



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

**INQUIRY INTO REFORMS INTRODUCING INFORMED
USER CHOICE IN COMPETITION IN HUMAN SERVICES**

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

TRANSCRIPT OF PROCEEDINGS

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5 **DR KING:** Good morning, and welcome to the public hearings for
Productivity Commission Inquiry into Introducing Informed User Choice
in Competition in Human Services. My name is Stephen King and I'm one
of the Commissioners on this inquiry. Sean Innis with me is special advisor
on the inquiry. I would like to begin by acknowledging the traditional
10 custodians of the land on which we meet today, the Wurundjeri people of
the Kulin Nation. 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
15 two stages: the first stage study report; and the second stage inquiry report.
The purpose of the study report was to identify the services best suited to
reform. 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
20 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 the priority
services. A draft inquiry report was released in June which presented the
25 Commission's draft recommendations for each of the services. We have
talked to representatives from the Australian State and Territory
governments, service providers and their peak bodies, unions, academics,
researchers and individuals with an interest in the issues and held round
tables throughout the inquiry. We have received over 570 submissions over
30 the course of the inquiry. We are grateful to all organisations and
individuals who have taken the time to prepare submissions and to appear
at these hearings.

This is the first day of two days of public hearings in Melbourne. We
35 have also held hearings on Monday in Sydney and on Tuesday in Canberra.
We will be returning to the same location tomorrow and to conclude
proceedings in Melbourne. Next Monday we will hold our final hearing in
Perth. We will then be working towards completing a final report, having
considered all the evidence presented at the hearings and in submissions as
40 well as other informal discussions.

A 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 reports released by the government
45 which may be up to 24 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. We would like to conduct all hearings in a reasonably informal manner, but I remind participants that full transcript is being taken, for this reason 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 issues raised in other submissions. The transcript will be available to participants and will be available from the Commission's website following the hearings. Submissions are also
15 available on the website. For any media representatives attending today, some general rules apply and please see one of our staff members for a handout which explains those rules.

20 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. Please follow the instructions of floor wardens at all times. If you believe you would be
25 unable to walk down the stairs, it is important that you advise the wardens who will make alternative arrangements for you. Please listen for instructions over the PA from the warden. Participants are invited to make opening remarks of no more than five minutes, keeping the opening remarks brief will allow us the opportunity to discuss matters in participant's submissions in greater detail.

30 Our first participants today are the Australian Dental and Oral Health Therapists' Association so if representatives would like to come down. And Mr Ngyuen?

35 **MR NGYUEN:** Yes, that's correct.

DR KING: If you could formally state your name and organisation so it is recorded on the transcript.

40 **MR NGYUEN:** Sure. So my name is Tan Ngyuen, I'm from the Australian Dental and Oral Health Therapists' Association, currently as president. So in terms of the scope of the report, we're very pleased that some of the issues that we are concerned about has been identified, particularly around making
45 sure that increasing access to services using a – and moving towards a preventative model of care is certainly important for the Australian

community and also identifying that the important role of dental and oral health therapists who could play a critical role moving forward in the private sector, being one of the primary health care providers to provide dental services, not only at a State level, but on a national level as well.

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Also, we do support a broader, I guess, integration of oral health in the oral health system as well. Yes.

DR KING: Just for people on the phone in Canberra, I think it is, can you please make sure you are on mute? I am not sure if that was them, but there was certainly some noise coming across the speakers, either that or we are about to have one of those unlikely emergencies.

Mr Ngyuen, thank you very much for your submissions. What I'd like to follow up with some questions on, really following up from your submission is to get more feel from you from your experience and from your organisation's experience on the practicality of our recommendations. So our recommendations very much go to, as you mentioned, a preventive type model, and what all that's based on a blend of payments type of approach.

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MR NGYUEN: Yes.

DR KING: Which is a mixture of capitation and outcomes payment. Now, it has been put to us by some other submissions that that would be unworkable, but a fee for service type of approach is better.

25

MR NGYUEN: Yes.

DR KING: Just interested in your feedback. Do you think the sort of recommendations we've come up with are practicably implementable? Where do you see the risks being? Is it in the movement away from fee-for-services? Is it in determining the risk waitings? A bit more on that would be very helpful for us.

35

MR NGYUEN: Yes. I think in terms of the payment models, it's a very complex area and I think traditionally the dental profession is very used to a fee for service model. It would be very difficult to change how that would work. Obviously there's probably a bit of work that still is required to understand what's the best way to remunerate based on outcomes, but I think moving from an outcomes base approach to funding is still very early days and so there's still a strong bit of body of work that still needs to be done to make sure what kind of outcomes is relevant, not only for consumers, but also for the service providers and also making sure that it's also cost effective and you know, maximises the public funding for services

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as well.

5 So it's very complex and overall, I think it does need a bit more work and a pilot of some sort is certainly something that we certainly would support to obviously test and make sure that any risks that are there, are minimised. Obviously because it's contained in a more of a pilot, sort of, approach.

10 **DR KING:** Good suggestions. Good advice. However, from your submission I got the impression, I may be wrong and please correct me if I am, but you very much focus on prevention which is also our starting point.

MR NGYUEN: Yes.

15 **DR KING:** I didn't get the impression or I got the impression that you were convinced that our approach, that capitation type approach, would be appropriate for prevention. Is that correct and if so where are your concerns?

20 **MR NGYUEN:** Yes.

DR KING: Because we thought it would actually better for prevention than fee-for-service.

25 **MR NGYUEN:** Yes, I think a capitation approach would probably be a better way than a fee for service model. Probably we didn't articulate clearly enough, but I think moving from a capitation approach is certainly something that we wouldn't support because we know a fee-for-service type of model has always been, you know, driven obviously through
30 remuneration and it really doesn't address an outcomes based approach.

DR KING: Just one more before I change tack a little bit. You've obviously got experience with the CDDS, I understand the CDDS has ceased but the CDBS is still going, the Child Dental Benefit Schedule.
35 Have you seen – well, do you think that the fee-for-service approach under those schemes has led to appropriately cost effective and clinically effective care or not?

40 **MR NGYUEN:** Yes. I mean, we feel that the current – I mean, even with the current service schedules, that's not only including the public service, but also under a Federal scheme such as the Child Dental Benefit Schedule, the type of services that are funded, they haven't really been reviewed appropriately using a similar process to the Medicare benefits review, and so that's a bit of work that we certainly would recommend to ensure what
45 kind of services that should be included is obviously appropriate and

relevant and it drives the right, I guess the right type of services for consumers and also it creates accountability for service providers.

5 **DR KING:** Sorry, just one more on this and then Sean. But one of the benefits we saw with our model, I am sorry I am backtracking a little bit because I realised I'd forgotten something I wanted to ask about. One of the benefits we saw of our sort of approach, moving away from the fee-for-service towards the capitation, was to give more freedom is sort of the wrong word, but create incentives for clinical dental practices who may
10 have patients that are registered through the public dental patients register with them, to choose an appropriate mix of workforce, including oral hygienists for example.

15 Do you think that that's likely to be the case or do you see that there would still be a tendency to, as we've had put to us, that well, the non-dentist, the push to oral hygienists for example, oral therapists, are pushed to one side and dentists tend to do most of the work. Do you see the incentives changing, I guess, between the systems for the workforce?

20 **MR NGYUEN:** Yes. I think moving from a capitation approach it probably would drive service providers to think about how to use that capitation per patient more cost effectively and so there's probably in a sense, for service providers to utilise the workforce in the right way, and maximise, obviously, the skill sets of different oral health professionals, and
25 yes, certainly the capitation approach is something that we would certainly support.

MR INNIS: Thank you, Tan. You mentioned that the CDBS probably hasn't been reviewed in terms of the services. Can you give me a sense of
30 how quickly treatment philosophies and understandings change in the dental world and how often you would need to review a schedule to ensure that it's up to date?

MR NGYUEN: Yes. I couldn't quite comment on how regularly it should
35 be reviewed. Certainly to have a review at all, is certainly something that we would support, because it's really been based on traditional schedules that – yes, through consultation that has occurred, but from our point of view, we haven't been consulted. We certainly are one of the professions that do you provide services, but as an association, we haven't really been
40 consulted on that schedule form the start. So we feel that's – how regularly is a bit hard to know, but certainly a start to review it is an important starting point.

MR INNIS: Can I ask, like you, we think a more preventative approach
45 would be good and we are conscious that some people don't like going to

the dentist. So even under a fairly generous scheme like the Commonwealth CDBS, I think we heard yesterday at a meeting that 37 per cent of people who are eligible do take up the service which leaves quite a number not.

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MR NGYUEN: Yes.

MR INNIS: Within that number are people who could genuinely benefit from that. Do you have any experience or advice on how to ensure the people who really would benefit from the services actually get them?

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MR NGYUEN: Yes. I mean, probably one of the most critical part of including oral health as part of the broader health is to include other health professions in the oral health space. You know, there's always a consumer perspective that, you know, we see the dental professional only when there's a clinical need, and so – and that type of emergency type care, so there's probably a need to strength the broader health system to include other health professionals in the oral health space, and to really think about how we can consistently streamline both, not only the private and public sector together because both systems are equally important in terms of providing a preventative model of caring.

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Also reaching out, not only to the age groups that we want to target, but also earlier than that, so for example the Child Dental Benefit Scheme only starts from two to 17 when really we should be thinking about pushing it to from zero because early intervention and assessment isn't before age two and certainly kids who do require dental treatment and do need to be hospitalised for care, certainly could benefit from having care earlier than the two year mark.

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MR INNIS: Just keeping going on this line of questioning. We're interested in understanding that when someone new walks through the door the process of really assessing them to get a long term sense of their oral health needs, is that something that can be done reasonably accurately and how do you go about that, I guess?

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MR NGYUEN: I guess from my perspective as a clinician, when we see a patient for the first time obviously we'll do our diagnostics and probably fundamentally a part of practice is important to determine a risk status which has been identified in the report as well. So the risk status themselves, yes, they provide a basis of how much clinical need for patients to provide services in terms of the scope, is required to provide that care at that point in time, but then over time we'd like to see and I guess that capitation of funding model, (indistinct) moving patients initially that are of high risk for oral disease, finding mechanisms to shift towards a lower

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risk status and then keeping that lower risk status maintained, and obviously moving towards a lower risk status, would mean that there's less cost to governments to need to fund to keep people healthy, rather than a mechanism like as I said, just treats the initial problem and not – doesn't really think about the longer term options and cost effectiveness for patients and for government.

MR INNIS: Can I ask, we're talking about the payment model? You've outlined some real strong benefits for capitation in your evidence and you talked right up the front, a bit about outcomes and a connection to outcome payments which we proposed. Do you think most of the benefit lies in the capitation payment or is the combination with an outcome important?

MR NGYUEN: Yes. I think combination of outcome is important. You know, there's obviously a bit more work to figure out which type of outcomes would match capitation, but I think essentially moving forward towards a capitation system that works around a risk status would be useful, and also for, you know, longer term modelling. For example, if you're looking implementing a funding program for one population and then that type of model could be beneficial to inform and expand scope for other populations.

MR INNIS: Yes.

DR KING: Slight change of tack now. We've had a good discussion on the model and your views on the capitation model. One issue that struck us with the current public dental system is the fairly high level, if I can put it that way, triaging of a patient essentially, 'Are you in pain?' 'Is the pain keeping you awake at night?' 'If so, yes, you can get in early, otherwise on a waiting list'.

We were hoping to be able to implement a much more nuance triage approach when public dental patients initially come into the system. Now, there's obviously a trade-off between costs in clinical assessment there. I was interested in your views on that. Can proper triaging be done through a phone interview with a patient? Does proper triaging when someone comes into the system, need a physical assessment by a clinician? If so, what level of clinician would it require and just in a sense, what sort of time would we be looking at – you know, is it the sort of thing where it's an hour per patient or anything smaller? Just on average obviously it differs patient by patient.

