doesn't have to have expertise and you can build up the palliative care services. But I don't quite understand what the recommendation is.

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MR INNIS: Thank you. So some more detail on how it would work and what it would involve would give you more comfort?

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DR McMASTER: That's right. It would.

MR INNIS: Can I ask also, we've talked about the local health districts. If you were moving toward where someone was actually caring and planning for the palliative care needs of a region, would that be the right body to do that work? So the planning and the making sure that the right people were broadly in the right spots? Is that where you would start?

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DR McMASTER: Yes, if they understood the needs. One of the problems is exactly that: the people who are running things don't actually have any clinical background and don't understand palliative care. You would be aware that in rural areas, for instance, there might be just a group of palliative care nurses – not a specialist physician at all – and they're reporting to a generalist nurse who's climbed her way out of the mass and she's now an administrator, usually doesn't listen to what's needed, doesn't understand what's needed, really, and that's hampered palliative care dreadfully.

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Similarly, in local health districts, it frequently happens that they get a little bit of extra funding for a palliative physician, for instance, but it's held up somehow in the LHD and the palliative care service doesn't even hear about that funding. A nice amount of money to use in another way. It would be good if there was some governance on that. I could imagine having a really good advisory service.

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MR INNIS: You've used that term a few times – “advisory service”. It sounds like there's a greater need to connect what I'm loosely going to call the normal medical system with the palliative care system so that people

hopefully don't start in palliative care; they move into palliative care over time. Is that one of the things?

5 **DR McMASTER:** Yes. But can I give you an example of how I think we could do that better, and that's in the acute hospitals. When I was a palliative specialist in Hornsby Ku-ring-gai area in Sydney, I used to visit Hornsby hospital. When I was there, each time the junior doctors changed teams – which was every three months – I would give the ones in the medical team a talk about palliative care. Then they knew me and they
10 could ask me when there were problems and they could follow me around if they had time. So that was a way to start at the grass roots to get people to understand.

15 And in hospitals such as North Shore where they have a palliative physician full time, he consults with the other clinicians and is well respected. That's very important. So acute hospitals must have palliative physicians and nurses, but particularly physicians, because doctors don't really listen to nurses very much, I'm sorry to say. They can be showing and modelling the right behaviour with patients. They sit down next to the
20 bed; they don't stand at the door and say, "I'm sorry to tell you, mum's dying." And that happens. They can model good behaviour, so people can learn. I think that's the way to integrate rather than have programs and schemes and regulations.

25 **MR INNIS:** Thank you. That's very helpful.

DR KING: On behalf of the Productivity Commission, thank you very much, Dr McMaster. That was very helpful.

30 **DR McMASTER:** Thank you very much.

DR KING: Can I now call on the representatives of the Australian Dental Association New South Wales Branch and the ADA. I think
35 Mr Stengos, Ms Miranda and Ms Sivaneswaran.

MS MIRANDA: Can we just clarify: is the federal ADA and the New South Wales Branch speaking together?

40 **DR KING:** Yes. If there's another member, please. I'll get you all to state your names formally. If you could state your name and your organisation for the record.

MS MIRANDA: Kate Miranda with the Australian Dental Association New South Wales Branch.
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DR SIVANESWARAN: Shanti Sivaneswaran, Policy and Advocacy Adviser, New South Wales Branch of the Australian Dental Association.

5 **MR STENGOS:** Stes Stengos, Chief Executive Officer, the Australian Dental Association New South Wales Branch.

MS IRVING: Eithne Irving, the Deputy CEO and General Manager of Policy for the Australian Dental Association federal body.

10 **DR KING:** I hope you've coordinated; if not, please, let me know, but I ask you to make a five-minute opening comment.

15 **MS IRVING:** Thank you very much, commissioners, for having the ADA again. We've had the opportunity to speak to at least someone from your organisation – I can't remember exactly who it was. We are really thankful for this opportunity to elaborate a little bit further on the submissions we have made during this whole consultation process. I don't think we probably need to tell you that we're the peak body representing the more than 16,000 dentists now registered to practice in Australia, and we are the
20 body that represent those, plus the students that are actually coming through the system as well.

Before I outline to you today our view on the draft recommendations in your report, I'd like to emphasise that any discussion on oral healthcare
25 policy must recognise at the outset that most oral disease can be prevented through good personal oral hygiene, adequate and appropriate diet, abstinence from substances such as tobacco and alcohol and, importantly, community-based preventative activity such as water fluoridation and regular treatment or regular assessment by a dental practitioner.
30 Accordingly, policy makers at all levels of government must provide investment and ongoing commitment to support and promote these measures.

Turning to the draft recommendations that relate to public dental
35 services, the ADA believes that we need a very, very strong public dental system in this country. But we feel that the recommendations do not adequately take into account where Australia's dental infrastructure and workforce actually are. In Australia less than 20 per cent of practitioners work in public dental services. The majority of the workforce and the
40 infrastructure are in private practice. At the moment, we also have an oversupply of dental practitioners because we are training more than we actually need and we're bringing more into the country through migration processes.

According to Health Workforce Australia, we're going to be in a state of oversupply for quite some time into the foreseeable future. Therefore, any increased funding or proposed models that the Productivity Commission choose to put forward must really reflect the reality on the ground. We don't feel at the minute that the draft recommendations do this. They don't adequately acknowledge how the states and territories have responded to the provision of services due to their lack of infrastructure by using voucher systems to effectively and efficiently help public system patients get the care they need.

In this environment where it is unlikely that governments – state, territory or Commonwealth – will commit to a large, sustained increase in investment of public dental services any time soon, we really urge the Commission and policy makers to recommend existing arrangements be improved and allocate the funding to dental services through the national partnership agreement processes rather than endorse theoretical models that are inadequately tested and not developed in consultation with the dental profession.

The thrust of the draft recommendations propose a consumer-directed care approach to public dental services that pays participating providers based on a blended payment model comprising of risk-weighted capitation payments, performance-based outcome payments and activity-based payments. They also envisage state and territory governments using a centrally managed allocation system to provide access to consumer-directed care as well as outcomes-based commissioning systems for public dental services from which greater contestability would be introduced.

From a consumer perspective, the ADA has no evidence that risk-weighted capitation schemes used elsewhere have been successful. Capitation schemes encourage cherry-picking treating priorities and do not enhance consumer choice of provider. They, instead, lock consumers to certain providers who may have capitation in place.

Capitation schemes are not a suitable model for procedures where patients have complex or special needs. The model is unlikely to be effective as it ignores the reality that a large proportion of prioritised patients already require emergency treatment. Dental care should, therefore, continue to be provided on a fee-for-service basis, which is the most competitive and efficient model and provides the most predictable outcome for consumers.

The ADA does not support the proposed blended payment and care model considering the constraints of the public dental system. The draft report already acknowledges that the reason public dental services do not

5 focus on prevention and early intervention is that they usually receive patients with major complex problems, emergency and restorative treatments. The ADA, therefore, recommends that priority patients still be able to receive the next available appointment irrespective of their dental symptoms rather than go on a waiting list.

10 Furthermore, there have been cases where patients who have received treatment are re-inserted on the waiting list, raising more doubts about the usefulness of the current methodology of waiting lists. Instead, these patients should be put on a maintenance program so their dental health does not deteriorate. This currently does not occur.

15 Thank you, and I know that my colleagues of the New South Wales Branch would like to add to my opening statement.

20 **DR SIVANESWARAN:** Thanks again for this opportunity to present at this hearing. Obviously we are the ADA New South Wales Branch of the federal ADA, and we represent dentistry in New South Wales and ACT. If you look at delivery of dental services, there is considerable variation across states and jurisdictions. The reason why we've put in two previous submissions is to highlight the issues that exist in New South Wales. Given the differences and complexities so far as eligibility criteria, the delivery of dental services, waiting time, reporting mechanisms, the population size and the differences across states, we felt it was critical that we put in our submission.

30 From our perspective we definitely agree with the Commission that public dental services definitely need to be reformed, and you've highlighted issues about difficulty in accessing dental care. For example, in New South Wales we have 47 per cent of our population eligible for dental care. Again, it varies across the states and jurisdictions. We have about 17 per cent of the dentists in the dental workforce. The latest data shows that only six per cent of the dentists access public dental care. So obviously there is a huge gap between eligibility and access to dental care.

35 Obviously there are reasons for reforming public dental service, but we do believe that the reform should be reducing inequalities in oral health and access to dental care which currently exist. Most of Australia's – and New South Wales – population have got good dental health, but there's a small portion – about 30 to 40 per cent – of the residents in New South Wales have disproportionately poor oral health.

40 There are also differences across jurisdictions about delivery of dental services, for example, in New South Wales there is a predominance of private practitioners. If you look at the latest child health data survey report,

75 per cent of children in New South Wales access private practitioners, and the national average is 50 per cent. So there is quite considerable differences and characteristics across jurisdictions.

5 Obviously to increase delivery of dental services to those currently having an unfavourable pattern, we need to use private practitioners because our major workforce is in private practice. So ADA New South Wales concurs with the federal ADA that a more competitive framework within the dental health sector can be achieved through a cooperative
10 approach between private and public sectors.

In our previous submissions we have provided evidence on how this works, and this in New South Wales has been since 2000 when the state government introduced a fee-for-service scheme and later more recently to
15 the national partnership agreement, so we have provided data on how using private practitioners has reduced the waiting lists in New South Wales.

In summary, the utilisation of private dentists and private infrastructure makes economic sense and has proven very successful in reducing the
20 number of patients on public dental waiting lists. But our submission also provides evidence that wide emphasis needs to be placed in investing and building the capacity of the public dental services for vulnerable groups of patients. Like Eithne emphasised, we really need a strong public sector. We talk about prevention, and Eithne has alluded to it. We are very lucky
25 with dentistry: we have got water fluoridation and New South Wales has one of the highest rates of water fluoridation in the country, except for ACT, which obviously has one water supply so they have 100 per cent fluoridation.

30 When you think of prevention, there is the community prevention and then there is the prevention at individual level. So I think with water fluoridation, obviously the state government has done a great job, and we need things for population health preventive measures, for research, for education, for training dental students, we need a very strong public dental
35 sector. So I think the underlying problem is the funding. The funding of public dental sector has been quite poor, and the Commission acknowledges this. I think for years it has been this buck-passing between the federal and state governments of who is responsible for funding. With every political cycle a new scheme comes in and then the next three years another scheme
40 comes in. The worst part of it is that none of it has been evaluated so we don't know which of these schemes work.

A well-supported public dental sector is required to deliver the oral health population strategies with strong emphasis on the social determinants
45 of health: research, education and training. Our submission also talked

about the importance of integrating oral health into general health. It's basically putting the mouth back into health. For a long time, oral health has been sitting as a silo. The WHO recommends that if you really want to improve oral health – which is really important because oral health is a risk factor to general health – they have recommended the approach of integrated oral health to general health, what we call the common risk factor approach where the risk factors for oral health are very similar to national priority health areas, like diabetes, obesity, cardiovascular disease. That is what we've recommended: integrating oral health into the general health and using this common risk factor approach to improve oral health and general health.

With regards to the latest draft report, Eithne has actually highlighted some of the concerns we have with it. We believe there's not enough detail, clarity or evidence base around some of the recommendations. I think in general we believe the proposed direction requires a huge paradigm shift and it needs substantial system-wide structural changes, a huge amount of funding and a strong national leadership to implement these changes. We've previously recommended in our submissions – and the dental profession has been advocating this for years – to set up an office of the federal chief dental officer. It is not just establishing a federal chief dental officer and appointing one but also have policy workers who have a strong technical knowledge in developing policies and implementing and overseeing the development and evaluation of these schemes. Or even maybe like re-establishing the National Dental Advisory Council, which was around a few years.

In summary, the fundamentals need to be correctly described in detail. Any public scheme that would involve private sector dentists needs to be well structured, adequately and fairly policed, incentivised, promoted with integrity and bereft of bureaucracy before it would attract participation of private sector dentists.

DR KING: Thank you very much, Ms. Irving and Ms Sivanewaran. Again, I'd like to ask some clarifying questions on your opening comments before passing over to my colleagues. Just on vouchers, one of the reasons that we've moved in the direction that we did in our draft recommendations was because it was suggested to us that vouchers aren't good value for money. Please, correct me if I'm wrong, I assume you agree with that. But how would we know if the voucher systems are good value for money for government and the taxpayer?

MS IRVING: I'm not a dentist, let me just put that out there upfront. I've never actually used a voucher or given one out or seen one, for that matter. But I guess my understanding of how the voucher systems work is that the

state and territory services recognise that they can't provide treatment in either a timely manner or in a location where that patient can receive treatment. This is correct?

5 **DR SIVANESWARAN:** Yes.

MS IRVING: But they determine what the value of that voucher is and what the treatment is that is intended to be provided. Am I correct?

10 **DR SIVANESWARAN:** Yes. I can speak on behalf of New South Wales. In New South Wales we do have a system called the priority oral health program, which is a computerised system. When a patient eligible for dental care wants to get an appointment, they ring a central call centre and they are asked a series of questions. Depending on how they answer the series of questions, they are given a coding. Each of these codings have a waiting time. So if it's an emergency time, they have to be seen within 24 hours. If it's more like general dental care, it could be anything from three days to about six months, depending on how many patients there are on the waiting list.

20 If they can't be seen within that clinically acceptable time frame, they are given a voucher to access private dental care. There are only certain items of services that they are allowed to access, and dentists who want to participate in this scheme have to sign up and register for it. With New South Wales there are about 16 to 18 local health districts, and each of the health districts have got a different number of practitioners participating in this scheme. So there are scheduled items of services that these dentists can provide, and they are also ascribed fees based on the Department of Veterans' Affairs.

30 So to answer your question, we know in New South Wales what is done has definitely improved access to dental care for these patients who currently cannot access dental care within that period of time. So we definitely have major improvements and we can see the waiting list has decreased. But to answer your question about value for money, I don't know whether there has been any modelling done to see whether that is value for money. All we know is that it's definitely achieved a goal of improving the access to dental care for these patients who were previously denied access to dental care. But I don't know about the economics of it and whether it is value for money. I haven't seen any evidence or any studies done that have looked at it.

40 **DR KING:** Part of my reason for that question is I know from your submission, the ADA submission, you raise some concerns about the IHPA's pricing for dental services in the hospital context and a feeling that

that pricing wasn't correct. Now the vouchers are based on the DVA pricing. I'm wondering how we put those next to each other – the IHPA has got it wrong in the hospital context but somehow the DVA price is a right price.

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MS IRVING: I can't speak to that one, Commissioner. The DVA fees would not be considered to be contemporary at the current time. There is somewhere between 5 and 35 to 40 per cent differential between the main fee charged by dentists across the country and the rebates payable through the DVA scheme.

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DR KING: Sorry to interrupt, but which direction? Presumably the DVA is lower?

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MS IRVING: Negatively. The DVA is the lower. So it's an issue that we raise with the Minister for Veterans' Affairs on a regular basis. In fact, the freeze that occurred as part of the whole rebate freeze on Medicare flowed through to the CDBS and the DVA. That has really caused significant difficulties for a lot of practices who are now providing services well below the cost of actually providing it, because they want to provide services to DVA. But unfortunately DVA is used as the benchmark for lots of different schemes, such as public sector voucher schemes. The Transport Accident Commission in Victoria use the DVA. The CDBS – the Child Dental Benefit Schedule – is based around the DVA scheme. But the problem is those rebates are actually well below what would be considered to be the mean fee charged in private practice. So they are a benchmark of sorts, so we wouldn't necessarily say they're what should be charged or what the rebate should be.

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Now with the hospital thing, what's happened is that the reason we don't support the DRG model as it's currently structured for dentistry is that there are only I think two DRGs that relate to dental, and one of them is DRG D40Z for dental extractions and restorations. That is a bit of a catch-all, so if you go into hospital and you require to have extensive restoration work done under general anaesthetic, let's assume that you're a patient who has some other form of disability or some complex medical problems that you can't actually be treated in an outpatient setting in a dental practice and you need to have that treatment done under GA, the hospital gets the same rebate for you as it does for maybe a six-year-old child who has come in and just wasn't able to sit in the chair and has no complications, it's a quick procedure.

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We feel that that DRG model does not adequately reflect the complexity of some of those cases. If you're having restorations or an extraction, you fit in this group, and it doesn't matter what else is going on

or why you needed it in the first place. We do have some concerns around the way the DRG model works in dentistry.

5 We've previously tried to support a submission from the public dental sector in order to have that DRG reviewed, but at this stage it was felt by the group who does that – the Australian Consortium for Classification Development – that there wasn't adequate evidence to justify splitting the DRG further. That's not to say that that is not the right body who could potentially come up with a model, but we would certainly want there to be
10 extensive consultation. We would need to get access to data about fees and services charged across the country, and the only people that hold the majority of that data are the private health insurers, and they don't make it public. I guess we're a bit nervous. As a general thing, we're not comfortable with just picking that model up and running with it. We'd want
15 you to unpick it; we'd want you to work with us to actually design something.

DR KING: You mentioned data and the private health insurers. Would you see a similar way forward in revising the DVA numbers so that they
20 reflect costs, or would you have a different way of setting those DVA voucher prices?

MS IRVING: We'd like the DVA to set them based on costs.

25 **DR KING:** But how would they get that information? How would that be done?

MS IRVING: Again, you need to really get access to the data and unpick it a little bit. At the minute the ADA collects a dental fee survey and we
30 know what the mean fee is charged by state and territory and across the country. Now, what hasn't been done is the next step, which is to take that and actually then go in and do a costing analysis of what did it actually cost to provide the service. I don't know if anyone's done that work.

35 **DR KING:** A couple of other clarifications from the opening comments: firstly, let me stick with vouchers for a second. We've had it put to us – and it's reflected in the interim report – that the vouchers are too broadly defined, the services aren't well-defined and that you get, for want of a better word, overservicing in vouchers in the private sector. At the same
40 time, we recognise your submission that vouchers enable consumer choice compared to a capitation-type model. How would you address this? If there is an issue here, would you see that the services and payments for patients under the vouchers should be more tightly defined? Do you think they're appropriately defined at the moment? What's your feedback on that?
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MS IRVING: I do want to comment on this suggestion that there's overservicing. I noted that was a point made in at least two submissions that you received. If we take dentistry out of the equation and we look at something much more simple like when I go to my mechanic or even if I talk about let's say a cardiac issue and I need a defibrillator. That might be a bit more closer to the thing. Actually, I've just had a hip replacement. I've just got back to work. Now, I went privately to have my hip done and my orthopaedic surgeon offered me a range of options, but he suggested a particular type of hip replacement, which is the ceramic hip replacement. That was the one that I chose, and so I'm lucky enough that I could afford to pay the difference of what my private health insurance covered. But I had the choice. I could have had the run-of-the-mill option or I could go with the ceramic one, which is the one that I did.

What happens in private practice in dentistry is very similar. When a patient goes into a dental practice and the dentist says, "Well, I've assessed what you need done and I can offer you this, which will do you and will probably last you five years, or I can give you this type of treatment which will probably see you through 10 years, but it's going to cost a little bit more." Patients will usually go for the 10-year one, not the five-year option. They don't get that same choice in the public sector; they're limited in the treatments they can provide, they're limited in the materials that they can use. So if you go to a private practitioner where it comes down to user choice, they're always going to give you the range of options that you can have. So I'm not sure that it's really overservicing; it's probably that there are more available options in the private sector than there is in the public.

Dentists generally use a preventive model. If we didn't – I'll use the royal "we" – why would we be promoting fluoridation which actually will prevent people needing to have any dental treatment in the future. Dentistry is all about prevention. It is drink fluoridated water, don't smoke, don't drink alcohol excessively, don't eat a sugary diet, don't drink soft drinks, do everything you can to prevent you needing any dental care done at all, and then come and see a dental practitioner regularly so that you get a check-up, you get treated early if you need anything and you can have preventive measures such as scaling and cleaning, fissure sealants if you're a child. Everything that dentists do is actually aimed to try and prevent treatment because we know that once the integrity of a tooth is broken, that tooth is going to need care for the rest of your life. So we don't want that to happen; we want to maintain the integrity of your teeth.