MR NGYUEN: Sure. I mean, definitely triaging is certainly something that is heavily relied on in the public service. I know there is some research that demonstrates whether a phone system type triaging is useful as a

clinical examination. I think from our perspective, probably a dental examination probably provides the most accurate way to determine patient needs and obviously understanding and unpacking obviously consumer perspectives of what their needs are in comparison to a – or a health professional's understanding of what their needs are as well, and then combining the two because you can't really determine the true needs just from a consumer perspective because many oral disease is, I would say – isn't symptomatic and yet it's only when there's pain at a late stage when most patients would come to see a service.

10 **DR KING:** Yes.

15 **MR NGYUEN:** So from that point of view, a triaging has that limitation. In terms of the amount of time that we would require to assess someone accurately in terms of their disease risk status, we would probably imagine that half an hour appointment which is a standard consultation for a dental examination would be sufficient to understand and develop a treatment plan for patients.

20 However, as proposed I think in our submission, that we would definitely support a system where we would have patients to be assessed for their risk but also to start a preventative of model care at that point of time so at that point in time, that preventative of model care would hopefully move and helps support patients to support the current disease status as it is, prevent it from progressing rather than triaging a patient based on need and then waiting for something to happen or waiting for, you know, obviously there would need to be a waiting list for different risk status so to speak.

30 So I think starting that journey from that point in time is important, and at the moment some public services the wait list is about three years and so many patients who are put on the waiting lists often will have lost interest or moved somewhere, you know, changed their address or changed their phone number and so you find that maybe 20 or 30 per cent of people who are on wait lists don't come back for the general care after three years because of those issues, they haven't started that journey at all when they should have, ideally should have started that journey at that point in time when they have interests to seek care.

40 **DR KING:** In some ways we've sort of come a full circle because we are back with the consumer again and the importance of getting the consumer patient to see the dentist. In your opinion – and there's a number of ways to try and promote and get patients into public dental. I mean, one is the current system which seems to be – well, hopefully you know you're eligible then when you're pain you get access. Do you think we – what ways can we do better than that? I mean, one would be some sort of

awareness campaign and so on. Another that we've thought of is, well, we sort of know on a population basis where to look for individuals who are likely to be having dental problems and need preventative treatment.

5 What are your views on those sort of approaches? Are they useful or really pie in the sky?

10 **MR NGYUEN:** It's a challenge. I mean, it's evident even with the current Child Benefit Dental Schedule that there's not a lot of uptake and so obviously public campaigning and awareness certainly has an important role, you know, things around mass media are certainly useful for different preventive approaches to health seeking behaviour, and it's – ultimately the public service is severely underfunded and it really needs a leadership from both Federal and State Territory governments to think about what's the best way to, not only make sure that people who need treatment are seen earlier, but also to expand the amount of service providers that are funding for it, to help cater and meet the demands already for at risk populations.

20 **DR KING:** Thank you. Last one from me, it's more a clarification. The other side of the consumers obviously that we're seeing more and more in other industries, is feedback, consumer rating their providers, start ratings or Uber-style ratings, for want of a better word. Your submissions suggest that that may actually be against the Australian Health Practitioners Regulation agency guidelines, and just from a general perspective, we were wondering which of the guidelines you're worried may be contravened because obviously we've got already things like Whitecoat, I think it's called, the NIB one.

30 **MR NGYUEN:** Yes.

DR KING: So just more clarification that anything else.

35 **MR NGYUEN:** So I mean under the current regulatory requirements individual practitioners can't really use testimonials to promote their services because it can be seen to be, you know, coercive and potentially also, create false expectations of what they would expect from that service if a rating system was to occur. I mean, the Whitecoat type of rating system is something that is a – it is run through a private health insurance and so, you know, they aren't subjected to that same regulatory requirement as a registered practitioner, so that's how you can get away - - -

DR KING: Get around it.

45 **MR NGYUEN:** Yes, get around it, and the same standards as this, also for practices as well in terms of, you know, not being able to or shouldn't be

able to use testing models to promote their practice. Yes.

5 **DR KING:** And it's a good point there. Uber problem of course is what's called five for five, in other words you may be a terrible driver, I may be a terrible passenger, but both going to give other a good rating for service, next time it matters.

MR NGYUEN: Yes.

10 **DR KING:** Yes, thank you for that. Sean, did you have any other questions?

15 **MR INNIS:** No, thank you. It's an important issue. I think a star rating system would add value and I guess I'm seeking your view about whether that's right or not, if the regulations are an impediment, you know, you can view it as advertising or you could review it as valuable consumer information and if the quality of the rating behind that is the same, then it sort of performs both, I guess. But having a quality standard and a quality rating, would that add value to consumers' decisions?

20 **MR NGYUEN:** I think it could provide value at, I guess, at a macro level.

MR INNIS: Yes.

25 **MR NGYUEN:** It certainly would be risky to put it at a micro level which is by individual practitioner, and I think when consumers seek care and they often obviously chose a provider they like to see, and then if they're unsatisfied then they make go seek elsewhere and so that's a quite common practice for consumers to seek different service providers until they're comfortable with the service provider that – not happy with but, you know, they feel like – that are meeting their needs and expectations, and so I think consumers themselves probably have a better understanding of where value they would find once they've stayed with a service provider that they're happy with.

35 **MR INNIS:** Thank you very much.

DR KING: Thank you, very much.

40 **MR NGYUEN:** Thank you.

DR KING: The next participant is Dental Health Services Victoria. Ms Cole, thank you. My apologies, I have a cold. Anna gave it to me. Do we need to speak up by the way? All right, we'll project better.

45

MR INNIS: Apologies guys.

DR KING: Ms Cole, would you be able to state your name and organisation for the transcript?

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MS COLE: Yes. I'm Deborah Cole, the CEO of Dental Health Services Victoria.

DR KING: Would you like to make a five minute initial statement?

10

MS COLE: Yes, that would be great. Firstly, I'd like to acknowledge the significant change in the reform proposals in this latest report and thank the Productivity Commission for listening and researching and recommending more of a value based reform direction.

15

I have just got a couple of points I just want to make under, I think, in relation to the two chapters in the public dental section. So under the reforms to underpin more effective provision of public dental services, I think one point that I've made before but I think we need to repeat, is that the total public dental funding envelope only provides for a small proportion of the eligible population to receive care. So across Australia that's about 21 per cent of the eligible population in any two year period receive care, and many of the recommendations and desired outcomes in this report of government are assuming, I think, a much higher funding level, one, I'd love to have the opportunity to spend.

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But one of the things that Dental Health Service Victoria and the other point is that we believe that even within the current funding level, there are opportunities for reform and improvement and that's why introducing the value based health care agenda where we provide better health outcomes for more people with the money that we have now.

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Value-based healthcare has funding models that drive value rather than volume. Bundled payments are recommended as part of that agenda, and you need to risk adjust for the patient complexity and you need to pay for outcomes. The model of care will drive a much stronger preventive and early intervention focus and with that, that will reduce preventable hospital admissions, that will reduce high cost interventions and the risk categories will actually be the determinant of the types of care regime that you will require but it's very, very different to probably what's provided now.

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Waiting lists, I think, still need to be more managed so we're looking very much at waiting lists being a different beast than what they are now, and that's an opportunity really to stop further deterioration and to assess the consumers activation, as we call it, or probably enthusiasm.

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With respect to your second chapter on user choice and contestability in public dental services, I'm probably not quite as convinced that in the current environment that user choice would work. I think a lot of it's because the dental profession is predominantly in the private sector and single person practitioners still, all very small practices. Value based health care needs are good evidence based clinicians that work in teams, at the top of their scope of practice and clinicians and patients that work together in partnership to deliver better health outcomes, and that requires a relatively complex environment and model of care.

This is a long-term change I think. It's not something that's going to happen overnight and it will require major curriculum changes at university level. It will be increased access to evidence by clinicians, particularly those single person practitioners, increased literacy of patients to be able to interpret the information they are provided, so it's not a short term change.

One of the other things I'd probably just want to comment on, is the report seems to consistently – critical, I think, of public dental sector and I just want to – and I did mention this last time I presented about the about to be published but now has been published results of the National Child Oral Survey.

South Australian Dental Service had been running a strong preventive early intervention program for 25 to 30 years for most of the children in the State, and when you look at the data there, the 'd' of decayed, missing, filled teeth for six year olds is measured at point seven of a tooth per person, compared to 1.4 nationally, a significant difference, and that's what I call a health outcome. So thank you very much.

DR KING: Thank you very much for that. If I can just clarify a few points on your presentation just to start with. I guess we see our system, certainly if (indistinct) with no waiting list, waiting lists reduced to a minimum, as the current system, it would need substantial increase of funding. I guess we saw it as being flexible, but in a sensible, as with the current system waiting lists expand and contract, subject to management which I want to come back to in a second.

Do you think our system or the sort of system including the private sector that we're talking about, would that be able to work on, if you like, a flexible basis or would it really need that substantial funding too, compared to the current system to be able to work?

MS COLE: Look, it would definitely need a significant funding boost to where it is now, but let's assume, even if there was a funding boost, I think

with value based care, one of the advantages of a more managed waiting list system is that it allows time to apply some of the preventative practices and provide information to consumers, so that the consumers can then choose as to whether they're going to participate in the process because it is
5 a two-way thing, it's not just clinicians doing things to people, it's actually people participating as well.

That will actually be some of the decision-making further down the track, as to whether you will apply some quite high level interventions like
10 the high cost type activities or not. I think at the moment in private practice and when you come off the waiting list in the public practice, we tend to just take the person as they are, do a whole pile of things on them, and hope that the expensive stuff that you've done is going to be maintained.

15 The advantage of a managed waiting list type process is that we can actually improve people's oral health in that period of time and then think, 'Is it worth investing in doing some of the more expensive care', and some people would choose, 'I don't want to play in this space, I just want to come in for emergency care' and I think we have to respect that there are some
20 people like that, and at different points in their life, that will change. You know, but we need to give them the tools to realise that they can change it if they want to.

So I actually see there is some advantage of time in any treatment regime,
25 whether it be called a waiting list or whether that's something that you'd incorporate into your model of care.

MR INNIS: Can I ask just on the managed waiting list concept? So in my language now, services start when you enter the door, a waiting list is not
30 just waiting in a sense, but it's not the high end in the chair services.

MS COLE: Yes.

MR INNIS: Should governments be looking to more behavioural type
35 analyses to learn what might work with people who are on the waiting list in terms of those fundamental behaviour changes that help oral health long term? Is that the sort of direction that - - -

MS COLE: Yes, one of the things that we've been looking at and it's a
40 brand name so I – but we'd looked at some work that's been done in the States called Patient Activation Measure or PAM, and that's exactly what they do, they look at behavioural indicators as to whether people are really ready to make some of the changes, because if people aren't ready because they're worrying about whether there's a roof over their head, they are not
45 going to be worrying too much about all of the - - -

MR INNIS: There's a hierarchy of needs there.

5 **MS COLE:** Yes. So it gives people an opportunity to say, 'I'm ready for this now and let's participate,' and then we apply different behavioural interventions at that point in time, as opposed to if somebody's not ready. So I think - that's something that we're looking at as part of the process in our model of care at the moment.

10 **MR INNIS:** Thank you.

DR KING: Can I understand how that would be practicably applied? It strikes me that you need two things additional to the current scheme if moving down that approach. First is, I would have thought you'd need
15 much more nuance triaging when someone first interacts with the system, and secondly, I guess to use our words, you would need the patient to either choose or be allocated, depending on the model, to a public oral health practitioner early but it's not clear to me that it would need to be a dentist, to have the waiting list treatment, for want of a better word, the preventative
20 sort of treatment, have I got that right, and if so, how would you see both of those, the triaging and the waiting list management working in practice?