Coming back to your issues, I don't believe there is overservicing. I believe that you just get better choice and there is a broader scope of services that can be made available in private practice that isn't offered to

patients in the public sector. I think that sometimes when patients go out on a voucher and the practitioner sees what they could do if there was funding, they are making suggestions about, “Well, did they consider that you could have had X, Y, Z done,” and that option hasn’t been given to the patient in the public sector because it’s just not a treatment they do. Would that be your experience?

DR SIVANESWARAN: To add to what Eithne said, in New South Wales there are only certain items of services that could be provided and also there have to be safeguards in place to prevent overservicing. So this issue about overservicing using vouchers, I haven’t seen any evidence to support that. Like Eithne said, probably all it’s doing is increasing the choice to the patient and not just being subjected to emergency-type dental care and relief of pain.

Again, how do you define “overservicing”? When I go to the dentist, which is usually every six months, I’ll ask for topical fluoride application every time in case I neglect my cleaning. Then when I go next time, two lots of topical application, what’s considered overservicing? Some people might consider that’s overservicing, you don’t need it. So I think the word “overservicing” is difficult in this situation. There is such a thing as supply-induced demand when there’s a whole range of services that could be offered. If I go to a dentist and it could be treated by a filling, a dentist might suggest a crown and bridge or something else. So I think with the limited scope of services which are very basic services, like preventive, early intervention and fillings, I don’t see how overservicing could occur or any evidence, because we haven’t seen any reports.

With all the safeguards in place and where there’s accountability and transparency because it all has to go back to the public sector who are monitoring and it is all done online now, I think they could easily pick up providers who are supposedly overservicing. I think it’s not like with insurance where a whole range of services are being allowed through the voucher system.

DR KING: I’m just noting the time, but one more clarification question. I apologise to my colleagues before I pass over to them. You’ve mentioned prevention. Clearly, that was a key issue in our draft recommendations, the idea that there should be outcomes-based assessment, and capitation, the blended payments model as being one way of doing that. I note from your submissions you seem to support the approach of outcomes-based commissioning in, for example, remote parts of Australia in outreach services. There seems to be a support for an outcome framework in the public dental system, but then you argue against capitation/outcome frameworks for private dentists providing services to public patients. I must

say, I have trouble understanding that position. It may be because I've got it wrong, but can you expand a little on that and how you see it fitting in with the preventive focus?

5 **MS IRVING:** I think it's more about the way you've lumped everything together. Had you unpicked some of those things a little bit, we might have given you a slightly different answer. I think there's not enough detail into how it would actually work. There might be components of it that might be sit more comfortably with us if we could just be allowed to work through
10 with you what they look like. The problem is that when you get blended models – and think you recognise this can potentially happen – there's cherry-picking that goes on. People start to take the easier patients because you know the costs will keep down and you'll be able to see all the patients that you want to see through that. As I say, I think it's partly that we just
15 didn't feel there was enough there to really explain how it would work in practice.

20 **DR KING:** If the risk weighting is done appropriately, would you see cherry-picking still as being a problem?

25 **MS IRVING:** The thing is that not everyone's going to participate. So is there going to be a heavier load on a certain component of the workforce than there is on others? I'm not really sure. As I said, I didn't really completely understand how this would work.

30 **DR SIVANESWARAN:** Like Eithne said, there's just not enough detail on some of the recommendations. Coming back to your question about the capitation, public dental services look after people who are financially and socially disadvantaged. So these are the group who usually have very complex needs and a lot of special needs. They are financially and socially disadvantaged, so they are medically compromised. I think there's a risk
35 there with capitation. Although, as you say, most capitation schemes are risk adjusted and weighted depending on how complex and how difficult it is, like, for example, if you're going to treat a special needs patient it takes three or four times longer than treating a normal patient in a chair. So unless
40 you have really clear weight or risk adjustment, I think being a provider, especially a private practitioner, I would choose not to have those sort of patients. There's also the risk that these patients will then again be left out and we will be back to where we were before – they just don't have access to dental care, whether it is public or private.

I don't know how that is going to work in this subgroup of population who are usually medically compromised, have special needs, have mental health issues and otherwise, a capitation scheme. There is also the risk of

cherry-picking. If I had a choice, I'd rather treat within that sort of money you are getting a patient who hasn't got any of the complexities.

5 **DR KING:** So is it a case of just making sure the payments for the more difficult cases, the more problematic cases, are set liberally, if I can put it that way, on the basis of the risk factor? I can see the issue if you're underpaying the harder cases.

10 **DR SIVANESWARAN:** It's not so much underpaying; it's also whether that patient will get the appropriate treatment and appropriate care. That's one of the issues with capitation from what I read of it. But coming back, again, to the payment method, the blended payment method, the Commission recommends the model that's used in the UK. Professor Jimmy Steele has done a review, an extensive review – it's called the Steele
15 review – of the national health services, the dental health component of the national health services, and if you're talking about the sort of model they've implemented – I think it was implemented in 2011 – in 2015, there's an article by Jimmy Steele that says they evaluated that based on 70 practices across the country and he said after four years there isn't robust
20 evidence of completeness to support a fair remuneration to dentists.

So I think the lessons learned from the UK experience, although the report does not tell in detail which model we're talking about, but just from the general experience and the review that Professor Steele – and he's very well
25 regarded in the dental world, everyone knows him for his critical analysis on things – he's come up to say after four years – I don't know whether there's any report since 2015 – that if you don't have fair remuneration to dentists, they won't participate in the scheme.

30 What our submission did was highlight the complexities, the concerns, the lack of clarity and the huge amount of funding and structural changes, communications strategies that are required if you're going to implement a national-wide scheme like you're talking about.

35 **MR SPENCER:** Just a quick follow-up question to that, because I think that capitation models, blended models, as you point out, are quite challenging. We're seeing that through the federal Department of Health with healthcare home models. Your words of caution, we hear them loud and clear. But if it's more of a direction of trials and seeing what can work
40 in practice, is that more palatable from your point of view, if those sorts of things would ultimately be part of our recommendations?

45 **DR SIVANESWARAN:** Yes, I think we support the Commission's intention of setting up pilot sites. I pointed out differences between each jurisdiction and there should be a pilot state in each state, because what's

applicable to Victoria may not be applicable to New South Wales or ACT. A proper evaluation and review of the findings is necessary.

5 **MS MIRANDA:** With a trial that we'd like to see happen in each state, as we're saying, our issue with the recommendations is that there's not enough evidence so we can't sit here and assess it and say yes it will or no it won't work. So by trial, with a few caveats around it that has the dentistry industry involved with it, then we can see what works, what doesn't work and then what we can change to ensure we've got the best possible outcome for patients. I just think it's such a big proposal, such a big structural change that to recommend to government that we just go ahead with something without doing trials that are then properly reviewed would be a mistake.

15 **MR INNIS:** If I may, a question coming back, what we found was that there were a group of people who were not receiving preventive care, and that was having big cost to them and big cost to society, and I think you said much the same thing. I'm conscious that, as a preference, you've said activity-based payments, at least at the national level. Can I ask: why do we think they attract the people through the door to that preventive mode? I'm seeing vouchers working for people – you kick them through the door a bit, but what I'm hearing from you is you need a sequence of both behaviour in the dentist chair and behaviour outside in terms of what you can assume et cetera. So tell me how we get to those people?

25 **MS IRVING:** There's a portion of the community that will never, ever attend a dental practice, whether it's public or private. History shows us that those people just don't and will not ever go. So I'm not sure how you're ever going to get to those people. There's not enough being done around education. People see going to the dentist as when they have a problem, and we need to shift that whole mind set into one where you only get one set of teeth – you're born with them, they're there from the time that you come out of your mother's womb – so you need to look after them from the beginning if they're going to get you through to 80, 90 years old, which is becoming the normal age.

35 We need to invest more in prevention in terms of education, of health literacy, because people don't understand a lot about this. As I say, they really think the dentist is only for when you have a problem. So if you can get people early – that's one of the reasons why we have supported the Child Dental Benefit Schedule so much – we know that if you can get good habits commenced at an early age, you will save money and that the people will have much better health outcomes down the track. So we have to get in early. We have to increase health literacy and we have to educate people. And we have to add messages on to those that are already going out around

obesity and healthy diets and sugar consumption and all those things so that we actually reduce the burden on the system down the track.

5 But there are certainly people that will never, ever, ever, ever go to the dentist, no matter what you do. Whether you give them the voucher, and we have seen that with CDBS, the uptake of that scheme is about 30 per cent, yet these families all have a thousand dollars per child and they're still not going. I don't know how we get to those people. Even the public system, people aren't going.

10 **MS MIRANDA:** I think the CDBS is a good example of where the scheme exists. It is there, and the government doesn't promote it. The government doesn't have the education or the public awareness campaign to back it up. I think they send out a letter once a year to eligible people who are probably
15 getting so many other things from Human Services that they don't know about it. Again, the education is not there. As much as we lobby government to try to provide that marketing campaign behind it, it just hasn't happened. It just falls on deaf ears. So with anything, with any sort of big change, there absolutely needs to be an education campaign with it.

20 The real purpose of that is to change behaviour. It's about changing behaviour and implementing those good old habits where you brush your teeth twice a day. There's a school in western New South Wales where 10 per cent of students own a toothbrush. So how do you get to those
25 people? If we went out there, as the peak body and hand out everybody a toothbrush and toothpaste, how long would that last? Would they go home and be cleaning their teeth every morning and every night? We just so need to go back to basics – really, really basic messages about oral health.

30 **DR SIVANESWARAN:** Coming back to your question about this group of the population that never access dental care or any health care, I think that's where we have to look at population preventive measures, like the upstream measures. Like I said, we're lucky we've got water fluoridation which does not require any behaviour change, financial incentives. All you
35 have to do is drink the water. I think one of the things we are also quite keen on is all these policies that have already been in place, like with smoking and alcohol, this also helps reduce the prevalence of oral disease. One of the things we are lobbying for is a tax on sugar-sweetened beverages, because it just does not reduce the risk of obesity but it also
40 combats oral diseases. It is more the upstream measures, and there's ample evidence to show that population health measures have played a greater role in improving health and oral health compared to one-to-one clinical services. I think parallel investment in the public sector where these sorts of things happen is really critical.

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DR KING: Thank you very much, all of you, for attending today and for helping us out.

5 Next I would like to welcome the representatives of Homelessness New South Wales, Mr Hartley and Ms Star. I can give you five minutes for an opening presentation but, first, if you could both please state your names and your organisations for the record.

10 **MR HARTLEY:** Chris Hartley, and I'm the Senior Project Officer with Homelessness New South Wales.

MS STAR: Natalie Star, and I'm the Consumer Advocate for Homelessness New South Wales.

15 **DR KING:** Thank you.

20 **MR HARTLEY:** Thank you for the opportunity to present with you today. So Homelessness New South Wales is a peak agency that aims to reduce homelessness. We have a range of members, large small and medium, throughout New South Wales, and we also represent the voice of people who are experiencing homelessness. Our submission and our comments today are primarily focused on the social housing component of the reforms and also reforms to family and community services.

25 In relation to social housing, our overarching comments are really that any attempt to reform the social housing system must be developed in conjunction with supply. From our perspective any attempt to address and reform the social housing system without considering supply is simply moving the deck chairs. In our submission we highlight four separate
30 recommendations in relation to supply, which I won't go through today. I direct the Commission to those recommendations in terms of supply.

35 We do support efforts to transition people from social housing into private rental. We do believe that that empowers and supports full participation of individuals. A caveat to that is that that needs to be done with a full understanding of the current social housing cohort.

40 Figures have shown that over 93 per cent of people in social housing in New South Wales are on some form of income support payment. A lot of these are on aged pensions and carers pensions, which make it inappropriate for them to be pushed into the employment stream.

We also note the many other structural barriers which prevent people going into employment, the entrenched discrimination in the private rental

market and against people who are on Centrelink and have been in social housing.

5 We would also like to note our strong concerns in relation to introduction of market-based rent. In our submission we again refer to the IPART process which has been complementary to the Productivity Commission's review. We note their modelling and their particular concerns about the introduction of market-based rent.

10 We are also particularly concerned about other submissions which have referred to allowing community housing providers and social housing providers to charge premiums based on locations. As detailed above, we consider that an authentic and detailed analysis of the social housing cohort reveals that most people have very little disposable income. In situations
15 like this, tenants would be sacrificing essentials such as food and immediate condition in order to obtain best quality and appropriate accommodation.

In relation to reforms to family and community services, again, we are broadly supportive of measures to increase the effectiveness of family and
20 community services, and our comments are mainly related in terms of specialist homelessness services. We note there has been reforms particularly in New South Wales with the going home, staying home reforms in relation to specialist homelessness services which have been quite disastrous for the sector.

25 In our submission we list a number of recommendations of how this approach could be avoided in the future, particularly recognising that homelessness and specialist homelessness services have a range of pressures beyond their control, so things such as housing exits into exits
30 from corrections and health are all systemic factors which play into homelessness which are outside the specialist homelessness sector's ability to control.

35 We also note that any move to an outcome-based contracting model will be a significant reform to the specialist homelessness service system and require additional money and resourcing. One of our primary faults that we see with the going home, staying home process was an uncoupling, again, of outcomes-based contracting and measures to supply and a failure to support a sector to go through a quite significant reform process. Thanks.

40 **DR KING:** Thank you very much for that. Again, I'd like to make sure I understand a few things before passing over to my colleagues.

MR HARTLEY: Sure.

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DR KING: Can I start with the market rent issue, which, as you said, you have concerns with it. You referred in your opening statement back to the IPART approach.

5 **MR HARTLEY:** Yes.

10 **DR KING:** We suggested the high cost payment approach as one way of dealing with that. I guess our other starting point was, of course, the majority of people eligible for social housing are actually relying on private rental accommodation at present, which, from our perspective, was a cause for concern. Do you see that if there was a move to a market-based rent in social housing what sort of additional financial support would be needed, is that reasonable or is that really just unreasonable? Could it be done through a high cost payment, or is that just not going to work? I'd really like to get your understanding of that?

15 **MR HARTLEY:** Sure. As I said, I think for us the primary issue is supply. I know that's probably not an issue that you're able to deal with. Again, any measures to do with market-based rent, even if it were to be successful within the scope of what it can achieve is simply just shifting the deck chairs.

20 In terms of the amount of increase to a payment to CRA or other payments, our submission, again, notes some concerns around the modelling that the Productivity Commission has introduced. Primarily it's looking at Victorian prices as well and our concern, obviously, that Sydney is a lot more unaffordable than Victoria. From our perspective, it's simply not going to address the huge waiting lists and the tenure times.

25 **DR KING:** Coming back to that supply problem, I guess, again, the problem I have as a starting point is that I do see large numbers of people, because of the supply problem, in the private market. I suspect it is unlikely that any state government is going to be building the sort of numbers of social housing dwellings or paying for them if they're built by somebody else, community housing, in order to house all families, all households that are eligible for social housing, do you see a way that we can bring the private sector in as a way of reducing that supply constraint and, if so, how would that be done and how would that fit in?

30 **MR HARTLEY:** Sure, the private sector does have a role. I would again couple that with concerns for us particularly around our client cohort that we find that there's entrenched discrimination as well as a whole lot of other structural barriers which prevent people from staying in or obtaining private rental. There's also issues, which the Productivity Commission has noted, of private rental not being as secure as social housing. You have things

such as no-cause and no-fault evictions which are a concern for our tenants and our services, which mean that private rental isn't as effective for social housing.

5 Again, coming back to an annoying point for me to come back to in some ways, but addressing supply is the solution. Increasing things such as encouraging longer term leases and addressing systemic barriers in private rental would be partially effective, but without supply it's going to be minuscule change.

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DR KING: Can I switch a little bit just on to the support services that you referred to.

MR HARTLEY: Sure.

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DR KING: What are the additional support services that are needed to stabilise the social housing recipients that need those support services? We've recommended separating off the supply of the support services versus the housing provider. I'd like to understand your position better on that and particularly understand what you see as being the role for the provider of the social housing in dealing with support and including dealing with issues such as rental stress, rental arrears, eviction. We've got some numbers on evictions that horrified me a bit.

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25 **MR HARTLEY:** Yes. It is essential. I would say part of the problem that we've found ourselves in is there's often a separation in practice in terms of someone going into housing and then no support provided, which is, again, an issue actually which I know the Productivity Commission has considered in private rental. If people do go into private rental, they do need support as well. A lot of our work is focused on debt and arrears as well, which you've pointed out. We have worked quite extensively on looking at alternative models around a work and development order system at the moment which applies to fines, on-the-spot fines, which we're encouraging social housing and community housing providers to adopt which would enable a tenant that falls into arrears to immediately be redirected into programs that might either provide support or enable them to get out of the current circumstance that they're in.

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40 **MS STAR:** I think the really important thing is what often happens is that when people get housed they get put in the place that they've got to live in but they don't know the people in the area, they don't know how to access services in the area, they don't know where to go to for help. They're often there isolated and often with complex issues. There's people with mental health, there's people with disabilities, there's other issues that factor in. To put somebody in the place and then go, "Okay, well, we've got a roof

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over your head, see you later,” actually compounds the problem and then can cause problems around the area because then people don’t know what they’re doing. They get distressed, it increases their stress levels, they may have some sort of response that wouldn’t necessarily be helpful in the community. So as soon as you get a service alongside them and they can go, “Okay, what are the needs here? What needs to happen? How can we address these needs in this situation,” it then alleviates all the stress and angst and it then helps people to work together. It then brings a bit more harmony into communities that can get disconnected because of the things that are going on.

The more services you can get around the better, and having someone who can identify those services is important and not impose them on the person but actually work with the person. As we know, whenever you get a parent-child kind of relationship, you get a rebellion. So if you get someone who comes alongside and says, “Okay, what needs to happen here and how can we make that happen,” the person’s going to feel supported and work more with the other people to get those services involved.

DR KING: Can I follow up on that. In your submission from I think February you commented on the going home, staying home process. One of the things that you said that was a problem with it is that it undervalued existing relationships, expertise and networks within the specialist homelessness sector. Is that similar to what you’ve just mentioned, that need to keep those networks? Do you mind expanding on that a bit more just so we understand where you think that’s failed?

MS STAR: Yes, I think probably Chris could give you a bit more information on that.

MR HARTLEY: In terms of going home, staying home reforms, it was the concern that services were suddenly competing with each other for funding. Funding was directed towards larger mainstream services rather than the small service providers which had those connections within the local community. So a similar issue in the sense that support networks which are kind of understanding of the particular issues that people face are incredibly important. But I’d say broadly it’s a little bit of a separate issue.

MS STAR: But it’s also specialist services. I think that’s the difficulty with the going home, staying home program. A lot of the specialist services were lost. They’re the people who know exactly the needs of the people in those areas. If you take those away and you bring in somebody else who has no experience or understanding of it, you’re actually going to cause more problems for the person than you would have if you had those specialist training people in there.

5 **MR SPENCER:** It overlaps, but with the family and communities and your comments there, you've indicate you're broadly supportive. But just some of those things we've been talking about, with the draft recommendations we have around longer terms for contracts, longer times for tenders to enable providers to get together and maybe do some sort of consortium bid – you've noted this as well, I think – the provider attributes, we've put some focus on that to have a clearer idea of what government is actually commissioning for.

10 **MR HARTLEY:** Yes.

MR SPENCER: Have we covered those things adequately or there are things that you think we need to still do around some of those issues? What are your thoughts on that?

20 **MR HARTLEY:** Yes, we're actually quite supportive of those recommendations that you mentioned. Our only additional comment in relation to that would be making sure that if there are particular outcomes that are placed on family and community services that they are also measured and placed on government services as well. But we're very broadly supportive of things like increasing tender times, the whole range of a number of recommendations raised we're quite supportive of in that regard.

25 **MR SPENCER:** And in terms of outcomes, we've talked about specialist homeless services – once again, you've mentioned this as well – the need for government to be more focused on the whole needs of the individual.

30 **MR HARTLEY:** Yes.

MR SPENCER: How does that work in practice? On the one hand we've got a specialist homeless service whereas there's a whole range of issues, as you mentioned before, about that person. One of the areas we're trying to encourage government is to try to understand all the needs. How does government commission to get that kind of outcome? Is it to get more consortiums of different expertise or is it to one agency? When you say specialist homeless service, does that address the needs of all the individuals or are you fundamentally just focused on the immediate needs? I'm just trying to work out how do we encourage government to get more around the needs of an individual.

40 **MR HARTLEY:** It's something that we are certainly pushing for, for a whole range of government agencies to come together to realise that it's not just an issue of housing; it's across government services. How you do that?

We've certainly tried quite hard to get both the New South Wales and federal governments to see it as a whole-of-government response that needs to occur. Often it's simply directed at housing or pushed back on the specialist homelessness services.

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From a practice point of view, specialist homelessness services have to work with a whole range of broader agencies, both government and non-government, to provide the needs of the client. So I think in terms of the practice that our members are doing, it is quite integrated. But from a government level, there's a lot of work that needs be to done.

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MS STAR: And I think the issues that lead to homelessness aren't just that they need a place to live. It could be that they're fleeing domestic violence, it could be that they've got some mental health issues that have led to it. It could be that they just were so priced out of the market there was no way to get it. Chris mentioned earlier the thing around rentals. It can take people six months to a year to find a rental property that someone will rent to a person. As soon as you say that you have government assistance or you're under the housing label, you're immediately put at the bottom of the list. The media presents a very particular type of person in housing, and that isn't a lot of them. There are some, but the problem is that you all get labelled with the same brush.

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The other thing that will happen is that people will say, "Housing tenant. I'll take that, because then I can take their bond because the government won't have the resources to follow up. They'll just assume the person has damaged the property." I've seen that happen quite a number of times. It's kind of one of the limitations that happens when you send somebody out, and it's quite soul destroying. We know that 50 people can turn up for a rental property. If you've already come with the bottom marker for people, it's a lot harder to get a property.

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MR HARTLEY: In saying that, I completely agree with Natalie's comments, but the options that are considered around head leasing are quite encouraging. I would direct the Commission to the Housing First approach, particularly the more scattered approach which is now considered the most effective way of addressing homelessness, which essentially involves or can involve a provider head leasing, working with private real estate and then providing wraparound services to that client. That's now considered best practice evidence in terms of addressing homelessness.

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MR SPENCER: Thank you.

DR KING: To follow up, you would see head leasing - - -

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MR HARTLEY: As a potential, yes. If done correctly, yes.

DR KING: Would you see that also as easing the supply problem?

5 **MR HARTLEY:** A drop in the ocean, yes. It would be a small assistance. But in terms of the broader supply issue, it still needs significant investment. But, yes.

10 **MR INNIS:** Thank you, guys. A couple of questions: one goes to this notion of how do we put support around a human being. One of the things we did in the social housing area is recommend more comprehensive upfront assessment so that it's not just one thing that's being given, which is some housing support – it is actually holistic. Is that a direction that you'd support?

15 **MR HARTLEY:** Yes.

MR INNIS: Is there any advice you would give us about how that should be developed, that assessment model?

20 **MR HARTLEY:** Yes, we would very much support that. In terms of how it should be developed, particularly if that person has existing support services, someone's needs should be considered in consultation with that existing service.

25 **MS STAR:** Also just taking up that point, when you house a person, housing them around their support systems. I think sometimes there's an attitude that there's a property here, "I'm going to put the person in this property." It immediately takes them away from anything that they have around them already. So then it creates more problems immediately. Like Chris is saying, keeping them in an area where they have a support system makes a huge difference and then being able to work with what they already have. So if they have a really great GP, then working with the GP to get what other needs need to happen, rather than seeing it as just an isolated housing problem. If they have a psychologist who's a real good psychologist, don't change those things that are already working, keep the things that are working and then add to what can happen. But in consultation with the client and then also with the services that are actually helping them at the moment.

40 **MR INNIS:** I think that moves neatly into, I guess, the second area I was interested in your views on. Clearly you've said supply of affordable housing to people on low incomes is an issue, particularly in this city.

45 **MS STAR:** Yes.

5 **MR INNIS:** You have a concern about the model that we've put, which is
a payment model. A couple of questions: at the end of the day, you've
either got to build or you've got to pay more. It's not an either/or
proposition, but at the end of the day, if you've got more people than you
have stock, you've got to do one of those two things. I guess my question
is: do you have a sense of how much more stock would be needed not just
to get to the waiting list but there's all those people who are self-selected
out of applying who are technically eligible. So do you have a sense of
10 that?

15 **MR HARTLEY:** Yes, I do. I'm trying to remember the figures off the top
of my head in terms of undersupply. I think it's around 200,000 that we're
looking at just in New South Wales. I can't recall if it's New South Wales
or Sydney. I might have to come back and correct those figures.

DR KING: So 200,000 dwellings?

20 **MR HARTLEY:** Yes. If I can provide that later rather than actually trying
to remember it off the top of my head.

MR INNIS: Sure.

25 **MR HARTLEY:** But, yes, there is modelling and research that has been
done in terms of the amount that's missing in terms of supply.

MR INNIS: I guess the question for us is, it's an and proposition. Clearly
there are things that need to happen around affordable supply.

30 **MR HARTLEY:** Yes.

MR INNIS: Governments around the country are seeking to do that. The
question I have is: is there merit for all of those locational issues? Once
you've built something or once you've bought something, you're locked
35 into location. So I guess what we've been seeing is not an either/or but an
and, and trying to give people as much flexibility to do the things that you
say. And the design of the high needs payment was intended for state
governments to look at their local circumstances and provide a payment
both to the people who need it at a level that's appropriate for their local
40 circumstances. Clearly, house prices here are much higher than they are,
say, in Dubbo. So that it would be a differential. I guess my question is:
as an and proposition, does this add value? I hear what you say about
supply.

5 **MR HARTLEY:** It doesn't take away value, is probably how I'd answer your question. So long as the modelling is correct and very much directed, again, as in your question, that Sydney has a particular need and that it's not just all modelled on Melbourne which is a more affordable city than Sydney. Measures to increase that payment and to facilitate people going into private rental, as long as the structural and support issues which you've raised are considered is not going to add to the problem, if I can put it that way.

10 **MR INNIS:** Thank you.

DR KING: Thank you very much for both attending and helping us out today.

15 **SHORT ADJOURNMENT**

DR KING: Let's get started again. The next organisation is the National Congress of Australia's First Peoples. Mr Slabb.

20 **MR SLABB:** Good morning.

DR KING: Again, formally for the record, can you state your name and organisation, even though I just did it.

25 **MR SLABB:** My name's Greg Slabb. I'm with the National Congress of Australia's First Peoples. I'm a senior program officer. I've been with the Congress for a couple of months now. I've hit the ground running and we're very, very busy at the moment, which is terrific. Thanks for the opportunity to have input into today's proceedings.

30 I've got a document here that I'll just go through and then I'm happy to answer any questions at the completion of it. The National Congress of Australia's First Peoples – the “Congress”, as we'll call it after this point – welcomes this opportunity to respond to the Productivity Commission's
35 draft report on introducing competition and informed user choice into reforms to human services. Congress is a representative voice for Aboriginal and Torres Strait Islander peoples. Established in 2010, Congress has grown steadily and now consists of over 180 organisations and almost 9,000 individual members who elect a board of directors.

40 Congress opposes legislation and policy that is or may be discriminatory, directly or indirectly, and/or may limit the rights of Australia's first peoples. Many of the social problems faced by first peoples today are the result of a history of coercive government policies, notably
45 forced removal from land, people lose that connection, relocation to

reservations and missions – there's quite a few of those still around today – assimilation, stolen generations, stolen wages and income management regimes.

5 Congress advocates self-determination and the implementation of the United Nations Declaration on the Rights of Indigenous Peoples. Congress believes Aboriginal and Torres Strait Islander peoples should be central in decisions about our lives and communities and in all areas, including our lands, health, education, law, governance and economic empowerment. It
10 promotes respect for our cultures and recognition as the core of the national heritage.

Just in regards to the introduction of competition, Congress agrees with the Productivity Commission's assessment, particularly in part 8, human
15 services in remote Indigenous communities, of the draft report of the potentially problematic aspects of introducing competition to the human services sector. In particular, Congress considers that the introduction of competition to the delivery of human services would weaken the relationships between service providers and recipients which serve as the
20 foundation of the sector's effective functioning.

Congress is, however, sceptical of the draft report's suggestion that a model of commissioning where providers compete periodically for funding to deliver services can be a sound model if implemented well. In particular,
25 it notes that many of the negative outcomes of the current government policies relating to Aboriginal and Torres Strait Islander affairs are the result not only of poor implementation but also of inherent problems posed by any competitive model of service provision. For instance, the draft report's observation that services are uncoordinated both between and
30 within governments and between service providers is exacerbated by any system which forces service providers to compete against one another for funding from the government.

Such a system reduces the incentives for service providers to co-operate
35 with one another and share cultural and logistical knowledge since they are in competition with one another. This leads to both the fragmentation and duplication of service delivery and, therefore, the wasting of valuable resources. What will happen in many cases is that at the moment if you've got a couple of organisations in town, they're sharing information – these
40 are Aboriginal and Torres Strait Islander organisations – because the end goal is for the betterment of the Aboriginal and Torres Strait Islander communities. But in a competitive environment, this may be lost because if you're in competition with someone else if you've got a better program or better access to communities, you're not going to share that information.

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As the draft report acknowledges, the isolation, inaccessibility and lack of technological infrastructure which characterise many remote Aboriginal and Torres Strait Islander communities renders any consumer-driven competition within the human services sector unfeasible. However, it is important to note that a government-driven, commission-based model is equally unsatisfactory. The failures of the Indigenous Advancement Strategy offers a poignant illustration of this.

Over half the funds allocated under the first year of the IAS were given to organisations and businesses not headquartered in the communities they were supposed to work in. Furthermore, Aboriginal and Torres Strait Islander organisations made up only 45 per cent of successful applicants in the first round of funding grants.

The application of funds to groups which are geographically removed from the regions which they are required to serve and to non-Indigenous service providers only exacerbates the cultural insensitivity and lack of needs-based approach which have plagued the Aboriginal and Torres Strait Islander services sector.

As the Department of Social Services suggested in its submission, competitive tendering arrangements tend to favour large-scale NGOs which have the skills and capabilities to develop effective grant applications. Congress notes that many smaller organisations, such as those run in regional communities by Aboriginal and Torres Strait Islander people, do not have access to the legal or logistical resources required to engage in the complex tendering process created by the Australian Government, and a lot of other governments to add to that as well.

Furthermore, given that many of these organisations are already understaffed and in a precarious financial situation, any competitive system of service provision requires them to devote a significant proportion of their scarce resources to seeking funding. It is unclear whether any of the suggestions made in draft recommendation 8.4 of the draft report would significantly alter the disadvantages which these organisations face.

Although community engagement and feedback may serve as useful supplements to the tendering process, formally compiling and coordinating diverse community responses presents similar logistical challenges to those involved in participating in the tender process.

The draft report is correct in identifying the tendency of the Australian Government's failure to take into account the advantages Indigenous organisations offer over mainstream organisations. As is noted by many family and community service organisations, including many non-

Indigenous organisations, the government tends to focus disproportionately on cutting costs and the quality of applications as opposed to the needs of communities and the appropriate means of fulfilling those needs.

5 For instance, although organisations which offer mainstream health services to remote Aboriginal and Torres Strait Islander communities may be able to boast reduced costs, such services fail to take into account the cultural and social particularities of our communities and, therefore, produce negative outcomes.

10 In contrast, Aboriginal and Torres Strait Islander organisations may, as the draft report acknowledges, provide greater health benefits, improved access for Indigenous people, deliver culturally appropriate services and be more likely to be committed to processes of clinical governance and evidence-based medicine and employ more people. Yet as benefits such as cultural sensitivity are difficult to quantify and evaluate in monetary terms, they are given scant consideration by the government.

20 As a result, Congress welcomes draft recommendations 8.1 to 8.4 of the draft report insofar as they encourage the Australian Government to allow Aboriginal and Torres Strait Islander organisations more time to both develop applications and build working relationships within the community which they serve. The suggestion that the government account for the cultural competency of service providers is particularly welcome. However, Aboriginal and Torres Strait Islander organisations cannot be faulted for remaining somewhat sceptical of the ability of the Australian Government to fund culturally appropriate service provision given the extraordinary number of similar promises which have been made and broken in the past.

30 Furthermore, Congress submits that draft recommendation 8.4 may only have a limited impact as a centralised government bureaucracy is structurally ill-suited to the evaluation of the needs of a diverse range of individual communities. Indeed, any competitive model of service provision has the adverse effect of forcing Aboriginal and Torres Strait Islander service providers to compete against one another, for instance, by proving that they are more culturally sensitive than their competitors, promoting a culture of antagonism in the sector and thus further fracturing it, which only adds to some of the mild antagonism that is present in some communities.

45 Congress in principle welcomes draft recommendation 8.5 and its call for more frequent assessments of the characteristics and needs of Indigenous Australians living in remote communities and the establishment of systems to identify and share information on what works in human

5 services in remote Indigenous communities. However, we note that any competition within the service delivery sector is fundamentally at odds with the aim of sharing information as an organisation which co-operates with other organisations effectively jeopardises its own ability to win bids for contracts with the government.

10 Furthermore, we submit that the goal of assessing the impact of service provision in remote communities may be particularly difficult. It is difficult to accurately gauge and quantify measures of wellbeing, such as cultural and spiritual connection.

15 In addition, Congress notes that the Australian Government is already constantly provided with information about the characteristics of remote Aboriginal and Torres Strait Islander communities yet, as a paternalistic and assimilationist programs, such as the Northern Territory intervention, now continues under the Stronger Futures policy and the community development program illustrate, the current failures of government policy are not merely due to a lack of information but, rather, the government's belief that it already knows what is best for Aboriginal and Torres Strait Islanders.

20 As a result, Congress suggests that it is not enough to merely publish assessments of the service sector; those assessments must also be given weight in government decision-making processes. Furthermore, Congress submits that in order for the Productivity Commission's recommendations to take effect, the Australian Government must revise the process by which it currently records assessments of development policies. The government's reliance upon verbal negotiations with organisations, failure to assess funding applications according to policy guidelines and inadequate recordkeeping of meetings has made any assessment of the impacts of policies and funding allocations virtually impossible.

35 Congress would like to note its appreciation of the devotion by the Commission of an entire section of the draft report to the analysis of issues concerning service provision in remote Aboriginal and Torres Strait Islander communities. This is a noteworthy policy area requiring reform. However, Congress emphasises that this action addresses the lives of barely one in five Aboriginal and Torres Strait Islander people. Therefore, while Congress believes the Commission's recommendations to be highly worthwhile and welcome, we urge the Commission to broaden its inquiry to tackle the issues afflicting the large number of our people who live in urban areas, which is very significant. I think in New South Wales alone only five per cent of the population – just using that as an example – live in remote or very remote New South Wales. In particular, we submit that the draft recommendations in part 8 of the draft report should be broadened and

implemented in these locations, particularly given that urban housing, health and education services can similarly be improved through an overarching needs-based and culturally sensitive approach.

5 Just in regards to informed user choice, Congress concurs with the
Productivity Commission's view expressed in its draft report that
facilitating the making of informed choices by users of human services
about their individual care instils empowerment, particularly by reflecting
their dignity and right to freely live their lives. Although Congress
10 acknowledges that this is not always possible, particularly in remote
communities, we stress that the ability to make independent, informed
choices should be afforded to Aboriginal and Torres Strait Islander people
wherever feasible, and to make these decisions align succinctly with the
values of Congress, which includes allowing our people to determine the
15 course of their own development and to enable the self-determination of
Aboriginal and Torres Strait Islander people.

 Informed user choice is of particular significance to our people due to
our history of being subject to generations of discrimination, disadvantage
20 and violence and the erosion of our self-determination, which has happened
quite significantly over the past few years. Despite several reports stressing
the need for our peoples to have a genuine say in our lives and decisions
that affect our peoples and communities, the Australian Government has
continued to pursue paternalistic assimilationist policies which have only
25 exacerbated our marginalisation. Congress, therefore, advocates for the
restoration of policy autonomy for our peoples and submits that the human
services sector, due to the sheer size of the population which it serves, forms
a critical part of that plan.

30 However, although informed user choice may appear highly amenable
to the goals and values of Congress and our people as a whole, there are
caveats to this effectiveness. A significant one is that which has been
discussed previously – that is, that any options from which our peoples are
expected to make an informed choice must be culturally appropriate and
35 equitable to Aboriginal and Torres Strait Islander service recipients.

 Furthermore, many communities and organisations lack the
infrastructure and manpower required to provide culturally appropriate
services due to chronic underfunding and lack of support from the
40 government. The draft recommendations of the Productivity Commission
must, therefore, be accompanied by a recognition for broader government
support of Aboriginal and Torres Strait Islander organisations and an
emphasis upon the needs to respect the autonomy of those organisations.

Many of the human services categories outlined in the draft report are highly relevant to the facilitation of informed user choice by Aboriginal and Torres Strait Islander recipients of social services. A crucial one is caring for people at the end of life. As the report highlights, although 70 per cent of the Australian population would strongly prefer to spend their twilight years in their ancestral lands, very few people are permitted to do so.

This is a particularly sensitive issue for our peoples. Firstly, our peoples have strong, cultural, emotional and spiritual connections to their respective ancestral lands. These bonds are extremely significant for our peoples, particularly in the twilight moments of life. Although the strong emphasis on familial care at this time is unachievable in more formal settings, hence many of our people unfortunately have to pass away in environments alien to them, often associated with the ingrained historical trauma and not sensitive to cultural dignity otherwise received in the lands of their respective peoples.

Secondly, there has been an enormous cynicism among Indigenous peoples due to factors such as the focus on the closing the gap agenda and not necessarily reflecting Indigenous people's objectives and priorities, particularly in relation to community development or governance issues. Congress considers this the culmination of an historical aversion to provision of critical human services, such as hospitals and aged-care facilities, that were provided by non-Indigenous actors. It is, therefore, unsurprising that a lack of informed user choice means that Aboriginal and Torres Strait Islander people are often reluctant to engage with such services in the first instance. This is exacerbated by their fear of not being permitted to spend their twilight months on the land of their respective peoples. Congress considers that this perpetuates a vicious cycle of separation from one's ancestral lands and rootlessness that afflicts a sizable proportion of our peoples.

In conclusion, the National Congress of Australia's First Peoples once again welcomes this opportunity to respond to the Productivity Commission's draft report on introducing competition and user choice within the human service sector. We strongly believe that the Commission is in the right direction in promoting and defending the rights of all Aboriginal and Torres Strait Islander people within the human services sector. This is apparent in a number of recommendations throughout the draft report which condemn the introduction of competition in a sector which so heavily relies upon the positive interagency collaboration and support, factors unlikely to survive a more competitive structure.

Confidence, too, is found in the continuous encouragement within the recommendations for government to work alongside and in partnership with

our people in devising culturally competent programs and services. Congress is keen to see these suggestions come into fruition. Thanks.

5 **DR KING:** Thank you very much, Mr Slabb. Again, if I can just start by asking some questions to clarify. A number of points in your opening comments you referred back to the desirability of Indigenous organisations being involved in service provision, the difficulties of having culturally appropriate services provided in current systems. I wanted to just see if I could get some of your responses to those expanded. You referred to draft
10 recommendation 8.4, for example, which refers to culturally appropriate service provision, community engagement, collaboration and employment and training for local and/or Indigenous staff. I guess one of the difficulties we have is understanding if those sorts of recommendations went forward, if they were accepted by government, would that be enough to assist
15 Indigenous organisations and help Indigenous organisations to be chosen to work together as service providers? Are we missing something in that criteria and, if so, what are we missing?