MS COLE: Recognising we're very early on in our development of this, and this has been worked on by a whole pile of clinicians and non-clinicians
25 designing this, and our consumers, but this is almost exactly as you said. We're looking at risk assessing people when they first come in the door from a triage perspective, so that we can identify basically high, medium, low type risk. Some of that would determine emergency care, but then what we would do is - - -

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DR KING: Sorry, just on that. Would that be still by a phone interview or would it be - - -

MS COLE: I think I would like to do as either phone interview or by
35 online. The more that we could do online the better. But then when people come in for care, they will get their emergency care and then they would be put onto this - so they will be made good, if you can. Then we would - because when you're in pain you're not going to be following toothbrush instruction or anything like that. So the idea then would be once people are
40 stable, then we would have probably oral health educators, so dental assistants with a Certificate IV training that are trained in oral hygiene instruction and diet and all those sort of things, and we'll start a program of them receiving care on the waiting list. It might be in group work.

45 It might be - we've got to find the most cost effective way, but it's

definitely not using a dentist, or probably an oral health therapist, at that level, and then we will look at how they are progressing over time, and it will be part of the commitment they'll have to do, is coming in for regular appointments. It might be telephone chats. There's lots of – and I think one of the examples you showed was, I think in Queensland, with people ringing up on the phone.

We will be looking at those sort of models as well, so they'll be a combination of face-to-face, maybe in groups. They'll be combination of phone. We will test out a number of things to find the most cost efficient way of delivering the right outcome, and it will be different for different community groups. So I would imagine if there were language issues, it would probably be a very different model that we would use for different language issues or cultural issues as well.

So at the end of that, let's say they've come off the waiting time, that's when we would look at the patient activation. Like we would look at the track record while they've been on – have they turned up to all the appointments? Have they participated? What's their oral hygiene looking like? All of those sort of things and that will determine are we going to just do the bare minimum to get them out of pain, keep them out of pain, not let people get worse, or are we going to say, 'Look, this person's got such commitment', we could probably go and do more treatment, you know, some of the more high end treatment.

MR INNIS: Can I ask, so we're talking about the front end of the system which is very important and you mentioned earlier that funding across the board would get you to about 21 per cent of eligible population. I'm conscious in the Child Dental Benefit Scheme which in theory can expand, we're at 37 per cent of the eligible population. At that front end, are there thing we can do to get the right people through the door?

MS COLE: Yes. I mean, one of our big – I mean, in fact with children, with a combination of public, the 21 per cent I gave you was for adults.

MR INNIS: Yes, thank you.

MS COLE: I just need to correct that.

MR INNIS: No. Thank you.

MS COLE: But for children, between the combination of public dental services and I think the Child Dental Benefit Scheme, it's just over 50 per cent, I think, that are accessing services.

MR INNIS: Thank you.

5 **MS COLE:** I can give that correct number if you want that. That's just out of the top of my head at the moment, but we would – sorry, I've totally lost the track of the question.

10 **MR INNIS:** So in a way I'm linking back to the South Australian experience and what looks to be a particularly good outcome, and that strikes me as sort of an outreach strategy, that I'm testing.

15 **MS COLE:** No, you are right. So it's about getting people in. One of the things that we are doing here in Victoria now, and I think a lot of other States are starting to look at, is how can we improve the take-up rate, and in fact, particularly in Barwon Health area or Geelong area, they've done a
20 fabulous job of significantly increasing the number of pre-school children accessing services and it's actually had a significant effect that they apply very much the sort of program I'm talking about with lots of prevention interventions, early intervention and we're actually starting to see different outcome, better outcomes for that particular area and they've probably been
25 doing it for about three or four years now, so they also had fluoride added to their water supply about five years ago, probably a bit longer than that, at about that period of time ago as well.

30 So the combination of those interventions are really starting to show some really good outcomes. So it does work but it requires quite a conscious and concerted effort. It's not simple to get people in and one of the things that I am constantly amazed about is how few people realise that they are eligible for care, and you hear it time and time again.

35 In fact, I had a consumer ringing me in tears on the weekend – I mean, the other night, at 9 o'clock at night really upset that one of her friends who was eligible, had gone out, paid for care, quite expensive care, and they were eligible for free care and she just couldn't understand how that had happened, and she thought she'd let this person down. She was one of our
40 consumer reps. But it was just – it is surprising that people still to this day, don't realise that they can access care.

45 **DR KING:** You mentioned outcomes and I'd like to swing around onto that. A number of the outcomes you've mentioned are population level outcomes, so the statistics in South Australia. Our system and I understand what Dental Health Services Victoria are looking at, is much more individual patient outcome measures. Can you fill us in a little bit on that? How practical are they? How much investment is needed to make them practical? Could they be rolled out and used on a national level using
50 outcome measures and I guess, the fourth part is, do you see that happening

or does there need to be some sort of champion in government, you know, it's been put to us, you need, to get this all working you need a chief dentist.

MS COLE: No.

5

DR KING: Someone who will raise the flag. So those sort of things. The practicalities, the workability of these outcome measures at a patient level.

10 **MS COLE:** Okay. Well, you know that I'm involved in the International Consortium of Health Outcome Measures for Developing Oral Health (indistinct) and we are just about completed doing the adult KPIs and we're about to move to the children KPIs. The only things we're looking at are for periodontal disease and caries, but considering that's 80 per cent of the disease, that's probably a good thing to be targeting.

15

20 So we are not looking at other oral diseases at this point in time, and it's quite interesting because there's an international group, like people from all over the world involved in this. So we are trying to make sure that we are picking indicators that can be used anywhere, in third world counties and first world countries, so it's really important that we have things that are pretty practical.

25 So the types of indicators we have are predominantly patient reported outcome are some of the measures. Then there's some clinical ones like the DMFT type – decayed, missing, filled teeth type clinical ones, and there'll be a periodontal disease ones as well, so the pure clinical – and then there'll be some, sort of, if things go wrong, some of the clinical indicators that things go wrong. So they'll be required at a clinical level.

30 All of these things, I think, particularly from a public dental point of view, probably right across the country, we're pretty right for most of the clinical things. Most of us probably don't do any of the patient reported outcome measures, but I don't think that – I personally don't think that would be very difficult to implement they are the sort of things you probably
35 ask at the time at different times, but certainly when you're doing a medical history, there are points in time, and it could be done on-line, quite a lot of these things at different points in time, and we have seen quite a lot of apps that are available that you can easily get, send out to consumers and they can fill them in before or whenever you want them in that point in time. So
40 I think it's applicable.

45 One thing that I suppose is, we're going to have to test this and check it. They will have to be validated. The adult ones are using tools that have been around for a while, in fact probably 20 or 30 years, which makes them probably, even the language has changed in that time, so they do probably

need to have the language slightly changed, and therefore they need to be revalidated, and they were probably designed for a slightly different purpose than what we're looking at using them for, but that doesn't stop them being useful. So I think it's all practically possible, but there's still a lot of work to go in.

DR KING: So I get the impression it would be quite easy, or in your view it would be fairly quick, to get the clinical outcome measures, the promise of a patient reported measures. A couple of years do you think that would be? Is that too optimistic or too conservative? Just to get a feel for - - -

MS COLE: No, I think it could be done in that time because we aim to finish this body of work, we were aiming for the end of this calendar year, but it'll probably be earlier next year.

DR KING: All right.

MS COLE: To be fair, it's taken a bit longer than we thought. So it'll probably be, you know, I'd say by, within the first quarter of next calendar year we'll have them. We will go through a process of validating. We will start using them in Dental Health Services Victoria probably as part of the validation process, and we will get some idea of what works and what doesn't work, so I think there will be some tweaking. So I think within a couple of years it would easily be - we will have the tools that will be usable.

DR KING: Anything else in this direction? I have just got another area I want to - - -

MR INNIS: No, I have got another direction, yes. So you go.

DR KING: I will do it. All right. I just wanted to swing back around to one thing that you mentioned in your introductory statement on the private sector so the choice side, and you noted that quite a few private sector providers are in small, individual practitioner clinics or small clinics. Do you think though - that's not all of the private sector. Would it be useful to all of them for supply and be able to meet the demand for public dental services if the government, for example, tendered and said, 'Well, larger clinics that are able to meet the level of and range of services that we need can, if they wish, apply to provide those services'. Do you see that as a useful intermediate step or is there something more fundamental about the private sector that you could put on this list?

MS COLE: Look, I have a view that as long as you're getting the outcomes it probably doesn't matter who's providing the care, but I am very aware of the fact that there's a - you know, the South Australian experience is, there's

a lot of thought in that. There is a lot of information. There is collection of evidence, there's constant, you know, reviewing the literature. Small private practitioners would have trouble doing that. You know, it's just, they've got to work and earn a living at the same time as keeping up with things, while we have, you know, I have a team of people that keep everybody up-to-date. It makes a big difference. So there would have to be a way of being able to provide that. Some of the bigger provider would be able to do that as well, but as long as you're getting the right outcomes.

10 I suppose the thing that I am aware of, this is such a major turnaround, turning dentistry almost on its head in some ways of the way we deliver care. It is a different thinking process. It is a very strong public health type thinking process. It is about value, that basic concept. I mean, when you talk value, people think value for money. They are not thinking of the health outcome value. So there's - and some people think values as in, you know, what's in your heart type thing, so we have got a long way to go even with the language about what does it mean, what are we really talking about? It is quite a hard-edged concept really, but you need people thinking like that when they're making the decisions about what resources they're going to put into the care of that person.

The other side of it is, the person involved has to understand why this is good because at the moment, yes, there would be a concept that good might be having implants or having, you know, beautiful cosmetic veneers. That is not necessarily, I mean, sometimes it is a good outcome, and I accept that, but other times it's absolutely not, and we actually have to take people on the journey of understanding why, you know this is a better outcome, and that's the same for clinicians as well. It is going to be one of, like, the process that we're going through at Dental Health Services Victoria. The hardest thing will be taking all of our staff on that journey too, saying all the things that you have been doing for a long, long time. It is not to say it's wrong, it's just we don't think they are delivering necessarily the best value for the consumer, and the fact that the consumers are really important. You know, their view matters.

35 **MR INNIS:** Thank you, and just a question about the future, the natural future of the private market, you have sort of given a sense, or at least that's the way I have taken it, but we're starting with a model of individual provider, you know, a one chair model, and I get a sense we're moving to a multi-chair with sort of a professional structure above it model. Is that how you see the sector emerging?

MS COLE: My view is, valued-based healthcare requires - - -

45 **MR INNIS:** Requires, that, yes.

5 **MS COLE:** - - - team-based care. I also think from a business model point of view, particularly as some of the margins have changed in the private sector, I just think it's inevitable that they will be moving, and some already have moved to bigger practices, more, you know, spreading the load, having a mix of people providing the services, and a lot of them do that. You look at a lot of orthodontic practices and they use a lot of hygienists, oral health therapists, dental assistants doing different sections of the work, and that's just a good business model, I think.

10 **MR INNIS:** Yes. What is behind my question is, if a positive change is occurring naturally at a policy level you respond to that differently to if there's a positive change that's needed and it's just not going to get there, and I think what I'm hearing is that, you know, the system will naturally trend that way which gives us a frame. Does that make sense?

MS COLE: Yes.

20 **MR INNIS:** So do you need to accelerate this in any way is - - -

MS COLE: Look, I think the major barrier for me is the mindset of people because it is a very different way of thinking, but I think once people get what it is, the value concept, then they will respond to that value concept. It is just a, I'm sure it's a bit like, you know, the health care homes. Once people got the concept they understood it, they, 'Oh, yeah, right, okay. That's, I just change my business model to suit that and it's a different way of doing it'. For some of them it might not have changed their business model, it might have been what they were always doing, which would have been handy, but it is a very different way.

30 I mean, if you're in a small business, or a medium sized business, you need to make a profit, so you need to be looking at how you can maximise that, and I think there's - so it's, if you have got a different funding model, then you have got to see how that works for you. I just think it's going to be a different way for private practice to make a profit, and they will need help with how do you make that work. It is not that they won't make profit. It is just that they won't make profit the way they do now.

40 **DR KING:** One final question from me, the way you have described the system sits quite nicely with the views the Commission has expressed about the importance of good stewardship, and can I say, I think you're exhibiting very good stewardship of the system, so I just wanted to pass that on. How do we ensure that that good stewardship occurs nationally, and I'm very conscious of an interaction between the Commonwealth and the States, roughly the same amount of money going into the public side of the system.