20 **MR SLABB:** I think it's important for a number of reasons for organisations to have some surety because, as we're aware, there are a lot of short-term programs or short-term funding in the current environment. Again, as long as everything is monitored and scrutinised, similarly, not overly monitored or overly scrutinised as compared to the non-Indigenous organisations. But it provides some surety so that the organisation can
25 provide the services with confidence, and it can also retain staff as well. Sometimes staff are looking at when the funding is coming to an end, so they could tend to move around.

30 A lot of organisations work very well. In a lot of remote and very remote towns in New South Wales, which I've had a lot of dealings with over many, many years, they work quite well. You'll have one organisation – sometimes it could have been established by a family or whatever, so it might have health and then it might have housing or whatever other services are provided – generally they work very well
35 together and then they will not so much share the information but point people in the right direction and where to go in regards to services with other organisations. They work very well.

40 Now, there's always competition within communities anyway to various degrees. Sometimes, too; communities are looked at as being either disjointed or not working well together or having differing opinions, but what I always say is, "Okay, have a look at your local shire council, your local government, your state bodies and then even within those organisations like the Labor, the Liberal parties, there's also factions in
45 amongst those as well." So there's always going to be differing opinions

there, but if organisations are supported, and I think, too, strengthening governance is a key area. If that support could be provided there so the governance can be strong and the message about working together is shared across all the various organisations within a location, that is going to be a big plus.

The Aboriginal people, like I say, I've worked across New South Wales and I did six months over in Western Australia up in the Pilbara working with Aboriginal communities up there. Aboriginal communities like to see people, and there have been cases where, like, a non-Aboriginal organisation is providing a service but it's providing it remotely. It might be 2 or 3 hours, 5 hours away, depending on where they're located, and people get frustrated with that because they like to be able to duck down town, make an appointment or whatever, go to the particular service and get that service. That's also very important, and a lot of organisations that are remote and rarely seen, they quickly become disconnected and then the Aboriginal people just stop using those services or they'll just complain about that service. Did that answer your question?

DR KING: Yes. I guess what extra practical things can we do? You mentioned security and surety at the beginning of your answer. We've suggested significantly longer contract lengths to try and create that security, and we recognise that as an issue. I guess it's more what practical things have we missed? I'll move on to the government and the issues in government decision-making in a second, but on the ground, when looking at relevant organisations to provide services on the ground, are there practical things that could be done that really we haven't covered off yet at the moment, or have we sort of, under our various headings have we captured most of it? More detail obviously might be needed, but I'm really after that.

MR SLABB: Yes. I think a lot of it has been captured, but you can always go into more detail. I know that various governments are doing not so much research but they're trying to capture cultural competency and those various things. I suppose the bottom line is to make sure that the organisations are actually connecting with the community and the community are using the services. That comes back to, like I say, cultural competency. That can be expanded and strengthened. But a lot of times, on most occasions, if you've got Aboriginal staff there, people in communities, they interact very strongly. Someone can move from Burke down to Dubbo or whatever. To a non-Indigenous person they could say, "Oh, that's a long way away, they mightn't know anybody in the new location," but people know people from all those different areas across the state or via surname or whatever. So you can say, "Oh, that person's from Moree." So you've got that as well. And then through that, it's an unwritten and probably hard to capture connection,

but through that connection, having Aboriginal staff, competent Aboriginal staff, then you can keep capturing people when they move about or whatever, but also in their local area as well so that you've got all those services. It just needs to be monitored to make sure that those services are provided.

Probably one of the areas, too, that organisations do struggle with is sometimes they go a little bit above and beyond what the funding is actually intended for. But it's all with good intentions because they want to do what's best for those communities, and that's always another difficult area as well. I think we are on the right track, but I think some of those areas just need to be highlighted and mechanisms put in place to make sure that those services are being provided. And sometimes, too, in an Aboriginal organisation some of those areas aren't as strong as what they should be.

DR KING: I guess the second area I wanted to get some clarification on, you referred in your submission and in your opening comments to the issue of centralised government bureaucracy, the difficulties of evaluating, having appropriate contracts, perhaps, for want of a better words, lack of trust. Recognising these issues, I guess we're faced with having to come up with practical recommendations to overcome that in a system where inevitably centralised government bureaucracies will be determining the service providers.

I'm just wondering: do you have any practical suggestions that we can look at further to be able to address that? Is it just a matter of trying to change the balance or does there need to be something more fundamental changed? How can we help the system, for want of a better word, improve?

MR SLABB: I think, obviously, if it's a selection panel, is that the determining factor, in a lot of cases it is. You might have government representatives and non-government representatives. So I think it's very important to have some Aboriginal and Torres Strait Islander people on those panels who assess the applications, for example, and make the recommendations. Because people on there will know the communities and they will ensure that people are given a fair go, for want of a better word.

The services in a lot of communities, especially with Aboriginal organisations, it is going to cost a bit more. A lot of that comes back to economies of scale, and obviously the bigger organisations can absorb some of these costs elsewhere across their business or their organisation. But some Aboriginal organisations are primarily focused on health or whatever. There are some that have actually branched out – they might have health, housing and whatever – and they do cross-subsidise sometimes as well. That's a big advantage for the bigger organisations. They can absorb costs.

In a competitive environment you need to make money to maintain a business, you can undercut the Aboriginal service provider because you can absorb the costs there. Once that competition is out of the road, you've got no competition so there's no other option.

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But the other side of the coin, too, okay, it's going to cost a bit more for the services to be provided. But if the participation and the success rate is much higher, money is going to be saved further down the track. As we know, by all of the latest close the gap reports and state reports, not a lot has changed. I think only one of the close the gap targets has actually improved and that's the year 12 retention rate. All the others – health and that – are going backwards, unfortunately.

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It might cost a bit more, as I was saying, but it could save money – a lot of money – in the long term. If it is going to be a selection panel, those sorts of panels should have Aboriginal and Torres Strait Islander involvement and those maybe added costs can be taken into consideration.

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DR KING: Finally, do you know of any research that's been done on comparing the short term versus the long-term cost? Again, it's put to us that, yes, it might be more expensive in the short term, but there are long-term savings. Of course, it would be great to be able to quantify them to help government decisions, so do you know of any research that's been formally done on those types of longer term savings?

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MR SLABB: No, I'm not aware. I'm sure there would be. We can provide that information if required. But I've travelled extensively across New South Wales for the last 15, 20 years. Prior to the Congress I was with the New South Wales state government for quite a period of time. I just finished eight years with the Aboriginal Housing Office and prior to that I was with the Department of Aboriginal Affairs, so I've travelled all over New South Wales and dealt across all the various sectors – health, education and whatever. Everybody, all the various sectors, are very much in the same boat. It's just anecdotal evidence that I'm providing but they all struggle with the funding aspect of it including short-term funding as well. It makes it very, very difficult for a lot of them to provide good services. As I was saying earlier, too, if you can't retain staff, that's very difficult because sometimes you might have a two-year investment in staff and they're starting to perform really well. As we know, it takes a little while to settle in and build and grow people. Then you're losing those people all the time because people, like the organisation, they like to have confidence and surety in their lifestyles. They could have a mortgage or whatever. So it's an important area, and I'm sure we can do some research and provide some information in regards to that.

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MR SPENCER: Thanks, Greg, that's very helpful. You described a whole range of issues there. Some are around design issues and structural issues, and that's what we're trying to get to grips with here, as to what will encourage over time better outcomes and then a whole range of implementation and performance issues by government. I'm just wondering what thoughts you have on how do we help government to be more accountable for its performance in all of this? You've mentioned a couple of times that there are notes taken at meetings, they're not actually recorded or they're not available. In terms of government's accountability back to communities, what flow of information, what could be helpful to encourage, frankly, government's accountability around what it's doing in this space?

MR SLABB: There needs to be clear guidelines and mechanisms in place so that that information can return to the community after meetings and whatever. What happens a lot is generally government are understaffed as well. The people serving in a particular area, you might have a person, just in regards to remote and very remote, you might have a person covering hundreds of square kilometres and there might be quite a few communities within that area. So sometimes it's just government being under-resourced and not being able to provide those services.

I think it's important, too, that the relevant Aboriginal peak organisation is involved. If there's a committee or something covering a particular area, sometimes, as you're aware, you might have a regional body covering an area, then there might be a state body or whatever. There can be several layers of bureaucracy sometimes across state and nationally as well. I think that's a key area.

Working through those peaks in regards to health or education or whatever, I think that will add value to many of the services. However, again, a lot of these peak bodies are severely underfunded and they are under-resourced as well. A lot of times they are unable to attend a lot of things that are happening purely through lack of resources. That's a very difficult area as well. That's something that could be looked at and modelled. It doesn't mean you set up a whole new massive bureaucracy but maybe look at how we can develop these mechanisms and get the best value for money to make sure that these services and this information flow happens. It's a two-way street. By "two-way street", I mean the organisations have to share their part of the process as well. Anything that needs to come from them, it needs to be provided as well.

As I mentioned throughout our response, sometimes with the submissions, they can be very, very onerous. You might have to take a person offline for two days to a week sometimes to fill out the submissions.

5 So that's always a difficult area. Maybe there could be some central point or sharing of resources or something in that regard to enable people to be able to adequately and effectively fill out the submissions and provide all the information that's required. Sometimes they do go in, all the information is not there or maybe the response was incorrectly read so they haven't fulfilled the requirements of a particular request. So you've got that area as well.

10 Probably across the board resources is probably a major area, but, like I say, it doesn't have to be a massive bureaucracy; it can be looked at and modelled to address a particular need.

15 **MR SPENCER:** From what you're saying, just to clarify, doing more of these regionally would make sense rather than, in a sense, trying to get away from a central bureaucracy. If you can regionalise some of this planning, you can have more direct contact between those people who are exercising government stewardship and people representing the communities, those things are going to add value?

20 **MR SLABB:** I think so. As I was saying earlier, Aboriginal people and Torres Strait Islander people, they just like to see people. It doesn't have to be all the time – it could be every second or third meeting or something like that. With today's technology, we can cut a lot of costs and time out of it. When you travel a lot, too, when you're driving, like, for example, if you're going to Burke, you fly to Dubbo, you jump in the car, 3 hours, 4 hours to get to Burke, so more or less that's unproductive time. A lot of it, people can have that connection but still use the technology so that those costs can be kept to a minimum. I think that would work well and encourage that relationship and through that relationship and having the right people there as well with some cultural sensitivity, to be honest, Aboriginal and Torres Strait Islander people, I've touched on some of the history there, a lot of times they don't trust government. If people come in and start spin doctoring, people can pick up on it straight away and you'll just lose that respect.

35 So if you've got good people there who can connect with people, provide information and provide it fearlessly as well – I've gone into communities and provided information that wasn't all that accepted, but you give people all the facts and figures or whatever, you know, the current landscape, and people are actually appreciative of that. Even though I'm an Aboriginal person, they expect that from anybody. They just want it in nice, clear language, the facts, and then there's a lot of sophistication in the community. They will look at all this information and they will make informed decisions. Through that process, you will get a lot more interaction and engagement as well. So I think something like the regional

bodies would work well and then that feeds in, obviously, to a bigger state whatever. Everybody's aware of budgets and cost-cutting measures and whatever we can do to improve efficiency and effectiveness and get value for money is good.

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MR SPENCER: Thanks, Greg.

MR INNIS: Greg, thank you very much. I am conscious of your time and the time of others here. A really simple question. I have been listening very carefully, and my reflection is that where the Commission's heading is a good direction but we probably need to do a little bit more thinking about how we ensure there's confidence and transparency around government decision-making and interactions with community. Is that a fair comment?

MR SLABB: Yes. What's happening at the moment is the Congress, we had a bit of a lull there for a couple of years to be honest, anyway, the executive we've got now are very active and well respected. They are certainly making inroads. What the plan is, what's happening at the moment is there's been six workshops held around Australia with all the Aboriginal peak organisations to do with health, housing, the development of a housing peak, law and justice and a lot of those organisations. They are all meeting and the Congress is bringing all those organisations together so that all the organisations work closely together. As we know, a lot of the various areas, such as housing, education, health, whatever, they are very much interrelated, so that's what the Congress is doing – they are bringing all those organisations together, peak bodies together, so that everybody works together. That would also be a good mechanism to work with government.

The Congress has been meeting with various state and federal Commonwealth ministers, so that's a good thing. We're also planning a ministers' forum next month to do with meeting with the various Commonwealth ministers in regards to the outcomes of those six workshops. There's a lot of good things happening in that area now. Hopefully we can just build and improve on that and then the interaction with government and input into services will be effective and Aboriginal and Torres Strait Islander will be listened to. That could shape and have an input into some of the policies moving forward.

MR INNIS: Thanks, Greg. Good luck to you.

MR SLABB: Thank you.

DR KING: The next participant is Yfoundations. I think we have Mr Stone. If you would just state your name and organisation for the

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transcript and take five minutes for an opening statement and we'll pop some questions to you.

5 **MR STONE:** Sounds good. Okay. My name is Chris Stone, I'm the Senior Policy Officer at Yfoundations. Yfoundations is the New South Wales peak body on youth homelessness. A brief statement – I don't intend to summarise my entire submission – I want to highlight a few points and add nuance. In particular, I wanted to talk about recommendation 5.2, the idea of, in social housing, increasing the social housing rent to market rents and having increased Commonwealth rent assistance, CRA, to kind of
10 compensate low income earners for that.

15 In our submission we did not support it largely because we feel that there needs to be more work on what are the implications of that. I guess I wanted to highlight that we do think that this is an interesting idea, but there are substantial concerns in the homelessness sector about what the implications are. I noticed that the Centre for Independent Studies put in a submission on this point as well, and their attitude was that there would be a substantial gap that would either require large increase of rents for some or large increases in government expenditure. We are obviously highly
20 concerned about large increases in rents for low income earners, and so if there was further modelling, you talk about a high rent compensation, whether or not it's always high rents is an issue. It might simply be low incomes that causes the gap. So just further information on that might change the sector's mind, and I wanted to emphasise that.
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30 The other thing that might need to be further explored in terms of the sector's attitude on it is the fact that the increased choice of going into the private rental market may not actually be there because of structural inequalities there. I believe Homelessness New South Wales has already spoken to this, but certainly in the area of youth homelessness we've had from the sector many examples of young people who have applied to multiple – and when I say "multiple", I'm talking 50 or even 100 – different rental properties and been knocked back every time. They can pay, but they
35 can't get in. So the increased choice may not be quite as much as would be expected because of discrimination factors. So there would need to be some discussion of that and reform around that.

40 I did note also the Centre for Independent Studies submission. When I was looking at that I notice they felt like this idea might not be possible because of the increased gap and they advocated as an alternative something along the lines of differentiated rents being charged by social housing providers. From the sector's point of view, we'd like to strongly urge not going down that route. Choice over, say, social housing properties in highly
45 advantageous areas, it's not a genuine choice when you've got, say, a family

on the higher end of low income who might be trading off coffees in the morning and dinners out occasionally versus someone at the lower end who might be trading off their medication in order to get into a place that they need to be. I sort of feel like in this area specific areas of social housing should not be determined on ability to pay; it should be determined on need, and it's not really a genuine choice. I wanted to make that point.

The other main thing that I wanted to raise was also about provider type, and this applies both in the social housing area and in the family and community services area. In the report it's actually described as not discriminating against provider types. I'm uncomfortable about the phrasing of that. We know that the evidence about provider type is that it's not simple. We can't definitely say that government, private or community sector is inherently better at everything, but we do also know that the evidence is that there are differences between the sectors, so that the choice of a different sector or selecting a particular provider within different sectors has consequences.

I gave an example in my submission – and it's only an example; one can agree or disagree with it – the idea of where you've got a service, the idea of which is already heavily aligned with community sector goals, the regulation of the community sector organisation can be fairly light touch because of the alignment of inherent incentives. Where you've got a for-profit provider, their incentive obviously is towards profit and the regulation may need to be more stringent and more difficult, therefore, to put up and perhaps even not practical.

So government needs to have the ability where it is offering for tender to make a judgment call about what sort of sectors it wants involved in it, so there needs to be some flexibility, I think, in the recommendations around sector. There certainly shouldn't be needless discrimination between sectors, and there should be an aim for a diversity of sectors, but there should also be the ability to select sectors where that is appropriate.

Those are the two major points I wanted to emphasise. Some more minor thing to raise are the choice-based letting trial. We thought that was, again, an interesting idea, but we did want it to be a trial because there have been some problems with its application to the UK and it's important to see how that goes.

Also just to note recommendation 7.2 on outcomes, in that first bullet point of recommendation 7.2, we do very much support a more outcomes-focused approach, but it probably should be more emphasised that there'll be a great deal of work to make appropriate outcomes.

A similar thing with 7.1 and mapping. Definitely support additional investigation in finding out what's out there, but that data will never be perfect and there needs to be sophistication in interpreting that.

5 Other points, contract length, it's fantastic to see an increased contract
lengths and fantastic to see some guidance on what exactly you are talking
about there, so the seven years. I'd like to see more on where that seven
years number came from, what is the basis of it. I realise that the research
on that is pretty sparse. I certainly couldn't find anything, so that would be
10 great.

 Then finally, recommendation 7.6 talks about the cost efficiency. It's
quite clear from the report that that's a broad view of efficiency that takes
into account things like effectiveness and the sort of development that needs
15 to go into making things efficient, including cross-organisational
communication and things like that. But it's not immediately clear in the
summary and in the recommendations, and it would be really good to have
a sentence or two just making sure that everyone understands what you're
talking about when you talk about "efficiency", because it is a term that gets
20 misunderstood. That's all I had to say on my submission. I'm happy to
answer any questions.

DR KING: Thank you for that. I think at least in a couple of areas we
could have been clearer in what we were after. If I can start on one of those,
25 because it does relate back to an issue you had on provider type. You're
happy, as I understand it – please correct me if I'm wrong – with an
approach that says there are differences between different types of
providers – not-for-profits, mutuals, for-profits, government provision –
and taking into account those differences when working out which is best
30 should occur. I want to make sure I've understood your position correctly,
so, please, let me know that.

 Secondly, if that is your position, how would the government,
whoever's allocating the contract, whatever part of government, how would
35 they actually do that? How would that be made practical?

MR STONE: Sure. I think I referred in my submission to a text book on
public commissioning by O'Flynn, I think, but there's certainly plenty of
writings on this. There needs to be decisions made about what sectors we
40 want where in terms of the provision of community services. What I'm
talking about here is giving government in your recommendations the
freedom to actually say, "No, in this particular section of the services that
we want delivered, this particular aspect of it, we feel we want it delivered
by this particular sector," whether that be government, community, mutual
45 or for-profit. That needs to be up to government knowing what it wants out

- of the services and based on what it wants and based on the research on what sectors do what differently - coming to a conclusion about that. That may mean in some cases saying, “No, this tender is aimed at the community sector,” or, indeed, “We feel this service should be provided in-house by government.” These are all the same sorts of commissioning decisions that need to be made by any organisation, but where you refer to not discriminating against provider types, it gives the implication that it’s never acceptable to ever limit it to a particular provider type, and I don’t feel that’s quite maybe what you guys meant and I don’t think it’s quite right.
- MR INNIS:** Chris, just following up on this point, I think we’d agree very strongly that what government should do is think very carefully about what attributes a provider has that will deliver the outcome sought.
- MR STONE:** Yes.
- MR INNIS:** Indeed, what our recommendations were intended to do was focus government much more strongly on that process of understanding what ingredients are needed for effectiveness, for service effectiveness.
- MR STONE:** Yes.
- MR INNIS:** The bit that I wonder about, though, is why you would translate that into a blanket for this type of service it’s always this type of provider, because what we’ve seen is that even in the same area, providers vary a lot.
- MR STONE:** Yes.
- MR INNIS:** What we’ve proposed is effectively always go for the attributes and the expectation is some services will lend themselves more naturally to a high proportion of one type versus another. But I just don’t understand why you would start with only this type of provider.
- MR STONE:** Sure. I think what it is that while there is a lot of variation within the sectors, there are certain inherent differences. So in the private sector there is a profit motivation, and that’s an inherent part of the private sector. That’s going to be a different set of motivations from the community.
- MR INNIS:** So where do you see the private sector as including NGOs?
- MR STONE:** Sorry, I’m not making a distinction - - -
- DR KING:** When you said the private sector, did you mean - - -

MR STONE: No, I mean the for-profit sector, sorry. I should be more clear. Yes, for-profit providers have a profit incentive, obviously, that's inherent, and it would be, I think, quite reasonable in some cases for the government not to want a provider with a for-profit incentive. Sure, in one sense that's merely a characteristic of the provider, but it's a characteristic that is inherently aligned to the sector differences. So, in effect, such a statement within the commissioning process would, in effect, rule out a particular sector. If you're talking about not discriminating against sectors, that implies that that kind of decision cannot be made. So that's what I'm trying to get here.

Absolutely, I definitely appreciate what you're saying. In a sense, we don't need to worry about sector; what we need to worry about is the inherent attributes of the organisation. The discomfort is that where you specifically talk about not discriminating based on provider type, it might seem like those attributes that are determined by sector cannot be used as a basis for making decisions.

MR INNIS: So it's not a matter of what we're proposing; it's a concern about how it might be interpreted within government?

MR STONE: Absolutely, yes.

MR INNIS: Thank you.

DR KING: One more little bit on this before clarifying some other areas: one of the other submissions to us – apologies, I can't remember exactly whose it was – suggested deliberately choosing a range of provider types to provide services in an area so that the government could learn from those differences over time. Do you think that would be something useful, which is a different approach from what you've suggested?

MR STONE: And what I'm suggesting perhaps only applies – I'm simply suggesting the government should be free to do what I'm talking about. Absolutely, in many cases across family and community services and other areas, the government might well make the decision and would be sensible to do so to say, "No, we wish to have a diversity of providers so that we can actually see what are the differences involved in having different sectors involved." Making a specific along those lines would, yes, also be appropriate in certain circumstances.

DR KING: Just coming back to the accessibility of private housing to young people at risk of homelessness, can I understand that accessibility a bit more? One is the money side, which CRA, whatever it's increased to,

would partially address, like need or high cost additional payments would partially address that also. Are there other barriers to young people accessing the private sector and, if so, are there any directions we should look at for solutions?

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MR STONE: Absolutely. I can send you this – we have done other submissions on this topic. We did a submission on the review of the Residential Tenancies Act. We think that there are some substantial problems with access to the private rental market and that we've had reports from many multiple different homelessness services that there is actually discrimination against young people, as well as against other groups. Certainly Indigenous, disabled and various groups suffer from discrimination when entering the rental market. There's very little control over that. Real estate agents have pretty much complete discretion to say who goes into a property and who doesn't. There's no way to actually complain about it or stopping discrimination under those circumstances. As I say, we've written with some suggestions about things that could be done – making the Discrimination Act applicable to that area in some way. In order to make genuine choice for people on low incomes, there is more work that needs to be done there in terms of access to the private market.

DR KING: One thing we briefly refer to in the report is government head leasing and the potential for the government to act as an intermediary, for want of a better word, between the private renters. They would rent formally to the government who would then be able to act in a non-discriminatory way towards potential households or for social housing.

MR STONE: Yes.

DR KING: Any thoughts on that? Do you think that would be a good way to explore further, or do you think that would not be an appropriate approach?

MR STONE: My understanding is – and social housing is just a tad outside my area so I may be wrong – that that, in effect, exists, because what you're talking about is actually renting of private market properties in order to make it social housing. My understanding is that that actually already can occur. Yes, I don't see any problems with doing that. It may, in practice, be difficult, but that's potentially one way around the discrimination issue, certainly.

DR KING: Particularly as we are in Sydney with fairly high rental costs, one way that we've obviously tried to address the regional differences is through a state-based and state-run high cost payment system, if we moved to market rents for social housing.

MR STONE: Yes.

5 **DR KING:** You note that we don't have a lot of detail on that in your opening comment, which I appreciate. Do you think, though, that if you were writing our policy, would that be something you would pursue and, if so, do you have any thoughts on exactly how that should be designed to be effective, or do you just think that's not, again, the right way to go?

10 **MR STONE:** I think that it's certainly an interesting idea in that it potentially at least opens up a greater choice for low income families. Certainly, I'd never be against any increase to welfare. We all know many parties have been crying out for increases in welfare, so the idea of an increase in Commonwealth rent assistance combined with a market level
15 pricing of social housing. I guess what I'd be looking for in terms of were I designing it is no disadvantage. I'd want it to be the case that we never ended up with a low income young person who had a substantial rent increase because of the change in policy. That's what we are looking for. These are people who are already - - -

20 **DR KING:** A substantial out-of-pocket – if I can call it that – rent increase?

MR STONE: Exactly, that's right. So their rent might well increase, but one would hope that that would be entirely compensated for by an increase
25 in benefits, because these are people who are right on the edge, often, of what they can afford. I'm not quite sure exactly how to design the policy to make sure of that. I note that you've got this idea of a high rent payment that could potentially slot in and cover that gap, and that sounds good. As I say, my only two comments in regards to that is, one, it's not necessarily
30 always about the high rent; it may be about the very low income of the individual. And the second is, what does that really mean in practice in terms of how much money are we then expecting the federal government to fork over? That's obviously a really important point in terms of advocating for this.

35 **DR KING:** Final clarification from me: you mentioned seven years and you'd be interested in more evidence behind that number.

40 **MR STONE:** Yes.

DR KING: What's your view of that number? Do you think that's too short, too long, about right, given your experience?

45 **MR STONE:** What I found talking to the sector was that many of them actually talked about five years, but the feeling I got is that they've been so

often dealing with three, two or one-year contracts that any increase sounds better than what they've got at the moment. I think once they got to five they'd find that actually, "No, we could do with a little bit more than that." Certainly you look at, say, the ferries, for example, they are on seven-year contracts. I don't know if that's where you got it from or not, but I really can't speak to that. As I say, I couldn't find any relevant research that actually gave what is the right length of contract. I just think that it's probably helpful to have more guidance behind that number rather than a flat seven years. I mean the flat seven years. If that's what you end up recommending, then many, many people in the sector will be happy, but some of them are saying 10 years. It would probably be useful to have something behind what are you trading off. Obviously there's length of contract, and that gives you a lack of flexibility in terms of changing what you're doing, but, at the same time, the longer contracts tend to encourage innovation and you have less transaction problems and inefficiencies. So some more guidance on what government needs to take into account when varying from that base of seven might be good to have, if it's possible. As I say, I don't know if it is.

MR SPENCER: Just to outline our thinking – I would welcome any further thoughts on this – some of the factors we were considering in that were the length of time to establish a service and, again, trust and confidence, which, in a number of the services we are talking about, is absolutely essential.

MR STONE: Yes.

MR SPENCER: A period in which, as you say, to be able to give certainty, innovation, getting to results which can be measured and evaluated. We're also conscious of the staffing needs of many of these services. If there's so much uncertainty, it's extremely hard to retain staff. And at the end of that, a period of transition. If there's going to be a transition, we've commented on that in the report that that needs to be handled well. So the evidence is informed more by principles of how does this work in practice. So any further ideas or refinement around that I think would be really helpful.

Just in relation to that process, one of the things we've said is there needs to be a longer time for the tender process what thoughts do you have on that? What should that be? What does that look like? What would inform and help government to have a better timetable for tenders?

MR STONE: I didn't mention that in my opening statement because, in fact, I'm entirely supportive of the comments that you've made along those lines. Absolutely our experience from the Going Home Staying Home reforms was that there was a real problem with constricted timetables for

tendering processes and we definitely did end up with organisations coming to hasty agreements that didn't work out all the kinks and then had problems down the line. We certainly ended up with organisations that damaged their relationships and didn't get into agreements when perhaps they should have and things like that. So definitely clearer scheduling of when exactly these tenders are going to occur and how long they are going to be for to give more run-up time and definitely longer periods for the tender.

And certainly in terms of how long that should be, there really needs to be an assessment by government about what is the complexity here. In the case of going home, staying home, they knew that they were reducing the number of contracts they had from something like 300 down to 149, so they knew that a lot of people would have to be getting into agreements together. Under those circumstances one would think that would indicate a much longer tender period than normal, whereas, course, if this is a normal rollover of tenders, you've come to the end of your seven-year contracts and you're fundamentally doing the same thing again, that would not require such a long period, one would think. That sort of thing needs to be assessed about realistically how complicated is this going to be in terms of doing that. To find that out, government needs to be consulting, as any organisation would do in order to run a decent tender press, find out from the selection of those who are bidding what are the sorts of things they need in order to give the best bid. This is just sensible practice. So consultation with the sector would be extremely useful in that regard.

MR SPENCER: Thanks, Chris.

MR INNIS: Thank you, Chris. A little observation about the contracting length to add to Richard and Stephen: we did look at some private sector contracting behaviours, and the Sydney Ferry example was an example that we did look at.

MR STONE: Yes.

MR INNIS: Fundamentally what we're trying to do is create an environment where government and providers work much more closely together over the life of a contract so that innovation, so that collaboration can express itself properly. As Richard said, we were very conscious of the time it takes to really build trust as a new provider and the time it takes to do a proper transition.

MR STONE: Yes.

MR INNIS: That said, you could pick a different number, but seven built on what people said about five, and then we adjusted for the beginning and end. That's sort of how we got there.

5 **MR STONE:** I see, that makes sense. By the way, sorry to interrupt, just on that point about that more relational approach that you talk about, we're very much in favour of that and I noted in my submission that that does actually in practice occur. In the good districts where there's a good
10 functioning relationship between the service providers and the regional FACS district, there is often a very relational approach, so it would be great to kind of encourage looking at what already happens in that regard and making that common practice somehow.

MR INNIS: I want to come back to social housing just for a second. We
15 certainly recommend that the Commonwealth do more heavy lifting around CRA. Part of our intention with the additional payment, which is a state-based payment, is to place an incentive on the states to get a balance right between the conditions that lead to high house prices and the support they give to people that live in their community.

20 **MR STONE:** Right.

MR INNIS: So I just wanted to explain that there was a connection there. So a place like Sydney where there are high house prices and arguably a
25 benefit to government through revenue, there's also a responsibility to government to support the people who are affected by that on low incomes.

MR STONE: I hadn't quite appreciated that the higher payment would come from the states versus the CRA from the Commonwealth. I see what
30 you're trying to do there, yes.

MR INNIS: I hear what you have to say about money is not necessarily the only and often not the critical barrier for people. But in the other bit of design that we were trying to do is an upfront assessment of people's needs
35 so that a package could be tailored for them. Should we focus a little bit more on the entry barriers to the private market for young people, for people who might suffer discrimination as well as the other things that I've heard you say in your submission? Is that a helpful direction?

40 **MR STONE:** Yes, absolutely. I think that needs to be raised as an issue. Definitely. There are multiple solutions, like head leasing, which does, in effect, increase the amount of social housing out there, and that obviously increases choice, which is great. But I note that, for example, there's the youth private rental subsidy at the moment, which is only in, I think, three
45 or four districts at present. The primary aim of that is a subsidy, a short-

term subsidy, to get young people into the market. But one of the interesting things that's developed out of that is FACS developing relationships with real estate agents in order to get the young people in. And that is, in itself, a benefit because it overcomes difficulties, so definitely those sorts of points
5 need to be raised, I think.

MR INNIS: Thank you.

DR KING: Thank you very much, Mr Stone. Thanks for your attendance
10 today and your submission.

MR STONE: It's fantastic to have this opportunity. Thanks.

DR KING: Next is lunch, so we'll adjourn for lunch and recommence at
15 1 pm.

LUNCHEON ADJOURNMENT

DR KING: Welcome back, and I'll reopen the hearings for this afternoon.
20 Our first organisation the GroundSwell Project, and Ms Williams and Professor Leonard. Just for the transcript, if you wouldn't mind stating your name and organisation, because in that way you can be recognised on the transcript.

MS WILLIAMS: Jessie Williams, I'm the Executive Director of the
25 GroundSwell Project.

PROF LEONARD: Professor Rosemary Leonard for School of Social
30 Sciences and Psychology at Western Sydney University.

DR KING: Thank you. Would you like to make a five-minute opening
statement and then we'll open up to questions.

MS WILLIAMS: We'll do our best to keep to five minutes, thank you.
35 The GroundSwell Project is an independent organisation that works to increase death literacy in the Australian community. I am very glad to have Professor Leonard here with me today. She's the Chair in Social Capital and Sustainability in the School of Social Sciences and Psychology at Western Sydney University and whose research and publications relate to
40 third sector research, particularly social capital and community development in ageing and end of life community support. Rosemary is a member of the caring and end of life research program, which is led by Western Sydney University in partnership with Latrobe and QUT. This internationally recognised research provides much of the evidence base for
45 our work at GroundSwell.

Thank you very much to the Productivity Commission for having us here today. We recognise the submissions made so far to this review and we recognise that each agency brings their own values and professional experience to the mix, as do we. We are innovators and we are independent. The central proposition we wish to make today is that the best thing we can do to meet this wicked challenge of being prepared for end of life is to get clearer on how we can think about moving from the call to have an advanced care planning chat to actually being prepared and how we can be clever about future interventions to this end.

I will make some key points in response to the recommendation 4.3 and Rosemary will speak to the insights from the caring and end of life program, which spans seven years of work and also, lastly, the development of a death literacy index which we have just commenced with Western Sydney University.

Firstly to the recommendation 4.3, we think this is fine, but we also think it doesn't go far enough. On its own it is not sufficient to create the kind of change that we need. Prevalence of advance care planning is not enough; we need to understand and monitor the changes that occur through these conversations to understand how we can enable social change around end of life preparedness. We ask why, despite funding of advance care planning education, are we not seeing a change in the higher uptake of people showing up with an Advance Care Directive.

I would like to make three points in relation to this question. Firstly, because education focuses primarily on individuals. When health interventions target individuals they do not necessarily alter the familial, social, and environmental conditions and cultures that work against good end of life planning but, instead, rely heavily on the individual's ability to navigate the health system.

Second, advance care planning continues to be primarily a hospital or healthcare-based activity and is separated from the primary place of end-of-life caring – the home and community.

Lastly, enhancing social networks of care at the time of a health crisis may do more to build capacity for the individual to cope rather than focusing on completing an Advance Care Directive. We have engaged in advanced care planning conversations across Australia with all ages, cultural groups and numerous organisations through our public health campaign, Dying to Know Day. The focus is to develop death literacy, which is the practical know how needed to plan well for end of life, as in Noonan et al 2016.

5 Dying to Know Day is in its fifth year next month, and to date there have been over 350 public events in health services and all types of community groups. We know that given the confidence, there is a section of the population that are highly motivated to support others to get comfortable with their mortality and to get planning. We piloted a workshop called “10 things to know before you go,” with 120 individuals, and we showed that 80 per cent of those people took action after that workshop. We think it is because the conversation happened in a social context and that knowledge is power.

15 I wanted to bring your attention also to an exciting body of work coming out of the City of Frome where our partners in the Public Health and Palliative Care Council led by Dr Julian Abel, have been implementing a new approach to advanced care planning. The success of the Frome project in a town of 30,000 people is dependent upon approaching a 50 per cent home death rate by 2018. So far they’ve shown a 30 per cent reduction in all emergency admissions to hospital compared to the rest of Somerset, resulting in a saving of \$3.25 million per annum in Frome alone.

20 So what are they doing and how is it that people there seem to be able to plan and have their preferred place of death? What their work has shown is that advance care planning can be used as a social intervention rather than just getting a piece of paper completed. Working with an existing health connections network, the team are implementing a range of initiatives, and the key one being the development of supported networks around the person who needs help, so not care viewed solely as a service to be provided but, rather, driven by the question: how can health workers work with those with a life limiting disease to build theirs and their social networks.

30 If savings were made in a population as large as Australia, this could result in savings of \$2.6 billion per annum. This figure was suggested by Dr Abel and Palliative Care Australia, who we partnered with in a public health symposium in February.

35 We hope you consider that advance care planning is only a first step in social intervention to get people prepared. We can have a positive effect on the low numbers of advance care planning conversations in the community if we strengthen the capacity for carers, volunteers, artists, educators and community services to play a role in normalising and, more importantly, socialising the issue. This is a crucial part of the public health approach to end of life.

45 I’d like to pause there and hand to Rosemary to speak to what we’ve learned through the caring and end of life team.

PROF LEONARD: Our research over the last seven or eight years certainly supported the work that GroundSwell have done, and we've done that in partnership. Some key elements in terms of what is required in order to have successful end-of-life care at home – first of all, the acknowledgment that end of life is, in fact here, and some basic death literacy knowledge about options and rights et cetera. That is number one. Number two is a principal carer and a support network of friends, family, neighbours, community members, preferably with somebody taking on the role of coordinator or communicator for the network. That should not have to be the principal carer, because their load is already heavy.

Access to formal medical and care services for equipment, training, home help et cetera usually requires a guide. So if they have a really good relationship with their GP, great. If they have a family member who happens to be a nurse, great. But it needs somebody who is willing to take that role and assist them to get access to these services et cetera.

Of particular value was the 24-hour palliative care telephone service that was available to some of our participants.

Just to say that the advantages of people dying at home were beyond saving money. Certainly we believe that it did reduce hospital admissions et cetera, but we found that in the networks people who had even a marginal role tended to learn more about dying and their death literacy, we call it, and would be willing to care again. Identity maintenance – the carer and the patient still remained the people who they were because of their connections with their friends, pets, gardens, memorabilia et cetera. The power of death – death can connect people. The bonds that are formed around caring at end of life tend to be very strong ones. And care for the carer continued after the formal services were removed, which often happened almost instantaneously when the person died.

Our research also led us to identify the need for some sort of measure of how Australians understand end of life. This reflects on recommendation 4.5. We support the need for a data strategy, but we would also like it to go a bit further. We're developing this national death literacy index as a benchmarking tool. It's a social rather than a medical measure that will help us assess both national and local interventions. We think that widespread use of this tool would help us to understand more about where and how to target ACP efforts and help us create local planning activities and measure their impacts.

MS WILLIAMS: In summary, there's good evidence that advance care planning works best when embedded in a social intervention. We need

move past prevalence studies and data collection to learn more about social impact, and the death literacy index and its application aim to achieve this. Thank you very much.

5 **DR KING:** Thank you. Let me start off by clarifying some of the things that you've just referred to. One of the issues that was raised earlier today was the need or perceived need for more qualified palliative care specialists, so palliative nurses, palliative doctors and so on. I'd like to understand a bit more, firstly, do you see that as being a workforce issue that's needed and, if so, how does that fit back into the framework that you're thinking about in terms of both the advanced care planning, the caring – I really like the idea of the care for the carer, by the way; I think that's a great idea. How do you see that fitting in? Do you see there's a gap there? Where's the role, then, for the GP or a nurse, a specialist nurse or more a family friend? How do you see that all fitting together?

15 **MS WILLIAMS:** Firstly, I don't feel qualified to comment on the request around specialist palliative care. It's not my knowledge base. But I will speak to where we need to learn more about the interface between formal care provision and informal social care. It's been recognised by the caring and end-of-life time and the public health palliative care group, which involves Latrobe University palliative care, QUT, Western Sydney University and our friends in the UK, that little is known about how we can work better to bring the best of those two worlds together. We call that Compassionate Communities. So everyone has a role to play in end of life, and what could that look like.

20 If I could share just a brief anecdote to bring that to life: at our conference in February we had a woman who was helping her friend's husband die at home, and she kept a journal. Over 10 days she looked back on it and she realised that she made 327 phone calls to people, carers, the chemist, the local palliative care service, to get what was needed for this guy to die at home. The biggest frustration she had was that when she rang the health services, there was no recognition for her role. There was no understanding of the role she was trying to play. So that's the invitation that we put out – how can we learn more.

35 I wonder if there's something from the network mapping work we did at caring and end of life looking at where health services came in as the outliers of the caring network that might bring that to life.