Is there a better way of doing that? Should we be thinking about the States being wholly responsible for dental with, or should we be looking to a more national model, or is this mix working?

5 **MS COLE:** It's unusual for me to back out of answering a question, but look, I - yes.

MR INNIS: It is perfectly reasonable for you not to answer. I am not - - -

10 **MS COLE:** Yes, I think that the whole federal/state funding thing is probably not something that I probably prefer to give comment on. I just think, I am seriously looking at, how can you do the best with what you've got?

15 **MR INNIS:** Yes.

MS COLE: It does need more money. Who it comes from is for governments to decide.

20 **MR INNIS:** Fair enough. Thank you.

DR KING: Thank you very much.

25 **MS COLE:** Thank you.

DR KING: Our next organisation is Community Housing Limited. It is Dr Flood, isn't it?

30 **DR FLOOD:** Yes.

DR KING: Yes.

DR FLOOD: Thank you, gentlemen.

35 **DR KING:** I like to make sure I'm using appropriate titles.

DR FLOOD: Everybody calls me Joe, that's all right.

40 **DR KING:** Dr Flood, would you be able to state your - - -

DR FLOOD: Except for Stephen.

45 **DR KING:** Except for that. I am doing this formally. I will say Joe for the rest of the half hour. Dr Flood, would you be able to formally state your name and organisation for the transcript.

DR FLOOD: Dr Joe Flood, Community Housing Limited where I'm Research and Policy Advisor.

5 **DR KING:** Thank you. Would you like to make some introductory remarks?

DR FLOOD: Yes. How long do I have, by the way?

10 **DR KING:** About five minutes if that's okay.

DR FLOOD: Overall?

15 **DR KING:** No, sorry, for your - - -

DR FLOOD: Conversation is about half an hour?

DR KING: Yes.

20 **DR FLOOD:** Yes, it's a long time since I spoke to the Productivity Commission, I think 1993 was the last time, and it was to the Public Housing Inquiry at that time. It was Industry Commission, of course, and at that particular - I gave the Commissioners a bit of a laugh because I said that once of the problems is that with the current structure of - with the
25 current structure of what is permitted in housing, people were unable to make the choice based on their income as a straight economics argument, and therefore as they were unable to make that choice, the community had an obligation to provide them with the house that they regarded as the minimum.

30 It is actually something that's hard to argue. At the time it was a theoretical point. Now I'm not so sure. As I stepped over a number of people coming here this morning, it's become a genuine issue in the community that people are exercising choice but not the ones that we regard
35 as acceptable.

Some of those choices, you know, if you're homeless person, what are your choices. You can get - you can choose what street to sleep on. You can choose where to go to get your next meal. Is it the Salvo's or the
40 Brotherhood? You can make a number of choices that are not available to the rest of us, but the vast majority of those people would swap it all for a decent place to live. There's no doubt about it, not all. Some will live that way, okay?

45 Now, I'm speaking on behalf of Community Housing Limited which is

the largest community housing organisation in Australia. I haven't worked all that long, 12 months now. Our boss, Steve Bevington, will come to the round table and he'll have a different point of view to me, and I looked at all the things that were in the last paper in some detail, and it gave me quite a lot of concerns.

Now, on the positive side there's a number of things that we're already doing which made us happy, of course. We do give tenants opportunities for choice. I have quoted in the paper that nearly a sixth of our tenants move within the first year within our stock, so they may not get exactly what they want first up, but they get there, and we make sure they get there because their choices are monitored and they have case managers to work with and we are managed housing which public sector doesn't necessarily do in that case.

Our issues about the proposal to lift Commonwealth Rent Assistance in line with the rental index which we regard as being sorely required because it's inadequate, but even that amount will not house a significant proportion of the people out there, particularly the hardest to house income groups. We are seeing particular ... [inaudible]... we have a lot of trouble dealing with them and so does everybody in the entire sector because they don't have the incomes to be placed in any accommodation that's normally regarded as acceptable.

As the (indistinct) has provided, we are involved in a number of activities, joint ventures with large private developers and funding agencies, evidence gathering, tender and management of the public stock, formal asset management systems, tender support for private tenants and a well-developed stewardship function. It is harder for smaller agencies to provide all those things, but the larger ones can do it. There are about five of us that are capable of providing all those services.

We agree that a more systematic approach to stewardship identifying community needs and prioritising services is long overdue, and outcomes for performance measurement are somewhat under-utilised so we use it quite a bit. We are considering an option for a mezzanine stock where people who want to take more expensive properties can do so and pay extra, which is not currently available. This is as a result of the NRAS wind down when we got a bunch of stock coming up which is allegedly better quality and we have to do something with it.

I suppose my main claim to fame was I raised something called the Housing Subsidy Study back in the 1980s and that was one of the main inputs into Commonwealth Rent Assistance when it started. The main argument was that private renters were getting nothing, whereas home

owners and public housing people were getting quite a decent subsidy, and as a result, it certainly wasn't enough to bring it up to the level of the other two, but at least it gave them something and we've functioned on that ever since, so it's magnified very substantially, of course. I forget what it's up to, \$4.4 billion, I think. I must say I never thought a paper I wrote would end up spending \$4.4 billion per year but that's how it's ended up.

We have a problem in operating our business, and you've nailed it in a way, that there is no relationship between outgoings and incomings. Our incomes are based on whatever tenants that are put upon us mostly, sometimes we're able choose our own though - whereas our costs are very clear and we're able to gauge those in advance. It does make it difficult for us to put in for a number of proposals. In the end we may have to say the risk is too great, we can't do it because we don't know what tenants we're going to get and whether we can keep them.

If we knew in advance what our income was going to be, it would help us a great deal, but we really think they probably don't need full market rent in order to do it. We need more than we're getting. I think I calculated it as a rough figure that public housing has been 45 per cent of market rental on average and we're getting about, something like 60. It's pretty low. If we could get up to 85 we'd be in clover frankly. So we don't really need full market rent.

The trouble with full market rent, and I'll come to it, is that it's very spatially, it's very - it differs a great deal over space. Inner city properties would be very hard to let to the current clients coming on board at full market rent based on what they're currently receiving. Either they'd have to receive a supplement, or those properties would have to go. If all those properties went, that would be a bit of a recipe for civil unrest. We've already got some in Sydney. You've got a ten-year moratorium on it, so it wouldn't happen overnight, but nevertheless along the way you can expect to see a lot of noise if that were to happen.

A lot of people are dependent on their inner city location to access services. If they all had to be closed and we had to move to the edge and provide services out there, that's very expensive and it's not very efficient either. Whether keeping them in high rent properties is the way to go, but you've got to remember, most of these properties have all got the same costs. They don't cost any more to run than any other property. It's the new ones that are the problem. We can't buy them in here. We've got very few. We've got a couple under NRAS but it's almost nothing. We have to buy in town and country areas because that's the affordable stuff. So we've got a problem at the moment that it's already being pushed out of town a fair bit.

I can say also in part of my introduction that this is not the first time this proposal has been put up. I think it's about the third in my memory so it's a case of forward to the past for us. We - it was specifically rejected for a number of reasons, and those reasons are pretty much the same as what they always were. For us it would be great if we could get more income related to the property so we could do our job and do our business, but not at the expense of affordable housing, and market rent is in no way affordable. If I can, I'll speak to this a little bit later as to why market rent is not affordable, but this is probably my ten minutes, so.

DR KING: No, that's fine. Thank you very much, Joe, and I want to actually start off on the market rent parts though, so I suspect you'll be able to fill in the extra bit just in a second. I think one of the things I take, certainly from the two days of hearings, as well as the submissions we've got, is that we probably didn't explain what we were envisaging as well as we could have, because exactly the concerns that you have mentioned in terms of movement to full market rent and affordability have been echoed elsewhere. I guess what our aim was and what we see it is, is more an improvement in transparency, as you said, able to give a predictable income flow and also getting rid of some of the inequity that you see between the majority of eligible households who actually live in private rental accommodation at the moment and does depend on CRA, which we think is too low, versus those who, for whatever reason, waited for a long period of time, whether they will be able to get into the social housing.

So we see ours as being, 'Well, yes, you move to market rents', but that means that for community housing provided on the State government, who receive those rents, then have more money, and they should be putting that back into, you know, in State government quite explicitly, a high needs or a high costs payment, so a subsidy back to those recipients who really do need to be in inner city properties for services, for continuity, because you know, schools, you know, because they're part of a community there, that can be.

So I guess we sort of saw it as more - certainly not reducing, in fact, increasing the amount of funding in the scheme because CRA has gone up, and formally getting, making it transparent and getting, or helping to start get rid of that inequity between the two groups of social housing eligible populations. So can you reflect back on that and why are we wrong? What have we stuffed up?

DR FLOOD: The first problem is, you didn't mention the National Affordable Housing SPP, or at least I couldn't see any mention of it anywhere. This is the \$1.34 billion question. If you do that, there wouldn't

be very much incentive for the Commonwealth to keep that up unless it was specifically tied to something. At the moment that effectively covers the deficit. So if the deficit is gone, why are we giving them \$1.34 billion? If that \$1.34 billion was diverted to the high cost payment that you mentioned, then, yes, it's manageable, it's doable, but it would be under considerable threat.

I did a few basic sums on it. I worked out that the difference between rent paid and market rent back of the envelope, like you did, was of the order of \$3 billion per annum; \$1.4 billion of extra CRA funded approximately; \$1.34 billion on National Affordable Housing; at least \$240 million have been met by tenants of the states, that's about \$611 per household, something like that; which is doable.

DR KING: If that \$611 was fed back into subsidies for the housing, because it's going to the - - -

DR FLOOD: It's extra money that people have to pay, and you know, the case would be how to make that equitable or more equitable than it currently is for redistribution.

MR INNIS: Joe, you mentioned something that we think is very important and that is, prices change depending on where you are.

DR FLOOD: Yes.

MR INNIS: And we thought very carefully about whether the Commonwealth Rent Assistance system could deal with that or whether there was another way to address that, and part of the thinking behind high needs payment was that State governments are best placed to respond to price changes across their geography, and in fact those States with very high house prices get a revenue dividend from those prices by way of stamp duty receipts. So we were thinking that, (a), you could tie the amount of high needs payment to where people lived, and (b), for very expensive locations where States were getting a revenue benefit, that it would create an accountability and responsibility for some of that to flow back into supporting people on low incomes. Does - - -

DR FLOOD: The States have never been particularly keen to put a lot of money into housing. They say they have other infrastructure responsibilities. The Victorian Government has been doing it much to everyone's surprise over the last 12 months, but a long, long time since anyone has done it. We have been looking at the stagnant system for a very long time. Now, are you suggesting that this, I don't know, \$1.4 billion gap should be met out of stamp duty receipts?

MR INNIS: No, what I'm suggesting is that it matters less where the money comes from. It matters more how it's designed to work for the clients.

5

DR FLOOD: It is not unreasonable that they are taking quite a decent income from that which was never really intended to perform such a large part of their revenue, and that was, you know, something we've argued from time to time, that it should be diverted into affordable housing one way or the other. We can't deny that. However, if we're talking about a sudden shock of removing a large amount of money from the system, or if we're talking about putting a large amount of money into the system, things will respond and often in unexpected ways. I actually spoke to the Economics Conference on Friday about the difficulties of judging what's going to happen in the housing market. I always regard it as something like a half-filled balloon. You push this side, it bulges the other. Governments often get it wrong and that's because they don't necessarily work out what's going to happen from the complexities of the issue, even from basic economic principles. Anyway, that's neither here nor there.

20

I presume that the commission doesn't want to see a situation where there's social unrest over this. Therefore, on the other hand, the Commonwealth is probably going to be reluctant to cough up an extra \$1.4 billion on housing. They never have before and, well, they did it once but they may not do it again. I've heard a lot of people say this won't go anywhere because it died several times in the past, but you're in a - you're better place to know that than I am. Certainly if it was somewhere near cost neutral, the Commonwealth would go for it, why not.