40 **PROF LEONARD:** Certainly, we did social network mapping on the carer, their network, outer networks et cetera. We also did focus groups with formal service providers. We called the report, "Working together

apart”, because these two networks just didn’t really talk to each other except perhaps through the principal carer.

5 When you talk to the informal networks about the network, they describe it quite well, but they hardly ever mention people who are in the formal service provision network. And if they do, they tend to be on the outer. Sometimes a community nurse or somebody like that will change over time from being out there to in here in the network.

10 I would also like to say in terms of the need for specialist palliative care that we certainly came across people who didn’t have access to it. And whether they didn’t have access to it because there weren’t enough specialists or they didn’t have access to it because nobody told them that it was there and they would be entitled to it was not necessarily clear. But we
15 looked at both urban and rural people and I’m pretty sure that the rural people lacked access to that expertise. We’re not talking about a population sample when we did our research; we’re looking at what worked. But from what we saw in our research, I would support the idea that you certainly need to look at the distribution of palliative care experts and people’s access
20 to them, because I think both of those things could be problematic. We had people who weren’t getting palliative care until the day the person died. That’s not okay.

DR KING: You referred to the Frome example in the UK and the
25 significant change of place of death there and hospitalisations. Two things to follow up on that: do you know of other areas overseas where we should be looking to gather evidence on good palliative care, good community engagement approaches? Secondly, the even harder one is either in Frome or elsewhere, are you aware of anyone who’s actually done the numbers if
30 I can put it that way? I think you said – sorry, I didn’t note down the number – a significant increase in deaths at home versus hospitalisations. Did anyone look at the savings associated with that?

MS WILLIAMS: The financial savings?
35

DR KING: The financial savings.

MS WILLIAMS: Of what it means to die at home if the rates of dying at home - - -
40

DR KING: Increase, versus the reduction in hospitalisations. Sadly, but surely, governments care about dollars. So those two bits to follow up on.

MS WILLIAMS: I haven’t seen any other case study that correlates cost
45 savings with home death rates that I can speak to. I can point you towards

a case study in Spain, Dr Emilio Herrera, a Spanish palliative care physician, who is also part of the international public health approach. This is part of the policy work we've been doing with Palliative Care Australia. Unfortunately I can't speak off the cuff of the key insights of that, but I
5 would be happy to give you that study. And I would refer you to Libby Sallnow – S-A-L-L-N-O-W – who's been doing some really interesting work around some interventions that are showing good promise. So the intervention in Frome as well as the work that Sallnow is doing is looking at what they're calling health connectors and community connectors.

10 Just very quickly, in Frome, it's more often than not that they have medical practices, so GPs, all together rather than individually dispersed GPs, and they're putting health connectors in there. So people just signpost patients as they come in to end-of-life conversations which are about
15 signposting them to other ways that they can enhance their social networks or their caring networks and other resources they can access rather than going into the GP and expecting the GP to do it all. It's kind of a nurse practitioner role. They're training up community connectors as well. So public-facing people, people who work in libraries, coffee shops, public
20 transport drivers, are going to workshops learning how to be a community connector. They're very mindful that they're not calling this a volunteer program; it's a lot more social than that. Everyone has a role to play. So at any point in time I could ask somebody, "How are you going? You've got a cancer diagnosis. What's that like for you? This is what I know about
25 our town in terms of developing your death literacy. Let's have a chat about it." So they're researching that to show what raising someone's death literacy is like and what the impacts of that are. It's early stage.

PROF LEONARD: The one in Scotland is still in progress. We have a
30 colleague working on an intervention in Scotland. I don't think she's got the results out yet.

DR KING: Just the last clarification one for me: reading your submission, you mention the "10 things to know before you go" workshop and the
35 significant – 80 per cent, I think – number that then took active steps in terms of advanced care planning. I was wondering: my cynical side of me, my academic side immediately asked was there self-selection there. "I'm interested in it, I've gone to the workshop, so, therefore, I've done - - -

40 **MS WILLIAMS:** Yes, I think there's an element of that. The people that come to the workshop rate themselves on average I would say 6 out of 10 in terms of their death literacy. They're confident to talk about their end of life. So, yes, to invest 4 hours on a Saturday means that you're already into it. What we know, though, is that's just one intervention amongst many.
45 So what's great about a public health campaign where we open up the

conversation is we see all these different ideas coming from community about how to engage. So some people show a movie. Some people have a death café or a dialogue café. We're running a large public free-to-the-public event at Federation Square in Melbourne, which is a death expo
5 where we have 30 exhibitors on display. They're ready to talk to you about your death literacy.

We're always delighted and surprised when the community comes up with different ways to engage people. People who just want to dip their
10 toes in the water or people who want to get what we call death fit – get everything done. They're usually 55-plus or they've had an experience of a death that has not gone so well.

PROF LEONARD: I think also with the networks around supporting carers at end of life, you get people who don't really want to get that
15 involved but they'll come and mow the lawn because that doesn't mean going inside the house, or they'll work the dog or they'll leave casseroles on the doorstep or pick up the kids from school, or even more marginal activities. But just being involved at the margins can then bring them into
20 desensitising, I guess, and they start to engage a little bit more.

MR SPENCER: Terrific initiative, well done. Just having heard of somebody who was involved in the early days of GroundSwell I can see why you're so entrepreneurial. My comment would be think ahead five or
25 10 years – and I'm sure you are – what would that look like and what would it take to get there, and what's your sense of the investment that's needed to really have the sort of impact, no doubt, you're trying to have across the nation? What would all that look like?

MS WILLIAMS: I think what it would look like is similar to the place of mental health in our society now, where it's not so unusual for someone in our society to say, "I have depression" or, "I have anxiety." Twenty years
30 ago that would have been, I think, quite unusual. So the vision we have is for a society who knows what to do. That includes knowing how to respond. For us, normalising something is usually the language of health. It's
35 essentially an attitude. We're interested in socialising it so it is an everyday part of life.

I think for us the vision in five to 10 years – maybe 20 – is that socially
40 at least we would not shy away from conversations around death and dying, and we would have an idea what about our values are. I think one of the ways that we can get there is we can invest in community development as a core capability of people working in health, working at that front line of health engaging with the community. I believe it's the EIU that talks about

Australia's end of life services being excellent, but they rate us quite low on our ability to engage with the community.

5 What would happen if 10 per cent of all palliative care services actually
engaged in community development to build capacity in their populations
for us all to play a role in this. That's a question that we ask, and we ask
that to the Department of Health. We also ask what would it take if we
opened up this conversation to everybody and allowed for innovation to
really shine through. I think the best thing we decided that we could do last
10 year was to develop this death literacy index, which is a social impact
measurement tool. We tried to get it funded through government and we
couldn't, so it's a philanthropy group, it's the Wicking Trust managed by
Equity Trustees, that is funding this work. We are very proud to partner
with them. What we realised in that journey with Wicking over nine months
15 is that we have a very fractured end-of-life system. So the one thing we can
do is invest in the measurement of the impacts that we are all trying to have.

20 So we are excited to start that. We will have something to show for
that next year. We want to continue the work around compassionate
communities, looking at a public health approach. We have a second mover
advantage where we can learn from the UK, but we are quite different in
Australia. We are not sure a charter approach would work. So another
piece of work we're doing in the next few years is to really build capacity
across health and community for the innovators who want to see a different
25 end of life system. We will be doing that work.

PROF LEONARD: I think moving on from our results around the
working together apart, we've also tried to get funding for work that brings
together the formal health and service providers with the informal networks
30 and ask the question what are the good models for them working together.
We haven't been successful so far, but we do believe that we need to work
on that. We need to look at the models to measure their impact in that press.

MR INNIS: Thank you, and congratulations on the work you've been
35 doing. As you were talking I had a personal reflection. We should all be
so lucky to have someone who's willing to make 325 phone calls on our
behalf, but, equally, we should move towards a system where 325 phone
calls are not needed on our behalf.

40 **MS WILLIAMS:** Yes.

MR INNIS: I can see that's part of the journey that you guys are taking.
The question for me really is in terms of the development of our
recommendations, beyond reflecting the importance of community and the
45 cultural aspects of making people more comfortable with having

conversations about death and about support, where do you see those recommendations changing?

5 **MS WILLIAMS:** My response is yes, and it's not to take anything away from the recommendations; it's to add to the recommendations. Splitting the health dollar is really challenging. I cannot speak to how to do that. I can only speak to the power of the positive outliers and looking for those positive outliers that are there in our community. There are so many social groups or social networks that have turned into caring networks where
10 caring is happening at the grass roots level across Australia. What would happen if we recognised those as a sector, all of us trying to solve this problem and sharing those stories and what could we learn from those. Yes, bottom up and top down, we know that that's where we can start to see those interventions for change. I think we need to do more to bring the
15 bottom up a little bit. I hope that makes sense.

DR KING: Thank you very much, Ms Williams and Professor Leonard.

20 **MS WILLIAMS:** Thank you so much for your time.

DR KING: Our next participant is the Centre for Independent Studies and Mr Potter. Could you just formally state your name and organisation for the transcript and then a five-minute presentation and we'll head into questions.

25 **MR POTTER:** Thank you. I'm Michael Potter from the Centre for Independent Studies, and I'm a Research Fellow at the centre. Thank you very much for having me along today. My discussion today will focus on one section of the PC's report – that's social housing. Our submission does
30 cover one other area, which is Indigenous. Sara Hudson thinks that what's in the submission is adequate and felt that my section was the more appropriate one for having a discussion with you about.

35 Just focusing on the social housing section, the PC has made what I consider to be quite sweeping recommendations for a major shake-up of the rent model for social housing. I agree with the concepts and philosophy behind this recommendation, but I've got significant concerns that the reform is not going to happen in its current form. So while I think it's a good idea in theory, I don't think it's going to work in practice, and that's
40 sort of the starting point for the submission.

The key problem is particularly evident in Sydney. Based upon some evidence from IPART in New South Wales, a move to market rents would mean an increase in rent for some people of almost \$40,000 a year. We're
45 talking here about the most vulnerable people in the community. There

would be no government ever which would go down that approach, at least for Sydney.

5 This gap, this \$40,000 gap, would not be covered in any way by a 15 per cent increase in rent assistance. Of course, this does not apply to the whole of Australia. The key thing with social housing is that the rent that a person in social housing pays is broadly the same across Australia, so, like, for example, somebody whose only income is the DSP would broadly pay the same rent across the whole of Australia whereas market rents differ
10 enormously across Australia.

The social housing rent is similar and the market rent is very different across Australia. Instead of this approach, I'm suggesting that the PC take a different approach which moves the rent setting for social housing in a
15 market-based direction without going to the full extent of market. I'm proposing that we allow full choice of properties for people who are moving into social housing for the first time or wish to move property and that social housing providers be allowed to set a rent supplement or discount to all of these people who are exercising choice.

20 The base rent would remain linked to income, which, I guess, is the key difference from the PC's approach. However, I do acknowledge that there are some issues with setting the base rent linked to income, and I suggest that deeper exploration of this issue should occur. I suggest that over time
25 you roll out this approach — setting higher and lower rents — to existing tenants over time, and there will be safeguards both for existing tenants and tenants who wish to move, and I detail them in the submission.

I also recommend that public housing should be transferred to the
30 community sector over time. This should not just be the management alone. The PC in its draft report says don't go down the transfer of assets, and I present some arguments in favour of transferring of assets in the submission.

35 Lastly, I recommend that government policy should apply equally to public and private housing providers. I note that there are quite a wide range of areas where there are differences in treatment, and they should be removed wherever possible.

40 In the submission I go through all of the benefits of this approach. It sort of mimics the benefits of the PC's recommendations. It doesn't quite have the same degree of benefits, but it doesn't have quite the same degree of implementation problems, I might say.

Some other people are arguing that there should be a significant increase in the spending on social housing, particularly expanding the number of properties or the government subsidy. The submission argues that there are a number of things that could be done instead of doing that.

5 One is relaxing planning laws to make building cheaper. I argue that concerns are raised about the financial stability of the sector and the broader reforms I'm talking about, including transferring of assets to the private sector to increase their scale efficiencies and the rent differentials, will help with that.

10

I also in the submission raise a concern, which is something the PC mentions, which is that there would be value in a broad strengthening of tenancy rights. I argue that there would be problems with doing that. That ends my opening statement, and I'm happy to take questions.

15

DR KING: Thank you. Let me just start off with some clarifying questions: this is one I probably should have raised earlier today. I don't quite understand why there's a concern around the dollars and the cost to government. Let me explain that. We've recommended a 15 per cent increase in the CRA, which clearly is a federal government impost. We then recommended social housing be moved to market rents and the potential for high income payment. But as a starting point, that's completely neutral because from the point of view of a state government – let's take public housing, so it's the state government that gets the rental income – they're getting an increased rental income, the tenant is worse off because of that, but then the state government has the ability to make a high needs or a high cost payment to an individual.

20

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So if the state government so chose, it could simply pass the money back, take it in its right hand and pass it back in its left hand, leave every social housing tenant certainly no worse off and potentially, from the state's perspective, there's an increase in CRA which means that the state is better off. That doesn't help the majority of households eligible for social housing who aren't in social housing, they're in the private market. But your starting point that this is too big an impost for government, I don't quite understand that. I don't actually understand why the starting point isn't, "Well, there's a 15 per cent increase in CRA. But other than that it can be implemented absolutely neutrally from a state government perspective."

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MR POTTER: Yes, just to reflect back what you're saying, what you would do is let's ignore the 15 per cent increase for the moment. What would happen is for a state government, they would increase the rate they're charging people, but then they would increase the subsidy at the same point in time.

40

45

DR KING: Yes.

MR POTTER: Yes, I can see that point. That's a valid point, I think. The question is: would that be something that the state governments would be willing to do? I'm thinking that they probably wouldn't. That, of course, is something which I can't guarantee that state governments would oppose that. Part of the thing is, for example, we have this gradual move of assets into the private sector and how would it work with them. So the private sector housing providers would get a dramatic increase in the money they're receiving, and that comes from the state government, but how does the state government get that back again?

DR KING: It may be with the community housing providers.

MR POTTER: Yes. I'm advocating a 100 per cent transfer eventually of the assets to the private sector. The state governments are heading in a transferral direction, much slower than I would be advocating, but they are definitely heading there. The percentage of assets in the private sector is growing every year, and COAG actually had an agreement to increase that transfer. So you might think, well, it's only a small problem with the assets that are in the private sector, but the private sector is growing as a percentage over time. So this issue about it's just a round-robin of money, if you think that you could do it in such a way as a round-robin of money, well, you have to figure out how to do it with the private sector, and the private sector is growing every year. I'm actually advocating it should be growing faster, but leaving that to one side, the state governments pretty much all agree there should be an increase in the private sector, and I don't know quite how you'd square the circle on that one.

MR INNIS: Michael, just as we're going through this, can I clarify: are you advocating transfer of title to community housing free?

MR POTTER: It may be, it may not be.

MR INNIS: Would community housing be paying for these properties in some way?

MR POTTER: Either option. I'm not saying it has to be for free. What I say in my submission is that if you do it at a discount to the market value, then you probably would want to do with it some degree of caveating of the assets so that the private sector operator doesn't just get this asset and sell it and then pocket the money and you end up with a reduction in social housing. If we're transferring it at market value, then that's one thing. But if you're transferring it at below market value, which could include free, then I think then there is an argument to say that property, that specific

property, or the value of that specific property as to be used in community housing.

5 **MR INNIS:** Under that model, there's no guarantee those properties would remain available for social housing?

10 **MR POTTER:** What I was saying is that the asset value would remain in public housing. If the recipient of the assets decided to sell it, they would have to apply 100 per cent of that raised capital to social housing. So, in other words, the idea is let's say the state government sells a property which is in a very bad location. The new owner says it's in a very bad location and they sell it, but then they have to apply the entire proceeds of that to social housing in one form or another.

15 **MR INNIS:** It's just not clear how that's a good way of maintaining or increasing stock.

20 **MR POTTER:** I guess I'm arguing that the private sector are better managers of assets. In theory the public sector is a good manager of assets. My understanding is that they are not particularly good at it and the private sector is better. So if there is public housing in the wrong location, they would be able to manage it better, and that includes selling it completely or it could include redeveloping it.

25 **DR KING:** Just to follow up on that point, because that hits another area I just wanted to clarify: why in that situation wouldn't you follow what's a fairly common approach in privatisation, which is that the government retains the ownership of the asset but contracts out the management of the asset? The obvious benefit of that being is that if there's a dispute or lack of performance, it's easy to replace private managers if you don't have to also build new assets. A simple example is the Met contracts in Melbourne. That's been contracted out and the private managers have been replaced either two or three times on the same railway. Why actually transfer that ownership? That's the bit I don't understand.

35 **MR POTTER:** Because there's a key difference here, which is that you're actually talking about optimising the asset itself. In quite a few cases you might actually want the asset to be knocked down and rebuilt or even sold and a new one bought. It's not like a train line where it's incredibly difficult to knock down and rebuild. With an apartment block, it's actually not that difficult at all. It's happening all the time. If it's a poor quality building or it's a poor location or it's under developed, let's say it's one storey but the height restriction is eight storeys, then you've got seven storeys that are not being used. These are all things that the public sector could do. These are all the changes that the public sector could do. My argument is that the

private sector is better at doing these types of changes. If you transfer over management only, none of those will happen. You won't get the knock down-rebuilds, you don't get the sell in one location, buy in another location.

5

DR KING: Just on that, I'm not sure if you're aware of the private redevelopment of part of the Carlton public housing estate in Melbourne.

MR POTTER: No, I'm not.

10

DR KING: Okay, that's fine.

MR INNIS: Who would be responsible for the tenants who are currently in those properties?

15

MR POTTER: The new owner. So you'd have to have some protocols about how you deal with that transition process. That's important. I haven't really dealt with that in my submission, but it is an important issue. I think that there have been a couple of other submissions which have covered that in much more detail, but I'm not going to delve into that detail.

20

MR INNIS: I've got a few more questions.

DR KING: I'll wrestle back control to clarify. I want to understand how you're differentiated rent model really worked. I've read the submission and I'm still not quite sure I understand how it would work in practice. So, as I understand it, there would be safeguards for existing tenants.

25

MR POTTER: Yes.

30

DR KING: The property manager/owner could set differential rents and you've got a choice system also working behind it. But would the existing tenant reject it, so they don't have to move and they don't have to pay a higher rent?

35

MR POTTER: Indeed, yes.

DR KING: I just wonder, would it actually lead and why would it actually lead to much practical difference. I looked at it and said the likely effect is that anywhere where the rent is going up, the existing tenant just says, "I prefer where I am at my current rent rather than paying a higher rent," so I'm not sure if you'd see much movement. In fact, what worried me is that it may actually exacerbate lock-in rather than assist moving because, of course, "I'm grandfathered on a specific location. If I move I lose all of those grandfathered benefits." Can you expand on that?

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5 **MR POTTER:** That's a fair point. I say that eventually over time we want to have everybody on a differentiated rent. You'd have to figure out the transition to that differentiated rent carefully. I've suggested one approach which involves a safeguard, but there might be other approaches to do it.

10 If you eventually end up with a situation where everybody is on this new model, then you don't have that lock-in problem, but I understand you might have a lock-in problem until you do that, which is fair enough. However, there'll be a couple of things. First of all, people might find it valuable to move regardless of the fact that there is a higher rent at the place they're moving to because it might be closer to the railway station or closer to potential work or whatever. There might be some other benefits. I thought I had one, but I don't.

15 **DR KING:** That's fine, thank you.

20 **MR SPENCER:** I just wanted to understand the consequences of the title transfer. So that happens, but the community housing provider loses its accreditation or goes out of business or whatever. So what happens then to the asset, because the asset is lost, isn't it?

25 **MR POTTER:** I wouldn't think so. If you did a caveat appropriately, then you'd say that the asset or its value has to remain in community housing in perpetuity. There are wind-up clauses for associations. You might have a similar clause in this that if the owner of that asset is wound up, the asset still has to be transferred to somebody else who's involved in community housing.

30 **MR SPENCER:** One other issue as well – it's escaped me for a moment, so, Sean, you go.

MR INNIS: Please jump in, Richard.

35 **MR SPENCER:** Sure.

MR INNIS: So you've just described the transfer, and this is – I promise, my last question on that.

40 **MR POTTER:** You can keep going on that for as long as you like.

45 **MR INNIS:** There are some other important things to cover. If there's a caveat that it must be on-transferred to a particular type of provider, wouldn't that result in a discount to the full value of the asset?

- 5 **MR POTTER:** Quite likely. Sorry, to be clear, I'm saying that it needs to remain in social housing. Governments can choose whatever caveats they want, but my preferred model would not be saying it has to be a particular type of social housing provider; it could be anybody.
- MR INNIS:** I understand that.
- 10 **MR POTTER:** So you don't do the caveat on terms of the provider; you do it in terms of the lease.
- MR INNIS:** The caveat is on the tenant?
- 15 **MR POTTER:** Yes. The tenants of these properties would be social housing tenants.
- MR INNIS:** I understand. Just to clarify: in your submission the sense I got was you didn't necessarily feel either for new properties or for subsidies to tenants there was a need for a significant increase. In fact, the tenor of your submission was that planning and other things which the Commission
- 20 has often spoken about would help with supply and that's a better path. Is that the position, that there's not a need for any sort of injection?
- MR POTTER:** Yes, that would be a fair interpretation. I guess there might be a need if you implemented these types of reforms, particularly the
- 25 transfer of assets. If you did the major transfer of assets and then you found you still had a problem, you might look at that again. But I think the key thing here is to do the reform of the sector and then determine whether you need to be injecting more funds once you've done that reform. It's too early to say what reform of the sector will actually do to the efficiency of the
- 30 sector and whether it will still need a major injection of funds or not,
- MR INNIS:** I think I probably need to understand why you think our recommendations could result in such large rent increases. Our recommendation is quite clear that existing tenants would be grand fathered
- 35 at least for a 10-year period and that the reforms would only apply to new tenants.
- MR POTTER:** Yes.
- 40 **MR INNIS:** Those new tenants are operating in the private market right now, so it's not clear to me why there's an assumption that rents would increase.
- 45 **MR POTTER:** Well, they would increase by that amount, but the question is whether it's actually going to have an adverse impact.

- MR INNIS:** Sorry, how are they increasing?
- 5 **MR POTTER:** Well, for a new tenant, the rents will increase compared to the current situation.
- MR INNIS:** Not for that tenant.
- 10 **MR POTTER:** Yes, that's right.
- MR INNIS:** The new tenant wouldn't be paying more money necessarily.
- MR POTTER:** Not paying more money necessarily, but they will be paying more - - -
- 15 **MR INNIS:** They will be receiving a higher subsidy than they are today?
- MR POTTER:** Yes. Well, after 10 years this problem will occur.
- 20 **MR INNIS:** Certainly there's a transition issue.
- MR POTTER:** At \$40,000 a year – that's the worst case, I should point out – increase in 10 years is still - - -
- 25 **MR INNIS:** Where is that property?
- MR POTTER:** You have to go to the IPART submission which I referred to in my submission. They don't say specifically which property they're talking about; they said there's some particular property in Sydney where
- 30 the market rent is that amount. It's all in the IPART submission.
- MR INNIS:** Thank you.
- MR POTTER:** But they don't say where it is.
- 35 **MR INNIS:** A final question: I heard earlier that, in theory, you thought the reform package that the Commission has put forward is good, but you worry about the fact that it might not be picked up in practice.
- 40 **MR POTTER:** Yes, I think that would be fair.
- MR INNIS:** Is that a political problem or is it a technical problem – ie, is there a practical barrier to implementing it, or is it political?

5 **MR POTTER:** I would say it's both. Right at the start we had this discussion about if you were able to do it so that you actually had a net zero effect, if you were able to do that, if you were able to do it so it was just a reshuffling of money, then clearly it becomes a political problem only; it's not a technical problem. I would just say that if you're able to design it with just a rearranging of dollars on a cash flow statement and there wasn't actually any net effect upon tenants or governments, then, yes, it entirely becomes a political issue. But, as I said in discussion, I think you probably wouldn't be able to design it in such a way. There is no - - -

10 **MR INNIS:** So your assumption is it has to be fiscally neutral?

15 **MR POTTER:** Well, obviously, if you're going to spend a lot more money, then you can do this.

MR INNIS: Final question, I promise.

MR POTTER: You can keep going.

20 **MR INNIS:** The reforms that you propose, why are you confident that they are more politically palatable? Have governments indicated support for those reforms?

25 **MR POTTER:** No. But they've neither said that they haven't supported it. Actually, I have received some correspondence from several state governments saying, "We're broadly moving in that direction." But I think that was probably more responding to the choice part of it than the rent differential part of it. I actually think that those two really go together. I mentioned this in my submission: IPART in New South Wales is recommending you give choice only without the rent differentials, and I'm

30 concerned that that may not work because you'll actually end up with excess demand for the good properties and insufficient demand for the bad properties.

35 **MR INNIS:** Thank you.

DR KING: Thank you very much, Mr Potter.

40 **MR POTTER:** Thank you.

DR KING: Our next organisation is the Business Council of Co-operatives and Mutuals with Ms McCluskey, Ms Morrison and Ms McFee. If you can state your names and your organisation for the transcript then give five minutes of opening remarks and then we will get into questions.

45

MS MORRISON: Thank you, Commissioner. Melina Morrison, CEO of the Business Council of Co-operatives and Mutuals.

5 **MS McCLUSKEY:** Su McCluskey, Chair for the BCCM Expert Advisory Panel on Public Sector Service Mutuals.

MS McFEE: Gillian McFee, Business Council of Co-operatives and Mutuals, Chair of the Public Service Mutuals Task Force.

10 **MS MORRISON:** We might share our opening statement, if that's all right.

DR KING: Yes, please.

15 **MS MORRISON:** We'll just keep to time, though. Thank you very much for the opportunity to follow up on our submissions made to your very important inquiry. That's the first thing we'd very much like to say. We welcome the release of the draft report, commissioners. In particular, we commend the Commission for its focus on finding ways to put the people
20 who use human services at the heart of service provision. Human-centric business is very much part of the co-operative and mutual ethos.

Our key message today is that a vital foundation for sustainable reform of human services is for there to be a diversity of providers across all
25 organisational forms. We've presented evidence in our submission that co-operatives and mutuals are important contributors to the diversity in human service markets. Compared to countries like the UK, Canada and parts of Europe as well as other jurisdictions, co-operatives and mutuals in Australia we feel could contribute much more than they do to human services
30 markets, although they are already important participants.

However, as the recent Senate Economics References Committee into co-operative and mutual firms showed in their inquiry, there are systemic barriers to co-operatives and mutuals competing, growing and innovating
35 on a level playing field with other organisational forms. The inquiry made 17 recommendations to remove these systemic barriers, being regulatory, attitudinal and educational that presently limit the full participation of co-operatives and mutuals in the Australian economy, and this includes the human services market that the Productivity Commission has been looking
40 at.

These recommendations received bipartisan support, and whilst the Australian Government has not formally responded to them, significant progress has been made towards implementation. However, the
45 Commission's draft report contains no acknowledgement or analysis about

these barriers. This was surprising to us given that the Commission acknowledged in the draft report that

5 *Good stewardship should ensure that the only barriers to entering and exiting a market are those necessary to ensure positive outcomes for users and the overall effectiveness of service provision.*

10 Because we raised the barriers that exist to co-operative and mutual providers with the Commission and provided details of the recommendations, the Business Council of Co-operatives and Mutuals was disappointed that this was not included in some way in the draft report. Removing these barriers is a vital part of creating the pre-conditions for co-operatives and mutuals to be involved in human service markets.

15 We consider that the motivation of the service provider does matter and is a critical part of government stewardship as well. So before handing over to my colleagues to make their short statements, we would like to suggest, with respect, the following three inclusions could be made in the final report: the first is that you could include a co-operative and mutual example
20 in the section comparing the motivations of for-profit and not-for-profit providers – that is, box 2.6, substance over form provided as motivation.

25 Point 2, you could expand the section on page 85 about barriers to entering markets to reference the findings and the 17 recommendations of the Senate Economics References Committee inquiry into co-operative and mutual firms, and, finally, you could include a reference to the role of funders and commissioners in developing markets and fostering innovation in human services that may include enabling new organisational forms of social enterprise, as has occurred in the UK, with worker co-operatives,
30 which are also known as employee mutuals. Thank you.

35 **MS McCLUSKEY:** I'm going to reiterate what Melina has said from the perspective both of being the Chair of the Business Council of Co-operatives and Mutuals Expert Advisory Panel but also as being a member of the Harper review of competition policy. A key recommendation of that review was really to open up the area of human services to put users at the very centre of service delivery and to look at a diversity of providers.

40 In doing that, of course, we looked at being able to introduce competition and being able to get greater productivity. Our final report specifically included a reference to the importance of mutuals as part of that diversity of service providers, and it was actually the BCCM in its submission to the review that brought our attention to this. So initially when we looked at this, we had done what so many people do – that is, look at
45 for-profit providers and not-for-profit providers. It was only when it was

brought to our attention that we actually realised that there was an important group of providers that are actually in between – that is the co-operative and mutual sector. Because of this, we actually brought Professor Le Grand from the UK across to Australia to participate in a conference, run workshops and engage with us, advise us and educate us on how the UK
5 actually led the way in establishing the public service mutuals force and how co-operatives and mutuals could play a really stronger role in the area of human services delivery.

10 That led us to the specific reference in our report and, of course, other reviews since, such as the McClure review have also referenced this. We actually think there's a lot of merit in governments explicitly considering how to foster the development of a diverse market in human services and one that goes beyond that binary view of just whether it is for-profit or not-
15 for-profit but does include other service provision, because it ends up being too simplistic if you do that. We think it's important to take account of other legal structures.

The other thing that you can end up having is there's an unintended
20 consequence where quite often people in the marketplace think that if you are just privatising something it's a bad thing. I have experience with another mutual that I'm on the board of. There is very much about being a guardian of the outcomes that you're delivering that is actually quite important, particularly to the recipients of service providers. That's why
25 it's quite important to us that we believe reference to removing the barriers to allow more mutual and co-operatives to enter this actually adds to diversity in terms of service provision. Thank you.

MS McFEE: Finally, I will just mention briefly that I was given the
30 opportunity in 2014 to chair the BCCM's Public Service Mutuals Task Force, which produced a white paper on public service mutuals. It built on the experience in the UK that Su has referred to around their Public Service Mutuals Task Force. Unlike in the UK, the Public Service Mutuals Task Force here in Australia was an industry-led initiative. Basically what this
35 white paper sought to do was to raise awareness about the co-operative and mutual form in Australia and to highlight through case studies some examples of how we could see greater involvement from co-operatives and mutuals.

40 I've had the opportunity to engage in advisory services and consultations with a range of organisations, including existing providers, mostly not-for-profit, I have to say, and some start-up organisations but also government who have been interested in actually exploring more about the co-operative and mutual form.

45

5 We are planning a second edition of the white paper to actually share some of those lessons learned and to make some firmer recommendations. From that experience so far we've identified three very discrete areas which align with the Commission's six priority areas where we can see opportunities for co-operatives and mutuals to play a greater part. The first is in social housing, particularly around enabling tenants as the users of services to form consumer co-ops and to be involved in the management of housing.

10 The second is in family and community services, and we include in that disability services, where we have been able to support what looks like being a very successful family governance model in disability accommodation, specialist disability accommodation, which has received support from the NDIA, including funding support.

15 The final area is in Indigenous service delivery where the co-operative service model and structure actually formally builds in a legal structure around ownership and also because of the broader way that we've defined co-operatives and mutuals in the white paper, it does actually enable multi-stakeholder approaches to focus on particular places. Thank you.

20 **DR KING:** If I can just start off with some questions just to make sure I understand your position on fitting into our draft report. Thank you very much for the three suggestions. Obviously we'll look at each of those and consider them. On the second submission, you mentioned discussion on page 85 of our report – I won't look it up to see if it's the right page – barriers to entering the market for co-ops and mutuals in human services. Looking through the Senate recommendations, they certainly have them relating to information. They've got broad barriers, for example, capital raising. But there didn't seem to be any there that were specific to human services. I guess my first query is: do you see there as being any specific barriers for mutuals or co-ops in the human services space as compared to other organisational forms in the human services space?

35 **MS MORRISON:** Thank you very much for the question. I'll invite my colleagues to add to anything that I might say now. There are some very specific barriers. To pick up on your first point, capital, which is often the thing that's the starting point, the threshold for innovating, growing and going into new markets that may require some large-scale investment, require of the market that if you're going to have contestability between organisational forms that those different organisations are equally able to access the capital from the market that they may require to genuinely contest some of the new markets which are going to be expensive, if you like, to play in.

45

At the moment mutuals are precluded from issuing shares that provide working capital for large-scale acquisitions, if you like, or investments – it may be to innovate in a particular way – except by doing so in a way that will actually demutualise them, so moving away from their ethos. That’s a counterintuitive thing to do if you want to remain a mutual. You want the structure to be mutual to provide the service. So the way the mutuals currently do that is that they use debt, which is fine, and they use their balance sheet, but at some point, if you think of the huge costs that are coming to society around health care and aged-care delivery, for example, that could stymie markets in terms of the number of players. It will encourage only those players that have the agility around capital-raising that, say, investor-owned corporations have to play in those markets.

The second recommendation of the Senate inquiry specifically pointed out and made a recommendation around co-operative and mutuals being considered in policy discussions, particularly in areas where community services were being discussed or considered. The reason that recommendation is in there is that it’s not an overt way necessarily but at the starting point of policy discussions, there is a way of viewing the world or a paradigm in which you see existing players. We have this characterisation of our sector as the ninja economy – it’s sort of missing in plain sight where sometimes we’re not considered at the very beginning of discussions so that we can be part of innovation. So that’s at the policy level.

If I can give a very specific example of how that can actually then lead to a systemic barrier, with the Indigenous Advancement Strategy, the way that that’s been set up with very good intentions around improving the governance models of Indigenous organisations so that they can more effectively deliver services to their stakeholders, the eligibility criteria for organisations that wish to continue to apply for funding under the Indigenous Advancement Strategy is restricted to two organisational forms. One is companies under the Corporations Act, the other are Indigenous Corporations.

Although co-operatives – in fact, 140 Indigenous health organisations in Victoria at the moment are formed as state-based co-operatives – can apply for an exemption, the prima facie threshold for them continuing to get their funding or increase funding or go for additional funding is that they have an organisational form that’s not represented in the eligibility criteria. That has flowed, I would promulgate, from co-operatives and mutuals being missing in the discussion that preceded that actually eligibility criteria in terms of envisaging how governance could be improved in Indigenous organisations. So they simply weren’t at the table. They’re a few examples.

5 **MS McFEE:** The only comment I would make is that in addition to agreeing with what Melina has said is that all of the recommendations apply actually to co-operatives and mutuals in human services because at the heart of the discrimination, if you like, is a question about recognition and awareness of the model. That's because it's not taught in business schools. There are some progressive universities that have started to actually develop modules around co-operatives and mutuals, and what we are finding in response to the white paper is that the organisations that are actually coming to us and showing an interest in potentially converting to some form of co-operative and mutual are those who really at the heart of it understand what it means to put their service users at the centre of the business model. These are organisations that might be at that threshold of converting, having to convert from an incorporated association to a company limited by guarantee. And because the company limited by guarantee is the predominant form, that's what all their lawyers advise them to do, because they don't know about the co-operative and mutual structure.

20 We're also talking to organisations, not-for-profit organisations largely, who actually don't have many members. Often the board are the members. So these are organisations culturally who are really trying to take it very seriously what it is that you're trying to achieve in these reforms, which is to actually put service users at the centre of design. And what better way to do that than through the legal structure of the organisation.

25 **DR KING:** Unfortunately I don't know it off the top of my head, but I know it's somewhere in our overview – which is far too long – but our main recommendation on organisational structure is that the government is neutral or not discriminatory. We've had some feedback today that perhaps the wording could be a bit better there. But the idea behind it is that the government should be neutral with regards to organisations taking on board that different organisations have different objectives and that should be taken into account by governments when deciding which parties, which organisations, should be chosen for human service delivery.

35 I guess my question is: from your perspective, is that going far enough? Would you want us to go further than that? And if we do go further than that, wouldn't that risk coming across as, in a sense, picking winners and favouring. Once we get into that space I worry it's a bit of a slippery slope.

40 **MS McFEE:** I'm happy to have a first pass at that. No, we don't think that you should be favouring any particular organisational form. That's not what we're saying. What we are saying is that you do have a responsibility to make sure that all organisational forms are coming to this new

competitive environment with a level playing field, because they're not at the moment. That's the key message.

5 The other comment I would make is that what we particularly learnt from engaging Professor Julian Le Grand at Su's suggestion in helping us frame our submissions to the inquiry is that we would also say to you that in making these changes, a really important part of the change management is that in terms of government stewardship – so we're talking now about the role of the commissioners – is that they have a responsibility to actually
10 inform themselves about these different structures and they need to understand how organisations will perform differently on those five stewardship levers that you talk about – the quality, efficiency, responsiveness, accountability and what have you – because different provider types will behave differently when they have to make trade-offs
15 on those, as inevitably they do.

That's basically what we're suggesting to you. At the heart of that, at the risk of being repetitive, is that these barriers need to be removed. That may mean just because there isn't the level of awareness that there should
20 be some consideration given to some positive initiatives, such as what I believe the UK government did with the Public Service Mutuels Task Force – some positive initiatives that actually perhaps enable some of these new prototypes to form and be evaluated.

25 **MS MORRISON:** Just to add to what Gillian said, absolutely to endorse that we warmly welcome and endorse the Commission's attitude towards market contestability and neutrality. We feel that the reduction of barriers where we believe they have been proven and shown to exist in reality and that there are a series of reforms that have been suggested by the
30 Commonwealth government to redress some of those barriers, that in addressing those underlying barriers, we will actually help this marketization to occur in a way that's generally going to allow the full functioning of the market, that diversity will increase that contestability and deliver these better consumer outcomes.

35 Polarising a market – not that I'm saying the Commission is doing this – in many circumstances in the view particularly of commissioners of human services, the view of the world of alternative service providers is falling between for-profit or not-for-profit entities or the status quo of
40 government provision does not work for us. In being part of that universe, co-operatives and mutuals can end up being missing in action simply because they're not not-for-profits and they're not for-profits; they're something else, but they do exist and they have that unique characteristic that can give them a competitive advantage sometimes in some markets.

45

5 **MR SPENCER:** Just a couple of thoughts. Thanks, Melina, for those three specific issues you outlined at the beginning, or three suggestions, because that's always very helpful to have very specific issues. I think what we're wrestling with is quite a complex problem - the desirability of the level playing field, as we've talked about several times. Our way of approaching that has been to really try and focus government on its stewardship role and the attributes of providers. That covers a multitude of issues about performance, about ownership, about motivations and the issues you're raising with us about what feature strongly with co-operatives and mutuals.

10 I have a sense that we've gone somewhere down the path. You'd like us to go further. We would like government to be more thoughtful about these issues as well. I think that's what I'm reflecting from this discussion. There seems to be agreement about where we want to get to, but it's a question of is the word "barrier" that you use – and I struggle sometimes with that word, because I always think of a structural barrier, but what you're reflecting to us, it seems to me, is kind of attitudinal and sometimes regulatory. So when there are specific things that can be addressed, they should be.

20 I suppose a general question: co-operatives and mutuals have been around for a long time. So from all the work you do, the number of inquiries, I'm just keen to understand why are we still at this point where you have a very strong feeling that it's not a level playing field when you approach these issues? Why is that? What informs that lack of understanding?