MR INNIS: I noticed in your submission you raise concerns about social unrest and I do want to understand that. Our proposals effectively grandfather everyone's current entitlements for at least ten years.

DR FLOOD: Yes.

35

MR INNIS: The people we're talking about noting that there is a group in Australia who are homeless, and often the issues behind homelessness are far more deep than financial, so I think it would be a mistake, as I know you know this, to simply say it's a financial issue or an access to housing issue, because often it's deeper. The question for me is, we're grandfathering effectively the current group. For all of the people who are eligible for social housing who are privately renting today we are proposing an increase in CRA and potential access to a high needs payment. I am just uncertain how that creates the conditions for social unrest?

45

DR FLOOD: Well, if I was running that and I had a high needs payment in my hand, I may well not give it to inner city housing. I would give it to high needs people rather than high needs stock. It would be - - -

5 **MR INNIS:** Our proposal is to give it to high needs people.

DR FLOOD: I know. The problem with that would be that, it wouldn't - it would only be a matter of time before you decide that this higher market rent stock was not sustainable and you'd be better off giving the money to
10 poorer people, you would have to close it, but at the moment you could sell it off and you would build equivalent number of houses towards the edge of town. What else are you going to do? They're already doing it to some extent.

15 **MR INNIS:** And does your company do that? Does your organisation do that?

DR FLOOD: Yes, we've got one actually going in town. It's a pretty - we can't act in Australia easily on our own behalf as I've already mentioned.
20 We constantly scrounging small subsidies to enable us to build affordable housing and we function on those. This is one of the reasons we moved overseas, we have far more freedom to move. In Australia all our housing is tied up in various forms of agreement with the States. We monitor 132 different compliance issues. We have a lady sitting there full-time doing it.
25 That's the nature of our business, that almost all our stock is tied. We are supposed to be able to borrow money on it, unlike the - and that is our big advantage, that we can get extra stock and multiply it. It's not very much, it's something.

30 If the CRA went up we could get more. It's risky. We are the only - as far as I know we are the only one that's done it up until now. We did it during the time of NRAS and - and the global financial crisis money, and that has left us in a little bit of a difficult situation outside of Victoria because we have that debt.

35 The others are just starting to do it now. They've finally got themselves a financial, a larger one. Two or three of them in Sydney are doing it right now as we speak. So there's nothing to stop the States doing it once they start getting -once they start getting rent allowance. Why would they give
40 properties to us? They don't like it anyway and they do it themselves, so there wouldn't be any incentive left very much except for these really high needs people to put them in our direction, unless it was for ideological type reasons.

45 Accordingly, I think we'd pretty well see the end of transfers, except

doing, political parties have felt that was the way to go. So we've been on our own. That's okay, we can do it, but we need the money, I agree with that. This would help to provide it, but we are concerned that we would not be able to provide affordable stock in the urban areas. We can still do it in rural areas and we can still do it on the edge of town, and we would not like to give up that - we don't have much anyway but we would hate to give it up because it has a purpose.

You know, there are other options available to us. We can start - what is a market after all? As I point out further down, market rent at the bottom end of market is not really a result of competition. It is a result of heavily constrained competition, it's very much a second best situation, and it has always been like that. It has always been very hard to get affordable stock down the bottom end of the rental, private rental market. This is not something, you know, that I say lightly. The markets are incredibly tight at the moment. I don't know if you've ever attempted to rent a house lately. I did two years ago. It took me five months, five bloody months, and it's in, you know, I'm a professional.

People who have little or nothing, I've got a daughter trying to get one. She can't get a house in the private rental market. I just went guarantee for her. Still they wouldn't look at her. They take the top three or four out of their 40 applicants, they send it across to the landlord, this is the agents. No longer do we get discrimination on the basis of race. Now it's all based on whether you look like you're a solid citizen or you've got a working income and they're the ones who get the houses.

You know, more and more people being pushed into the rental market. You might think that with all these landlords coming on board that it would be less tight. No, it's more tight, because we've got a greater number of people who want to be home owners coming on. So it's been tightening and tightening. It's, what, 1.6 I saw, in Victoria's the last figure, it's 1.6 per cent. It's about as low as it's ever been. This has to compare with USA, for instance, where it runs at 9 to 11 per cent, much the same as home ownership, and public housing. So we've got a very, very tight rental market, so the whole idea to suggest that the private rental market is going to take up all these people exercising their choice is not one that I see easily happening.

There's no incentive on private developers to build in that area. It's too risky for them and the returns are too low. They don't - they build them the next level up. They'll build it, what they call affordable housing which is medium level, and that's where we come in. We - they have a, what's the word for it, we have various joint ventures where maybe 10 to 15 per cent of it is to be affordable housing. It's not that affordable but it's not bad.

MR INNIS: So is the answer to all of this funnel more money through your organisation? Is that - - -

5 **DR FLOOD:** I don't want to say that because we're not here to - we're not here to plug my organisation. This is the overall - - -

MR INNIS: But that's the impression we're being left with.

10 **DR FLOOD:** I'm working for an organisation, so obviously I'm looking at it from the point of view of that organisation. If I was coming in here and talking as a member of the public, I would be looking at it from the point of view of public housing obviously, but today I'm representing Community Housing.

15 **MR INNIS:** I understand that.

DR FLOOD: And Community Housing would see it this way. There are people who would like to funnel money through our organisation. Yes, it could be considerably bigger than it is. They are in Britain, for instance. Whether that's an answer, I'll leave it to policy makers and our boss to fill you in on, but it's certainly an answer. It's one of our advantages, we do give good service, as you kindly pointed out. We have very good response in maintenance, for instance, so we provide a high level of matching of services to tenants which is, we go into partnership with them. Some are good, some are not. We're able to sort through and stick with the good ones wherever we can. So that's our two jobs in Australia. One is to provide services for clients with multiple needs.

30 **MR INNIS:** Sorry, Stephen, what proportion of your tenants would you consider are good and what proportion - - -

DR FLOOD: We don't like using those words.

35 **MR INNIS:** No, I understand, but - - -

DR FLOOD: I will get my opposite number, the Victorian Manager, very angry if I start saying things like that.

40 **MR INNIS:** I will leave that.

DR FLOOD: We have difficult tenants in some places. Tasmania is the worst probably. There's a sense - we've had to do a lot of work on community development in Tasmania to try and improve people's status of life and their relation to their community so they don't go around burning

45

down our houses. That's the toughest location we have.

5 Here, as far as I know, we get a - we get - I think about one-sixth of our
tenants get evicted which is pretty normal. That seems to be true in res.
properties and other properties. I've done the numbers on it, so you know,
mostly because they don't pay their rent, but there are others. We have
people who have difficulty with their neighbours. We have a lot of difficult
tenants. I sit there and listen to people dealing with them every day, but
you know, that's our job. We do it. We provide housing for people who
10 really need housing and we provide housing for people who have difficulty
functioning in the private rental market. I couldn't - I'd hate to give you a
specific number because I'm not in a position to do so.

15 **DR KING:** Could I circle back to two things that you said in your opening
remarks, and I just want to make sure I understand one of them, and just get
some more details on the other. So the first one is, understand your position
against market rent, but you did note the difficulties when the income is so
variable, and I got the impression that you said, 'Well, if it was 85 per cent
market rent actually that might be a good thing, or that would be a good
20 thing'. Is that right?

DR FLOOD: Yes, we could manage on it.

25 **DR KING:** I mean, is that something you think you could support?

DR FLOOD: Look, we're getting 65, so if we get 85 obviously we're far
better off. We could actually go out and buy stuff on that basis which we
can't at the moment unless we can find some form of subsidy or assistance.
We still continue to look for places that require - that have those sort of
30 benefits because it's our job to provide affordable housing. The cheaper we
can get it, the better, if we can get cheaper land, if we can get other forms
of deals, but we do spend an awful lot of time trying to get ten houses from
someone, and you know, we'd rather have a more substantial way of
expanding, I suppose, that was less about the exigencies of day-to-day
35 struggle on spending the whole organisation effort on trying to get five
houses which we currently do, and we don't do that overseas. We are
capable of getting much larger - we just got quite a big one in Africa, for
instance, which is far bigger than anything we've ever had here.

40 **DR KING:** Yes. Just the second point, you said that, or you mentioned
that a sixth of your tenants move stock within the first, or within your stock
within the first year.

45 **DR FLOOD:** Yes.

DR KING: So this managed leasing approach. Can you briefly explain, how does that work? How do you do that?

5 **DR FLOOD:** All I did was the analysis of our exits which I did for a paper on what we were going to do to respond to NRAS and I quoted the figures from that. I got a paper on it which shows how - what causes our tenants to exit. The major reason was movements within the stock, particularly our own stock. We've got to (indistinct) stock so people can move within it, and what I can is, it's pretty much the same - there's a lot of movement
10 within the stock in the public sector. I'm not sure how great it is by comparison.

I've never seen anyone do the analysis on it. I'm in a lucky position that I can access all our tenancy data. I analysed 7200 tenancies going back to
15 the mid-90s and worked out where they all went and whether there was any difference between the different classes of stock, so it was quite an interesting piece of research. I just did that in the last month. So yes, there's movement, and we can do it, there's no doubt about it. Obviously the more stock you've got the easier it is to do that because you've got more choice.

20

DR KING: This movement tends to be based on the preferences of the tenants?

DR FLOOD: Yes.

25

DR KING: A tenant says, 'Look, I'd prefer to be in a - - -'

DR FLOOD: They just come in and say, 'Look, this doesn't suit us. We need an extra bed', or, 'This is no good. We've got, you know, Aunt So-and-so's over there and', 'Oh, we've got to get to work over there and if we stay here we're going to lose out WorkCover', and, you know, and that's going to be another issue if people start going to the edge of town, that they won't be able to keep their - that's another point, I think, that some of my colleagues in other organisations have brought up that it is fairly easy to
30 disrupt various forms of social security payments, and that will be hard to keep the system running based on that, but you know, we do it as it is, so I suppose it's possible.

35

Do you want me to just speak briefly on the private rental section, and
40 I've put a diagram in here which I thought was pretty interesting from the same analysis. It's only small, it's towards the end of the document. I don't even know if you can see it properly though. You can on the on-line version. What it does is, it looks at the rental on all our NRAS properties across the country which is pretty - and compares that with what people
45 would pay on 10 per cent deposit and current Commonwealth Bank rates of

interest to buy that property. That's the market rent versus home ownership payment.

5 The line is virtually straight all through the bottom. In other words, the rental price is being set by the exit/enter harmoniously if you want to put it that way. That is, the - that's where it's being set rather than by supply - the supply and demand is operating over several tenures, okay? Except it differs as you go up and down that price stream. So the diagram is actually market rent versus market value, but I've scaled them - - -

10

MR INNIS: So this is right at the end of your submissions?

DR FLOOD: Yes, it's on page - have I got page numbers on this? Appendix B.

15

DR KING: It is in the appendix, yes.

DR FLOOD: Appendix B, second last page.

20

DR KING: Yes, it is one that you, sort of, need to blow up.

25 **DR FLOOD:** And you'll notice that as it gets up, the rent gets cheaper versus what's effectively the market price, a lot cheaper, and we think that that is mostly due to the famous capital gains effect, but it only operates up at the top end there, so there's still a big myth out there in the industry that this is keeping rents down. It's not keeping rents down for the bulk of our properties. It's being - it's being traded as a, in terms of what you would expect from a rational market, except right down the bottom you've got a lot of crowding of people who have high rents relative to the value of the property, substantial amounts. So that's the place where the difficulties are and have always been in this area that you've got a crowded bottom end, no entry.

30

35 The only way to do anything about it would be to relax health and other requirements which people are illegally doing already. I quoted several examples from the newspaper in this. I think you can see more of it if you start doing market rent, you know? If you come from another country where it's commonplace to put eight tenants in the back room at, you know, ten bucks each, yes, you can pay your market rent no problem, and I think we'll see a lot more of that rather than having people move out.

40

MR INNIS: I don't understand why market rent does that. Most of the people on these incomes are already paying market rent, so - - -

45

DR FLOOD: No.