30 **MS McFEE:** I'm going to tell a personal story. Richard, as you know, I've been involved in human services for many years. I have been CEO of one of Australia's largest not-for-profit organisations, wonderful organisations that do their very best in terms of service delivery. But it wasn't until I actually left the not-for-profit sector and went to work for a mutual that I actually felt and experienced the difference. It actually felt different to be part of an organisation that lives and breathes what its members are about. That's a cultural issue. That is a deep cultural issue that needs to be addressed in the not-for-profit sector, in particular, if the reforms you're talking about are going to get traction.

40 I think the systemic reason why we have not made further progress is because of, whatever you want to call them, these barriers, and it's a lack of knowledge about the model. People don't know about it. When they go to their lawyers to say, "Help us draft a constitution," the lawyers just immediately go to a company limited by guarantee. I have sat through seminars for the Business Council that Melina has sent me to where pro bono lawyers from the big end of town actually talk to not-for-profit

organisations about their legal structure and what options and they say nothing about co-operatives and mutuals and I have had to put up my hand and say, “What about co-operatives and mutuals? Why don’t you include them?” And they’re lost for words. They actually don’t know about it. So
5 it is a systemic issue, and it needs to be addressed.

MS McCLUSKEY: I might add something there because, Richard, I’m very interested in the wrestle you have with not wanting to pick winners, which, of course, we wouldn’t want you to do. But this issue about how do
10 you actually focus on the outcomes of putting users at the centre of this and getting greater user choice, getting diversity that all go towards that desirable outcome. Part of this does go to stewardship, and it’s systems stewardship. It’s the role government has – and I know the stewardship challenge, given that it was a recommendation and we left it to others to
15 really say what it meant – having given more thought to this, government in terms of opening up the area of human service delivery still has a role about the system and how they are guardians of that system to ensure that the best outcomes are achieved because their guardianship is around the community of Australia. In human services, we are really talking about
20 community services.

I think that is where the role comes in terms of being able to ensure that in achieving those outcomes you can get a diversity and that you can ensure that even if there is not direct government intervention in terms of getting a
25 level playing field – and there may be in a regulatory perspective – but in other ways that there is an openness and that there is a facilitation and an awareness so that users really do have that choice. So I think that’s where we would see that role, and that’s where we’re keen for you to perhaps go a bit further in terms of what you may say to allow this diversity of
30 providers.

MR SPENCER: Thank you.

MR INNIS: Thank you very much. As you can see, we’ve been listening intently and we’re wrestling around what I think is, at its heart, a very
35 agreed concept, which is that one of neutrality, and governments should be very thoughtful about who they select to deliver a service based on the attributes rather than the organisational form, which is what I hear you wanting to get to in practical terms.

40 I just want to test something with you about our recommendations because one of the things we’ve tried to do in the area of families and communities and remote Indigenous in particular, but, truthfully, this applies to all grant-based systems, is do much more foresighting by
45 government in providing much more certainty about what will happen when

and that when things are open for contest that there are long enough time periods for people to organise.

5 I guess if there is more certainty in the system, if you can predict in 12 months or 18 months there's going to be an opportunity for a new tender process around something and you're going to have a reasonable period to put together a proper bid, does that assist co-operatives and mutuals even the playing field a little bit because there's enough notice to be organised as against the not-for-profits who are already, in a sense, incumbents, if you like?

10 **MS MORRISON:** Any assistance that's given for any organisations in terms of forecasting, readiness, preparedness to be able to competitively tender for something that they think that they can deliver well within the objectives are going to be welcomed by not only our sector but, I would imagine, not-for-profits and for-profits. I do take the point that there's a great danger in picking winners and reiterate that this is not special pleading; we're not asking for special recommendations. We're asking for acknowledgement that the underlying barriers or challenges for competing in these markets are structural to the point where long-time minds or other tendering or procurement processes that recognise the importance of organisational form or the objectives, the stewardship objectives of organisation, that aside will not sufficiently redress the situation for co-operatives and mutuals in that they can step up to their full potential role in the Australian economy.

15 To go back to Richard's question, we do have that question a lot. If co-operatives and mutuals deliver very well and can compete and are strong providers of services and products in the Australian economy, why is there an issue? I think it's the issue about why we're sitting here today and why there's an issue around human service delivery. Whilst the business model has remained the same since its invention back in the dawn of time and more pointedly in Australia in the 19th century with Australia's first mutual, Australian Unity in 1844, that business model is still quite pure to its original design and ethos. The context in which we deliver human services has completely changed.

20 One of the things we did in the white paper back in 2014 was to look back at what had actually occurred with human service delivery where there'd been a transfer, essentially, from the community since much of human service and social care was delivered by mutuals before the advent of the state, if you like, and the welfare state. There was almost a whole scale transfer over to the state and responsibility for welfare, which was welcomed by many communities and it was part of becoming a

Commonwealth and federalisation, but it was also part of us thinking as a nation that there had to be a social services safety net for people.

5 These are all changing contexts for delivery, and now we're in a situation where the rising costs of social care present an existential risk to budgets and to society. So we want to be here at the table with all of the other providers trying to invent the future in a way that's going to deliver on the objectives that are enunciated in the draft report so we can actual put humans, the clients of these services, at the centre.

10 We do need some of those underlying not only regulatory and education issues; it is a moot point how much can the Commonwealth government do about the fact that lawyers and accountants don't learn about mutuals? We can change the legislation in the Corporations Act to allow
15 mutuals to raise capital like other organisational forms. We can insist that regulatory impact statements are mindful to include co-operatives and mutuals when they're thinking about the impacts of a change or eligibility criteria. We can enunciate in quite fine detail how these might apply to human services markets, those 17 recommendations, which are, in many
20 ways, are quite esoteric in the way that they're written. We do understand that, but underlying them are threshold issues that will allow these organisations to compete fairly.

25 **MS McFEE:** I'd just like to also add to that by giving a pragmatic response, which is to say that in response to the white paper and where we have actually had opportunities from government to explore the co-operative and mutual model, such as, for instance, in the supported independent living co-operative, which the NDIA and Christian Porter, in particular, supported, it has been because there has been a public servant,
30 usually a senior public servant, who understands the model, recognises the cultural issues and the need for innovation and is prepared to put their name to it and to find a way within the probity arrangements that governments have and that we respect to enable something to happen.

35 **DR KING:** Thank you very much.

 Ladies and gentlemen, that concludes today's scheduled proceedings. For the record, is there anyone else who would like to appear today before the Commission? Please come up first and give your name and
40 organisation. I will ask all people to come up to the table. If you could state your names and what organisation you're representing in or particular area you're representing if you're not an organisation.

45 **DR TALIANA:** My name's Raul Taliana. We're representing ourselves as individual dental practitioners.

DR LENARD: Andrea Lenard.

DR TAM: And I'm Patrick Tam.

5

DR KING: Welcome.

DR TALIANA: Thank you for the opportunity to make a brief comment. I will try and keep it brief. I'm a dentist in the public sector. I've worked
10 in the public sector for 17 years, and I've also been a private practitioner during that time. I've got post-graduate qualifications in public health and health management and my accompanying colleagues have similar experience and qualifications. I represent the view of the other co-contributors to our submission to the draft recommendations, who also have
15 similar experience.

We have experience in delivering general and specialist dental care in the metropolitan, regional and rural areas of New South Wales. Firstly, we'd like to congratulate the Productivity Commission for the manner in
20 which you are conducting this inquiry into human services and the draft recommendations for reform. Commissioners King and Spencer and Mr Innis, we unreservedly offer our first-hand experience, expertise and qualified intelligence to the Productivity Commission to progress the draft recommendations made to ensure that all objectives are achieved.
25

We interact with the eligible population for public dental services, including our first peoples, every day. We understand the issues they face and the social determinants that influence their lives in terms of health and social wellbeing. We have considerable expertise in the management, issue
30 and use of dental vouchers and the recently closed chronic disease dental scheme.

We are experts in dental workforce development at both graduate and post-graduate levels, including public health. We have an acute awareness
35 that oral health is only one part of a very big picture, and that people in our communities face a plethora of issues outside of the dental sector. We applaud those who have spoken in relation to these other sectors included in the inquiry.

This has emphasised the need for highly integrated solutions to improve the health and social wellbeing of the Australian community as social impact investment demands. We are excited about the government's mission to improve choice and patient outcomes through the contestability of public dental services, but we believe that only partially addresses a
40 preventive population approach.
45

5 The public dental sector does need strengthening through well measured funding directed towards training and retaining its workforce and with better utilisation of public health experts that have chosen to remain employed in the public dental sector to provide effective population level preventive approaches.

10 We would like to thank you for the opportunity to speak and we hope for the opportunity to work with the Productivity Commission to optimise reform so that value-based dental care is delivered effectively, economically and sustainably with integrity, resulting in very significant outcomes for our community. We believe that this is only possible with very clear lines of transparency and accountability from all parties involved in delivering dental care. Thank you.

15 **DR KING:** Thank you. If I can just ask a few questions on that. I also have your submission in front of me, so thank you for providing that. In terms of your individual positions as outlined in your submission, I understand that subject to appropriate minimum standards, appropriate performance monitoring, you feel that there is a role for the private sector as well as public sector to deal with public patients, is that correct or have I got that wrong, and apologies if I have got it wrong, because I have only had a chance to scan.

25 **DR TALIANA:** No, absolutely that is correct. We understand that the workforce ratio of public to private is not favourable and doesn't match the demand for public dental services. So we're realistic about what's required. We understand that it may have been considered early as another option to build the public dental workforce rather than commission private sector. However, we feel as though the Productivity Commission's approach to involve the private sector through very effective public-private partnerships is the way forward.

35 **DR KING:** Do you have views on the particular blended payments model that was suggested, whether it's the right way to go, the wrong way to go? We heard earlier today some views that it wasn't an appropriate way and that a fee-for-service model would be better. Do you have views either individually or as a group on that? If not, please, say so, that's fine.

40 **DR TAM:** With the discussions we've had amongst ourselves, we see that the fee-for-service model we see the future of dental care happening alongside health care in general and that it's going to be a value-based healthcare approach where it provides value not only for the patient but also the funders, whether that is a public funder or a private funder as well. The aim is to achieve sustainable outcome for that patient that's going to provide

long-term sustainability as well, not just a clinical outcome, but also looking at financial sustainability from health services.

5 **DR TALIANA:** So in terms of supporting a blended payment model, we do support that. We feel as though based on experiences from the enhanced primary care dental scheme which then became the chronic disease dental care scheme, caution is required. And we certainly agree with the suggestion of having a pilot and evaluation. We think there should be input from all parties involved in the transaction of what is a very important
10 service for our community. So, yes, in the end, we are in support of a blended payment model.

DR LENARD: Just one thing on the fee for service, too, it tends to promote treatment as opposed to preventive care, and that's been well documented
15 in the NHS.

MR SPENCER: That's very interesting. I think we all share the goal of trying to move to the preventive end, so in terms of looking at that sort of blended model, you have a sense that that helps to encourage more getting
20 to the prevention over time? Obviously this is a longer journey than just a couple of years, but that's very helpful to understand, if I've correctly understood your view on that.

DR TALIANA: Absolutely.
25

MR INNIS: I'm just interested in learning a bit more how you see a value-based model working in practice. What looks different to today?

DR TAM: Probably that would involve, again, data collection to look at which procedures are going to provide the best outcomes for particular
30 patients. And it's going to involve a collaborative approach as well. Following the teaching, so to speak, of ICHOM , International Consortium of Health Outcomes Measurement, we are just studying around that at the moment. Because it's a collaborative approach where there's data
35 collection which will allow an evidence base to be developed which will identify the procedures or any particular part of the clinical treatment that's going to provide the best outcome, that process will drive that value's based agenda.

40 **MR INNIS:** Patrick, can I reflect back and let me say it's lovely to be talking to someone who's as quiet as I am. At the heart of it is a much greater focus on patient outcomes and what's delivering patient outcomes so we can build a stronger feedback loop into practice. Is that sort of the heart of it?
45

DR TAM: Yes. Again, it's a common mantra – it's value rather than volume, quality rather than quantity.

5 **DR TALIANA:** I think the value should be defined by the patient rather than what we think is value for the taxpayer and for the provider. The value has to be defined by the patient. So has the preventive care or has the dentistry actually provided the patient with the value so they are confident with their smile without being embarrassed, so they can eat the foods that they want to eat, so they can be confident in applying for a job, so they can
10 laugh without hiding their teeth.

MR INNIS: Forgive me for asking, but the sense I get is the public construct at the moment is not delivering that. So there needs to be a greater focus, as opposed to the activity, the flow-through, a greater focus on
15 patients as patients and their holistic oral health needs, is that the essence of it?

DR TALIANA: Very much so. I guess in a public arena you're faced with trying to instil a preventive behaviour while someone's presenting in pain with a big hole in their tooth or they've got rampant caries across their mouth. So it's very difficult to ignore the immediate needs while managing the prevention within these individuals and managing their habits.

MR INNIS: Yes, of course.
25

DR TALIANA: It's really not just about saying you need to brush your teeth twice a day and you've got to stop smoking; you've really got to understand the behaviours or the influences behind those behaviours to make a difference. And that happens over time. Yes, we're overwhelmed
30 with patients coming in to the public hospitals with swollen faces, with rampant periodontal disease and caries. We can't ignore those. We would love to spend more time on preventive strategies, and we feel as though we can do that on a population level. We have the expertise within the public system to deliver that. We just don't have the resources.
35

MR INNIS: Thank you. This is, I promise, the final question from me: earlier today we heard a slightly different story – that, on the whole, dentistry is about prevention. I just want to confirm, from your experience as public practitioners, that's where you'd like to be but the system almost
40 prevents you from being there. Is that the current system?

DR LENARD: I don't think it is; I think it's the population that we're dealing with. So I think we have a very well population.

45 **MR INNIS:** So it's the people rather than the system.

5 **DR LENARD:** In private practice, yes, as we would be people that access private care. The populations we are dealing with have all the other issues that the other people have been talking about. So there's homelessness, there's chronic disease. It's not just their oral health; they're integrated with all the other services and all the other problems that they have. So it doesn't matter if they went to a private practice; those social issues are going to be there.

10 **MR INNIS:** So it would be wise for us to think about that carefully in the way we frame the final recommendations?

DR LENARD: Definitely.

15 **MR INNIS:** Thank you.

20 **DR TAM:** If I can just provide an example: if we come back to the question about social investment, one patient I've seen in the last 12 months, I begin a conversation with "How can we help you?" The patient's response was, "I'm tired of being on welfare. I would like to go and get a job, but I will not be offered an interview because I'm missing my two front teeth. Can you help me?" And the opportunity there to provide some social mobility where it's not only confined to health but there are multiple government agencies involved. This patient wanted to reduce his dependence on government to be able to be independent to contribute as a member of society. I think, again, if we come back to the question of value, that's contributing value at a number of levels for that patient but also for the health system.

30 **DR KING:** Thank you.

MR SPENCER: That's a very good example.

35 **DR KING:** Thank you very much.

Someone who has been with us all day, if you'd like to come up.

40 **MR LOBB:** My name is Reginald William Lobb – L-O-B-B. My various backgrounds enable me to make some informed comments on what has happened today and the proceedings that have happened today. My first qualification was as an accountant, and there the mantra was scarce means with alternate uses. That was given as a definition of the economic problem. My take on that would be to add to it the effective use of the resources, and I have seen a lot of waste in my years as a district officer, district manager,

within the New South Wales public service – whatever it's called today – I think it's the Department of Family and Community Services.

5 Community housing has been a major issue, social housing. My son bought his first property, which he went to live in, thankfully, and left us, and it was a property that had been rented to the Illawarra Community Housing. He didn't actually go immediately; he was home for a little while. There was a tenancy agreement he accepted that he would not have occupancy for a period. Now, when he went into that property, the tenants
10 had not been quite educated in how to look after a property and they had cats, and those cats did inside what they should have done in the kitty litter or outside.

15 I make that point because people do need to be educated into the properties they are in. In our family there are four properties that are let, rental properties. It is very difficult getting tenants that will look after the properties. Firstly there's a major problem with estate agents. They usually give the job of property manager to the person who's just left school. There has been something of a change in that regard, I think, because I and my
20 wife deal with two property managers. Now they are mature-age people who have experience. One of them told us recently that she had a rental property that had been a meth lab, so she has somewhat experience in property management. The other is an older gentleman who we have found quite effective. But prior to that one particular property involved, there was
25 no income for over 12 months. The rent just wasn't paid. The property manager wasn't doing her job.

So what I'm leading up to is there has to be education or people have to be assisted to become responsible tenants. The Illawarra Community
30 Housing were very good to my son – the carpets were pulled up and the flooring was treated and the best job possible was done. That was very costly to community housing.

35 I was on the board of the Anglican Retirement Villages for 12 years. I am very pleased that in more recent decades they have moved into, in a small way, providing accommodation for some people in former hotels where they've utilised some of that. I think that is a very good move.

40 I'm concerned. I walk around the city a lot, and I'm concerned that there are a lot of people living on the streets. They now have dogs, and that's a little bit of a problem. I don't know how you're going to educate these people. They've got their networks. They all know each other, and how that is going to be resolved, I'm not sure. There was a gentleman here
45 this morning from the shires and municipalities association.

5 I don't have much sympathy with the dental people who were here before. I was in a regional city and knew personally one of the dentists who had actually an association with the family I was involved with. I mentioned to him that this particular lad had a major dental problem. He needed dental work. And, "Oh, well, the dental hospital in Sydney." So the boy went there. I'm talking about an early teenager, he might have been 13. Such a mess was made of his mouth that I'm sure would not be made today that he was very, very angry and wanted to sue the dental hospital. Now, I don't know how he got on in that regard.

10 My view, having been just on 30 years in service delivery in DOCS, Family and Community Services, there needs to be a contribution for professionals where they don't want to be paid as much as they might be entitled to. I know of a number of professionals – a very close friend of my wife's – a couple are gynaecologists, they're retired and they now spend 15 three months of each year in India undertaking gynaecological work. And the reason they go, they say, "We can go there. The people want us. They don't want to sue us if something mightn't be as successful as it could be."

20 On the matter of mutuals, I have had a bit of experience with mutuals. Demutualisation has been an absolute failure. The AMP demutualised. I had and still have a number of life insurance policies, but the incompetence of the management on demutualisation meant that something around – and I'll be conservative – three-quarters of the value of that organisation was 25 lost when they took over an insurance company which had re-insurance arrangements that bled the AMP when they found them themselves owning that company, not aware of the liabilities there.

30 I had occasion to meet some young individuals – young, 30s – employed by the NRMA, or Insurance Australia Group at the moment. They said the reason NRMA demutualised was that it was the younger individuals that wanted the money or the shares that they could sell.

35 There's a problem with people wanting everything very quickly these days. We used to buy something very small and be satisfied with that until our family grew and we had to get something bigger.

40 Sirs, I thank you for listening to me at this short notice. I do consider it a privilege. Thank you very much. Would you like to ask me any questions?

45 **DR KING:** Thank you, Reg. I just have one: you mentioned your son's experience with the house from the Illawarra Community Housing, I think you said. So obviously one of the areas we're considering is that role of the government as an intermediary between a private landlord and a social

housing tenant for a range of reasons, one, to allow for more certainty of tenure from a tenant's perspective but also to provide a degree of certainty, a degree of protection, if I can put it that way, from the landlord's perspective. So taking on board what you've said about education, from your son's perspective, would you say that the Illawarra Community Housing body acting as an intermediary, in a sense, it obviously them to replace the carpets, but from your son's perspective as a purchaser and landlord, was that effective?

10 **MR LOBB:** Yes, it was very effective. Fortunately he did move out – you like your children to go. I'm sure if he, for instance, had accepted an appointment in the country teaching, he have been happy to have other tenants in. I believe so because I think that's – thank you.

15 **MR SPENCER:** That's fine, thank you.

MR INNIS: No questions, but, like you, we think it's a privilege, so thank you.

20 **DR KING:** Thank you, Mr Lobb.

Thank you all for participating today. I adjourn these proceedings and the Commission will resume tomorrow in Canberra. Thank you all.

25 **MATTER ADJOURNED AT 3.03 PM**