DR KING: You're in the private sector.

DR FLOOD: In the private sector, yes.

5 **MR INNIS:** People are in the private sector paying market rent, so - - -

DR FLOOD: They're not, that's the problem. Those low end properties -
- -

10 **MR INNIS:** They're not paying market rent?

DR FLOOD: They're being pushed down from the top all the time, from
people who would normally be in home ownership who entered the top and
15 we're going to get trickle down rather than a trickle, what's that a trickle, a
trickle in, and they're pushing it down all the time, so those properties are
being taken up by people who once would not have been renting those sorts
of houses.

20 I mean, I looked in it. I saw people occupying houses that they wouldn't
have dreamed of occupying before, people with three kids in a little two-
bedroom apartment. They wouldn't have done that once. They would have
owned a house out in the sticks. They say it's too expensive, they can't
25 never get the deposit together, and that's the way we think - it's all very well
to say public housing is broken, but the whole housing market is in a fairly
shaky condition at the moment frankly.

MR INNIS: We agree, there are changes that need to be made in the
broader - - -

30 **DR FLOOD:** Anyway, that's the problem. You can't easily increase that
supply to match the increasing demand due to this downward push, and at
the same time we're seeing more people coming up with complex needs,
okay?

35 **MR INNIS:** Okay.

DR FLOOD: So in a way we're trying to fill that gap. We're trying to
build the houses that should be there and we're doing it by finding the
40 cheapest option all the time.

DR KING: Yes.

DR FLOOD: If you switched the market round, so we won't have a lot of
45 reason to do it frankly, because we know we're going to get our money, why

do we need to go run around trying to save a couple of grand, you know? There's no - you know, people can't compete with us, the private sector can't compete in this area. Sorry, they just can't. They never have and they never will. It's too risk for them, not enough return.

5

DR KING: Thank you very much, Joe.

DR FLOOD: Okay. I hope that's helpful.

10

DR KING: Yes.

MR INNIS: Thank you.

15 **DR KING:** We will now have a break for morning tea. Yes, we have a break for morning tea and we'll recommence with Family Care at 11 o'clock.

ADJOURNED

[10.35 am]

20

RESUMED

[11.00 am]

25 **DR KING:** So let's get started again, so recommence our hearings and the next organisation is Family Care. Mr Tennant, if you wouldn't mind introducing yourself, stating your name and organisation for the record.

30 **MR TENNANT:** Thank you very much. My name is David Tennant. I work at an agency called Family Care in Shepparton, Victoria, and I'm also attending today as a representative of the network of regional community service providers that are located in Shepparton and four of those agencies have made a number of written submissions through the course of the inquiry. We have provided a brief introduction to that network in those submissions. I thought though it might be worth just revisiting that briefly
35 in these opening comments.

DR KING: Yes, please.

40 **MR TENNANT:** In mid-2015 the Helen Macpherson Smith Trust, which is a major provider of non-profit assistance with its base here in Melbourne, launched a Shepparton-specific capacity building funding round and the four agencies that now make up Shepparton Community Share are all independent not-for-profits based in Shepparton. The Bridge Youth Service, ConnectGV, Primary Care Connect, and my own agency Family
45 Care, we were all contemplating making applications but decided to do

something novel and talked about what we had in mind and whether we might achieve more doing so together rather than entirely separately.

5 So each of the applications, whilst they were standalone, were linked
with the intention of operating as a cooperative network, and we would each
be responsible for our own undertakings if the applications were successful,
but we also committed to share the benefits and in the process create an
environment that could guide our future actions with each other and our
community. We are grateful that the trust funded all four of those
10 applications but it was for a relatively modest cumulative sum of just under
\$120,000. Two years on and our cooperative activities are not only
continuing but we're starting to see benefits that none of us really had
predicted at the outset. So we've put together our relationship in a more
formal network document that guides the way that the relationship works
15 and we are now actively working on projects together.

From my own perspective, it's confirmed the importance of basic
building blocks and successful joint community work. Shared values and
trust are much more important than the quantum of the funds that are being
20 offered and you have to want to work together, rather than being required
or directed to do so. An independent evaluation of Shepparton Community
Share has been commissioned and is being undertaken by Latrobe
University and we've made mention of that in some of our submissions. I
had hoped that it would be ready in time to share before today but
25 unfortunately that's not the case. I have spoken with both the trust and the
evaluator about sharing the report when it's available and I hope that will
occur, although perhaps not in time to contribute to this inquiry given the
timelines that you have.

30 Across the course of the inquiry to date we've provided those
submissions that are focused on several key themes and in response to the
draft report we combined our comments to Chapter 7 which deals with the
commissioning of family and community services and that's really the area
that I feel comfortable commenting on today. There are several areas in
35 which we've welcomed the Commission's views and the evolution of
discussions throughout the various steps to get to this point. More and
better tools to identify need and help plan responses would be very useful,
particularly in regional and rural areas, as would proper recognition of the
actual cost of providing services in places other than major metropolitan
40 areas. So we welcome that recognition. The reality of distance in country
communities with poor or little public transport is not well understood or
accommodated in current approaches to resourcing service delivery.

Other observations in the draft report have caused us some concern,
45 however, and in particular we've expressed a strong objection to the draft

recommendation that governments commissioning family and community services should not discriminate on the basis of organisational type and specifically not discriminate between for-profit and not-for-profit providers. On one level, the logic that capacity to deliver outcomes for service users is more important than organisational type appears sound, but there is so much more to it than that. The Commission's earlier commentary that acknowledged the importance of not ... [inaudible]... smaller not-for-profits, volunteering and localised forms of philanthropy and altruism seems to have diminished in the draft report and we were surprised that it received such little attention in reaching that draft recommendation.

As noted in our most recent submission, the latest Australian charities report estimates there are 2.97 million volunteers in Australia and ACNC Commissioner, Susan Pascoe's June newsletter acknowledged that four out of five charities relied on some form of volunteer support. Those are remarkable statistics and in regional communities they take on a more immediate relevance and we, as service providers, get to see and touch those every day. Communities work because people give it their time, their energy, their skills, and when they can their money. Often they give their money even when they really cannot afford to do so and that's particularly so in a regional community. And it's because those people want their towns to be better places; they want their kids to have sporting teams to play in; they want their schools to have books in the library or even basic things like contact to go on the books so that they last longer.

Not-for-profits don't create this sense of community or sustain it on their own but they are inextricably linked to it and the motivations are largely shared. Each of the boards of the Shepparton Community Share network participants are local volunteers who live in our community. They are teachers, builders, lawyers, accountants, social workers, retired people and a variety of other backgrounds and interests, but they contribute because they want to and there's very little in the draft report that considers why and what might be at risk if the opportunities to participate and contribute in that manner diminish.

In the 2010 Commission inquiry into the contribution of the not-for-profit sector the expression of the value of that work was rather broader than it seems to be today and it's hard to weigh that against the blunt recommendation in the middle of 7.2. We think there are vital differences between for-profits and not-for-profits that shouldn't be muddled together with ability to deliver on outcomes because they're different things. Capacity and performance are very, very important but so too is motivation.

DR KING: Thank you very much for that. I want to actually start off on that point because what we were trying to communicate, and I think again

5 this may be one of the areas where we need to focus on whether we've got
the reform right but also how we communicate it. Was that - we see there
as being - or a preferable approach to government and contracting as being
taking into account motivation, taking into account the incentives that
10 intrinsically are associated with an organisation and then - and taking that
into account in the contracting process, so that there will be many situations
where a not-for-profit mission-based organisation is the best contractor.
There may be other situations where a cooperative, say for example an
Indigenous cooperative in a remote Indigenous community may be the best
15 organisation, even though it may not be the lowest cost.

20 ... [inaudible]... don't get 'waved in the air' when I say cost in the
narrow sense, not in a proper sense. But there also may be situations we
could envisage where perhaps a for-profit would be the best party to deliver
the services, and we wanted to make sure that wasn't ruled out, recognising
15 that they will have underlying different motivations and incentives. So I
just wanted to understand, do you see that as a reasonable position or - and
I'm more than happy for you to say that you don't agree with that - do you
see that actually, given the motivations of for-profits, it's best just to have a
20 blanket rule or be just not involved in this area?

MR TENNANT: I don't think blanket rules on anything are particularly
helpful and so it may be a question of nuance and explanation. But to go
first to the question about contracting as a vehicle for explaining that and
perhaps setting out those parameters so that the importance of motivation is
25 properly recognised and, indeed, preferenced if that's a good thing to do,
I've worked in the community sector for almost 23 years and I've had
experience of models that encourage and invite suggestions for
collaborations and models that require it and that set out, you know, rules
30 about why providers should be motivated to be acting in the particular
space. And I also came to the community sector from being a lawyer.

I think contracts and contractual rules are a poor proxy for people
wanting to do things because that's the reason why they exist in a service
35 sense. And not-for-profit agencies do not always get it right. They certainly
aren't lilywhite or so clean when it comes to always performing in the
manner that you would expect them to perform. But performance questions
and those of motivation and being driven by a mission that is not primarily
linked to profit is quite different, and it then motivates others around those
40 who are delivering the services to behave and respond differently. I don't
think that you can achieve the same outcome by requiring people to behave
in that manner to come to you in a commissioning process because, in a
sense, it is still a commercial directive to behave in a particular manner to
45 get a particular outcome, rather than the reason why you're there in the first
place.

5 The experience through the HMS Trust activity, even though it's a very modest one, you know in some ways bears that out because each of the providers that came together did so entirely voluntarily. Not because the commissioning process required them to. It certainly accommodated them doing so, but the motivations were those that were driven by the parties that were coming to the table and not one that was tied up in the commissioning process.

10 **DR KING:** No, and fully understand the limitations of contracting the change incentives. If I put a health hat on, we often - we in fact rely often on relatively small for-profits and often sole traders, but they are formally for-profits but we continually say, well a motivation is professionalism. If we actually had to run a Medicare system, for example, based on contracts rather than a degree of trust in the parties that were providing medical services I think - well I think we'd be a lot poorer society. Let's put it that way.

20 **MR TENNANT:** Well, and you did ask the question specifically, should there be a blanket exclusion on for-profits entering this space? And I said that personally I don't agree with blanket exclusions, and that also plays itself out sometimes in rural and regional communities because if you don't have a ready, capable not-for-profit, or even one at all in the service area that you're trying to address, but you do have someone who might, say, operate a small business who does have both experience and expertise and is job ready to do an activity, does it make any sense to say well we'll do nothing, rather than present the opportunity for that person with the capacity to actually do the job.

30 So I think it's preferable to have a framework with a strong preference for a particular type of provider, and then say, 'But other types of providers, including those with a for-profit motive may be considered in the event that there are no other providers available or capable of doing that work'.

35 **MR INNIS:** David, can I just test that a little bit further. Noting what you've said about relationships and trust and the community value that comes with good not-for-profit organisations, and I think we both recognise there are outstanding organisations and there are organisations that have performed quite poorly, as you note. If we reframed what we said, to say not-for-profit should not be excluded, as we would say with other organisational types, mutual and cooperatives for example, and then went on to say that government decisions should be based on the attributes of the organisation and the ability to deliver the outcomes being sought, would that be more comfortable?

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5 **MR TENNANT:** Personally, I would prefer something that made very clear that the preference is for providers, particularly those who are dealing with, you know, very vulnerable and disadvantaged people to be not-for-profits and those who then add additional value in their communities. With the fall back that other providers may be considered in the absence of it.

MR INNIS: So you would have a strong preference for a not-for-profit - -

10 **MR TENNANT:** Yes, absolutely.

15 **MR INNIS:** In the system. Can I ask, swirling around this area. So, one of the things we are conscious of is that governments interact with organisations in broadly two ways: (1) they support the mission of organisations; and they do that through tax concessions, they do that through the encouragement of philanthropy, et cetera. And governments are agnostic beyond the public purpose around what is done, and your sporting example I think is a terrific example of that.

20 What we've focused on, however - and let me emphasise, the Commission sees great value in that, as our 2010 report indicated, and hopefully we've captured that in the current one but we can look at the wording. So we see great value in that. But what we focused on here is much more where government, as representatives of society, say certain people need extra support. They need extra services. So the intent is to really focus on those human beings, rather than the organisational structure for delivery.

30 I guess my question is, when you're coming to those sorts of decisions, how do we balance the delivery of the outcome for the user versus those broader organisational attributes? Is it just an absolute preference? Noting that, you know, history shows that we've got quite a range of performance by organisations in that game.

35 **MR TENNANT:** It does, and in some respects the reason why we were particularly keen to both engage with this inquiry and stay engaged, in a number of our early submissions we pointed out that Shepparton was selected as a welfare reform trial site in 2011 and remains so today. That decision was made without much forewarning for the community of Shepparton, and apparently without much forewarning to the State of Victoria that funds the overwhelming majority of community services that are delivered in our region. The outcomes that the layers of government seem to be pursuing are not always compatible and the Commonwealth's approach is very much embarked on one that prioritises the reform of welfare by creating more rules for people who are recipients of or reliant on

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welfare benefits to do certain things or risk the reduction or removal of those benefits.

5 The state-based resources are mostly focused on support for people that builds on their strengths. It gives them opportunities to try things and sometimes fail. Those two approaches are not compatible easily, which is in part why we were saying no one, I would expect, from our sector would argue with you on the importance of outcomes. But exactly what those outcomes are and who agrees on what outcomes are most important is
10 extremely difficult and at the moment we're in a place where the differences in those outcomes is being played out.

As a longwinded way of coming back to your question, the reason why that's critically important for not-for-profits and the difference that that
15 mission and values focus brings to your engagement with government is that sometimes you are in that uncomfortable position of needing to say to your commissioning body, 'What you are doing is wrong. It's actually causing harm, rather than the intended positive outcomes that you say are your focus. So stop doing it'. Now, in a purely commercially focused
20 arrangement you wouldn't see that type of conversation happening and I'd suggest to you that my experience is that for-profits are really poor at having those types of conversations.

They might be familiar with doing, you know, more soft lobbying around
25 how regulatory structures are put in place, or how policy settings are arrived at, but sometimes some of these things are around the public discussion of what good policy looks like for low income people. And at the moment we just happen to live in a town where we're around, you know, the pointy end of that and it is an uncomfortable misfit between the way that one level of
30 government is behaving and the broader level of government from the Commonwealth level where ... [inaudible]... a distributor.

DR KING: Can I follow up on two things on that. Firstly, the outcomes measurement. From your submission and from what you've just said.
35 Scepticism, is that a reasonable word to have, you know, great goal; doesn't work in practice or hard to put in place in practice. Where would you sit on that spectrum between - there is some - look, you just can't, you know, nice in theory but will never be practical in the family and community space versus others who would say, 'Look, it's just a matter of finding the right
40 measurement. That conversation, it should be the case the not-for-profit goes to the funding organisations, here's the outcome measurement, you're meeting it. You have set up a system that isn't working and the outcome really measurements help'. So where do you sit in that spectrum? Where should we be aiming at? Where is the sweet spot for practicality in terms
45 of that outcomes-based approach?

MR TENNANT: Look, you probably need someone who's a bit more capable than me to try and articulate that. But we absolutely accept the value of building in more outcomes-focus and trying to come up with measures that will probably address outcomes and not simply outputs. I don't think you need to ditch outputs on the way to get there because there is value in doing both; both counting what you do and measuring its value. But on the question of how you attribute value to particular, you know, service activities, they're not the same values for each client you're working with, and the more difficult and entrenched the problems are, the more careful you need to be in setting your outcome measures. And governments also probably need to be more accommodating of a range of outcomes, rather than presuming that the only outcome is the positive one that it set.

For many of the people that we work with it is important to provide people safe places to try and perhaps not get it right the first time or even the second time. One of the most important programmes that we run at Family Care is a very small one, it's called Cradle to Kinder and it works with a very, very small number of clients in comparison to our overall total. But it gives us the opportunity to work with particularly vulnerable families, from the moment a baby is born until they enter kindergarten. And that's probably a recognition of the reality that success in that family is just keeping them together, and that requires intensive support over a long period of time that is not routine or reasonably funded through the normal commissioning models. It is risky for governments to do those sorts of things and sometimes they don't work out, but the alternative is, say for that small group of people, that invariably those children will enter the child protection system and all of the evidence that we have says that we will get worse outcomes if that's what happens.

MR INNIS: David, what you say about outcomes I hear and it's very important for government to get its counterfactuals right and I was once responsible for homelessness policy in the Commonwealth, and what struck me was the only acceptable outcome was a happy family out in the suburbs and for many of the rough sleepers we were seeking to help, actually a stable place in a boarding house was a huge leap forward but still classified as homeless according to the formal statistics.

So understanding the client group and as part of what we're talking about the demographic stuff that you're talking about, understanding what's the most likely path for people and what a good result is, as against those paths, I think is something that we'd certainly agree with. Also agree that it takes a lot of work to do that well, but our view was that the journey's worthwhile.

MR TENNANT: And we wouldn't disagree with that. We are simply

saying that the detail is important. Our current impression of the way that those things play out, when governments use language like ‘the creation of outcome measures’, the commitment of the time and the effort and the resources to actually drill into what those measures might look like, and how they might be developed, the more difficult the matters are that you're involved in, is rarely there. It has also been a new experience for me personally working in a regional area. The relationships between the various levels of government are extremely complicated at the moment.

10 In fact, I think you could probably say they're broken, and the communications between State and Commonwealth are slow, reactionary, sometimes even combative. For a service provider working with difficult clients it would be terrific to see those levels of government actually putting as much time into working their own stuff out as they seem to with keeping an eye on what we're doing, and some of it will require trust and occasionally saying, ‘Well we mightn't be absolutely of the one mind in where we want to go or how we want to get there, but on occasions it will be better, say, to trust our colleagues at a State level to have carriage at that area and we can communicate about it every six to 12 months. At the moment we have relationships that are running in both directions all of the time and often in conflict.

DR KING: Can I just follow up directly on that because there was one part of your submission that I just want to clarify. In your submission, and I'll quote it: ‘In order for relational management to flourish there would need to be a greater level of trust developed, not only between contract managers and service providers’. Were the sort of things you're just been talking about what you're getting at there? Trust between government and providers; trust between different levels of government. Can you expand on that, please?

MR TENNANT: Yes, and it is absolutely that. Trust that those who are working in the area delivering family and community services at a State level would not be so wildly different from those who are working delivering and designing family community services at the Commonwealth level should be a given, I would have thought, and yet it isn't. So, why not? And, you know, we also had income management delivered to us in Shepparton as part of the welfare reform packages. We are the only community in Victoria that has income management.

40 One of the parameters of income management delivered to Victoria was the child protection officers for the State should have the capacity to exercise the discretion of Commonwealth officers to refer people for compulsory income management. The extraordinary thing was that that information did not seem to have been shared between the Commonwealth

and the state before the announcement was made, and so none of the administrative arrangements were in place. We were left in the position, as the main provider of child and family services in the town, of writing to the State to say, 'We think that's a very poor outcome and in fact we would
5 much prefer you not exercise that discretion'. And, indeed, there is an incentive for people who voluntarily participate in income management and a very practical one because at the time they would've received an additional \$250 payment every six months if they agreed voluntarily to participate, which could form part of a relationship building with child protection
10 officers and with family services providers.

So it's a very practical example of how broken communications between different layers of government with different policy drivers at the time actually led to confusion on the ground. And there were people in
15 Shepparton who were reading those announcements, making judgment calls about whether or not they should be moving town before income management commenced. As it turned out it wouldn't have mattered if they did because the class code would follow them. But it was entirely inappropriate in delivering a programme at that time to leave all of us
20 scratching our heads, including the people who were affected by it and worrying whether their lives were going to get harder rather than better.

MR INNIS: So David, in response to that we say rather gently in the draft report that there may be merit to move to more community-based planning, which we're seeing emerge more strongly in the health area through local
25 health or hospital districts and the primary health network. Is that a direction of planning and coordination we should be considering more strongly in the family and community space, as a way of trying to overcome some of these problems?

MR TENNANT: As a concept model, definitely. I have read the reference to primary health networks and - it's probably outside the scope of what we put in our submission, but my impression of it is primary health networks
30 are certainly playing an important role in starting a different type of conversation, but their relative level of resourcing in comparison to the overall bulk of the health system, it's a little bit like throwing a rope from the dock and pulling a cruise ship in by hand. I mean I think it will certainly
35 involve people in talking to each other perhaps where they haven't before, but will it change the nature of that service system? I doubt it very much.

The models that are perhaps better in Victoria's example would be we deliver our child and family services as part of the Child FIRST system, which has a legislative framework, and we have alliances that oversee that
40 at a governance level and then regularly come together to deal with operational matters and the actual delivery of programmes and individual
45

services. There are community partners in the alliance and government, as the child protection provider is also part of that alliance.

MR INNIS: Is the Commonwealth represented?

MR TENNANT: No.

MR INNIS: Look, I did have one more brief question. You gave a lovely example of collaboration up front and one of the things that really struck us was that the system of commissioning today provides little incentive or time even for organisations to form partnerships. And in our recommendations we try and make a much more certain system in terms of timing of when tenders come out; much longer periods of time for organisations to build their tenders; much longer periods of time where people are transitioned from one provider to another in fact if that is then happening. I appreciate what you say about collaboration. You cannot contract collaboration, but you can create conditions where it's more likely. And I guess my question is, is that a helpful set of recommendations in creating at least a slightly better environment for collaboration?

MR TENNANT: Yes. We were positive and welcomed the suggestions. I think we expressed some reservations about the length of time. Perhaps I was just feeling giddy about the potential of seven year contracts, but at the moment there is such an array of contract terms and I'm sure it's not unfamiliar territory with others that you've received commentary from. But regional communities' service providers tend to do a number of different things, which means they have - they're juggling a number of different contractual relationships. We have got at least a dozen different contracts with different periods of time that they run for. Some very, very short. Some five years.

The logistics of trying to juggle and manage and report on those are impossibly difficult, so consistency would be great. Better time to be able to talk to colleagues before you put in proposals would be fantastic, and an opportunity to have more meaningful communications with those who are commissioning, to find out what they're after. Rather than strict rules of probity that really are again an expression of that risk aversion. I think sometimes probity is misused in the manner that privacy legislation often is, to prevent meaningful conversations. And it's not helpful. As much as I still respect my colleagues in the profession that I left, lawyers can sometimes make a real meal out of things that are not nearly as difficult as they are made to seem.

MR INNIS: We promise not to quote you on that one.

MR TENNANT: Goodo.

MR INNIS: David, thank you.

5 **MR TENNANT:** Thank you.

DR KING: Thank you very much, David. The next participant is Council to Homeless Persons, and I suspect I have the wrong name in front of me.

10 **MR PATTERSON:** I am not Kate.

DR KING: We had 'Jenny' down.

15 **MR PATTERSON:** That was the person who was meant to be here. I am Damien Patterson, and I am the Policy and Advocacy Officer with the Council to Homeless Persons.

DR KING: Welcome, Damien.

20 **MR PATTERSON:** Thank you so much.

MR INNIS: Okay, Damien, welcome. Would you like to make a five-minute introduction?

25 **MR PATTERSON:** Thank you. So I'm here today on behalf of Council to Homeless Persons. We are the peak body for homelessness in Victoria, representing about 150 different homelessness agencies and over 105,000 people each year accessing those services. I want to thank you for the opportunity to present here today, as well as for the opportunity to submit
30 to four proposed stages of this inquiry.

The voices and experiences of those who experience homelessness are some of the most marginalised in our community, and we take our responsibility at CHP to amplify that voice very seriously. Homelessness
35 consumers have a lot to offer discussions of reforms to human services. It is important to note that there is not some inevitable baseline number of people who will always experience homelessness. Each instance of homelessness represents a failure of the human services system. Having intimate knowledge of where our systems are failing, the expertise of
40 homelessness consumers should be harnessed by this inquiry.

CHP's first three submissions to this inquiry focus largely on whether or not our sector was an appropriate target to reform to make it more competitive. We advised that where resources are insufficient to support
45 all clients, and indeed here in Victoria homelessness services turn away 108

people every day, it is appropriate that resources are allocated by a prioritisation mechanism. We also advised that in major crises like homelessness people do not benefit from the serious administrative burden inherent in a competitor system. Instead, contestability in commissioning is the best way to ensure that services remain accountable to both our users and our funders. We are pleased the draft report drew a similar conclusion. We further advised that current processes around last minute short-term funding renewals lead to significantly worse outcomes for consumers for services and for funders. The draft report again draws similar conclusions.

Homelessness practice is by its very nature collaborative. Your first consumer for the day may require crisis housing, case management and material aid; while your second requires support to sustain a tenancy, mental health treatment, financial counselling and support for gambling addiction. No one agency can offer all of these services and all of the services that those who experience homelessness require. Most of these needs will be met by referral. They sound like small things, but support for collaboration through funded service coordination, through longer timeframes for tender development, and through recognising the cost of service provision in regional and rural areas can have a big impact on ensuring that the system works as best as it can. Such supports are recommendations of the draft report.

It will come as no surprise to commissioners, having read our response to the draft report, that less welcome is the recommendation to charge market rent on social housing. This recommendation seems to be based on the flawed premise that those who are on social housing waiting lists are the same cohorts that are currently occupying social housing. This is not the case. Three-quarters of social housing allocations go to those from the priority lists. In Victoria, that is those with multiple experiences of homelessness or those with significant disabilities. Those who occupy social housing have significantly higher support needs than most of those who currently sit on the waiting list.

The advice from consumers and services alike has been resounding. The social housing tenant profile now largely consists of people who would not sustain market rent housing. This remains true, even considering possible new state-based payments. It should be noted that for much of CHP's membership an increased Commonwealth Rent Assistance represents a significant financial windfall, and yet despite the money on offer we are rejecting this proposal. As one service stated, 'What's the point of more money if we're unable to help consumers achieve their goals?' Our member organisations are mission driven, rather than profit driven. Their mission is to end homelessness and this proposal will see it drastically increase. Further, the research supports the conclusion that low income housing

payments do not increase the provision of low cost housing. Where the obvious need across Victoria is for low cost housing, this responds to the actual needs of consumers.

5 Lastly, I want to touch on the proposal to expand tenancy support programmes, including to those in private rental. Tenancy support programmes represent significant value for money and they're a critical mechanism for people to avoid homelessness. Currently tenancy support
10 programmes are extremely small. Our advice to the Commission is that any expansion of this role would see the creation of a large new programme which currently does not exist. Obviously there are funding ramifications for such. I now let myself open to your questions.

15 **MR INNIS:** Thank you.

15 **DR KING:** Thank you. Perhaps I'll start on the issue of the market-based rents for high needs payment, and thank you by the way for the numbers because the group who are in social housing are demographically - systematically different from the group who are on the waiting lists outside.
20 Although again, I think our starting point was that we have - not everybody who is high needs, if I can put it that way, has managed to get social housing, as opposed to relying on a private rental market, and our starting point was a concern for what we see as an inequitable, quite frankly, system that's been set up.

25 As you correctly noted, there's funding implications and our proposal - the proposals put together, including the market-based rent, the aim there was to bring more funding into the system, including the increase in CRA; whether or not that's large enough, and parties have put to us that it's not,
30 but to put more money into the system so that both the State Government through the public housing and the community housing providers through the community housing would in a sense end up with more funds which could then be used to protect current tenants and/or - and before this we've got to have various protections in there relating to ten year grandfathering -
35 and/or they would be able to say, 'Well, actually we can divert some of these over to those really high needs people who haven't been able to get into the social housing and are stuck in the private rental market'. So, I guess our starting point was that we were thinking we're actually making, in a sense, a fairer system without necessarily making anyone worse off.
40 Clearly, that's not your view and I really want to understand where have we gone wrong?

45 **MR PATTERSON:** So one of the big problems for us is that what the proposal seeks to do is to - it identifies a service that is achieving outcomes well for those who are accessing it and its public housing. And it seeks to

5 take funding from that, essentially remove - like to remove - I think we've said that it fatally undermines public housing in our submission - and to take the funding and then move it to a system that's not actually working that well, moving it to rent assistance. So the question of, if we're trying to achieve outcomes why would we, like, take funding from something that was working and move it to something that was not is, I guess, is critical to us here.

10 **MR INNIS:** Damien, can I - so just unpacking some of this, we are conscious that this is a system as we say is broken. So we form a slightly view of public housing. Perhaps we agree it delivers benefits for the majority of people in it, but outside social housing are people on the same incomes, living in the private market. Now, not all of them are on the street; in fact a very, very small proportion of them are what you and I would call
15 homeless. So, what we sought to do was carefully separate financial support and service support. And on financial support what we tried to do was design a system that was more flexible in terms of supporting the needs of people where money was a fundamental issue. We protected those in the system by grandfathering at least for ten years, and in a way what we
20 wanted to do was say, 'Well governments, you can quickly give people more money. It takes a hell of a lot to build a public housing dwelling'.

The second thing is, and I think we've agreed but I really do want to test, is that the - there's more work to do on providing service support to people
25 because in fact you know the people you described fundamentally need service support, who might need financial support, they need service support to be successful even in public housing. So I just want to, in a sense I want to test have we got the balance of that right? We actually want to shift the system a bit, away from this big focus on dwellings and the
30 arguments to looking at the person and getting a better balance between service support and financial support.

MR PATTERSON: I guess the question becomes whether we can look at this as a zero sum gain. So, under this characterisation dwellings are a
35 financial support?

MR INNIS: So dwellings are dwellings. So say if you're giving financial support you're giving access to dwellings.

40 **MR PATTERSON:** Look, I don't think it would be accurate to say that the need is for more services and that's not - and that the need is not for more housing and more access to housing.

45 **MR INNIS:** No, that's not what I said.

MR PATTERSON: Sure. Did you want to - - -

MR INNIS: So accept there's an undersupply of housing. Yes.

5 **MR PATTERSON:** Yes. I think also though was probably fairly notable
is that our role is as the peak body for homelessness, rather than the Housing
Providers Association. And yet what we find ourselves calling for at - for,
you know, as long as I've been active in this sector CHP has been a voice
10 calling for more housing. The main thing that is stopping us from being
successful in supporting people who are experiencing homelessness, out of
homelessness and into more secure forms of tenure and also into, I guess,
you know, better outcomes across a whole range of, like, domains, is that
there is a lack of housing for people; a lack of affordable housing.

15 **MR INNIS:** So, you would advocate just a straight increase in housing
availability?

MR PATTERSON: Yes. Which isn't - - -

20 **MR INNIS:** As opposed to service provision?

MR PATTERSON: If we were looking at where is the greatest need for
increased support, the increased need has been for additional affordable
housing.

25 **MR INNIS:** Thank you.

DR KING: Can I just follow up on that a bit further, because you
mentioned in your comments - and it's really clarification, so that those who
30 are in social housing - and apologies this is sort of paraphrasing what you
said - are largely those who wouldn't sustain market rent housing. I just
wanted to check. So is that within social housing, if you went up to market
rent, even if there was a high needs payment, that would be a problem; or
are you trying to raise a different point which is those who are in social
35 housing are really those who would be - could not gain tenancy, regardless
of the financial back up, they couldn't gain a tenancy in the private market
because they would simply face - they would be at the bottom of the pool,
if I can put it that way.

40 **MR PATTERSON:** Sure. While the second argument is valid, I
understand that what you're suggesting is that public housing would remain
and in particular its role would be to, you know, increase security of tenure
and to prioritise to those who face other forms of discrimination in the
private market, so that it would continue to have a role. So it's not so much
45 the second argument. The real argument is around how people are going to

sustain their housing when they're paying such a huge proportion of their income, when they're left with - really the question is when they're left with so little at the end of the week to pay for their - like, for their most other costs. I don't need to tell you what people have to spend money on.

5

MR INNIS: Earlier you said that tenancy support programmes were important.

MR PATTERSON: Yes.

10

MR INNIS: And in fact we agreed and were proposing they be expanded, and be available to people who are at risk in the private market, because our assessment is actually there's a lot of people there who face at least some risk. I just want to make sure I've got this right. That if we had an extra dollar you would say build a dwelling before providing a tenant support programme?

15

MR PATTERSON: If we had an extra dollar, that's the argument that we would put.

20

MR INNIS: Okay.

MR PATTERSON: We can talk about the importance of - - -

25

MR INNIS: If we had ten extra dollars. I am just trying to get a sense of where the line is.

MR PATTERSON: Then totally there would be a division that wouldn't be ten zero.

30

MR INNIS: I understand the point you're making, I just wanted to confirm that.

MR PATTERSON: Cool. Did you want me to talk about some of the importance of - how we would come to that decision?

35

MR INNIS: Happy to. Also happy and keen to talk a little bit about - you started with the story about collaboration and the fact that particularly homeless people have often, at the complex end of homelessness, have a multitude of needs. So I wouldn't mind coming back to that at some point, if that's okay?

40

MR PATTERSON: Sure. I just, I guess would state briefly that one of the things that we would advocate against and why the housing is such an important issue for us and why - is because the current public housing

45

system really does take - really does support people with significant complexity. People with really enduring needs. And so to take resources from that system and to move it to those whose needs are less, would seem to us to be, you know, a negative thing.

5

MR INNIS: Your assessment is that the current group of people who are technically eligible for social housing but not currently in social housing have lesser needs?

10 **MR PATTERSON:** That's right.

MR INNIS: Okay. Coming back - - -

15 **DR KING:** Sorry, can I - I just want to jump on a couple of things, just to make sure we cover it all off.

MR INNIS: It's all right.

20 **DR KING:** Because in your submission, and again this is just more clarification of what's in your submission, in your submission you note through the interviews that a number of tenants, more tenants than not, support choice, and I understand that to be mean choice-based letting. As I understand it though from your submission, you have some concerns about choice-based letting. Have I read that right, or am I missing something?

25

MR PATTERSON: Kind of. Maybe I have failed to differentiate the different shades of grey that we're looking at here. So we've supported choice-based letting. The consumers with whom we talked were extremely supportive of choice-based letting. We wanted to discuss in the content of our submission some of the detail. There are concerns about choice-based letting; should it be delivered in a way that's inappropriate.

30

In particular, choice-based letting represents a really significant shift from - of power, from the prioritisation list where somebody gets to the point where they're getting housed and it moves that power to the housing provider, presumably under a system where the roles were separated it would be the tenancy manager. And so that's good, but it's important that we make sure that there's an appropriate mechanism there that ensures that prioritisation is still a really important function under that, so that one person doesn't sit at the top of the list for three months because none of the providers want them because of their housing history.

35

40

DR KING: Okay, yes. My understanding you have is choice-based letting has been done overseas is that, yes, when you reach the top of the list it is your choice, not - - -

45

MR PATTERSON: Yes.

5 **DR KING:** So that explains that. The other bit that I just wanted to clarify in this is, you referred to complexity of an applicant's needs. So choice-based letting selection criteria based on the complexity of an applicant's need, and I wasn't quite sure what you meant there and why complexity of need - I can understand complexity of need is critical for the support services, but why is it critical within a choice-based letting approach? Why
10 is it more important than, say, somebody who may be on a lower level of income or someone who's at a high risk of homelessness, rather than complexity of need as such?

15 **MR PATTERSON:** Because access to housing is an important support.

DR KING: Yes.

MR PATTERSON: And because there are those people without access - who without access to housing will not stabilise their crisis. And so if
20 somebody has a significant - has significant complexities in their crisis, it's more likely that they're going to need this housing and they're going to need it - I don't like to use medical terms, but more acutely. Their need is going to be greater and it needs to be something that is factored into the process for allocations. And so - - -
25

DR KING: Sorry, just on the - but on the choice-based bit, rather than on the 'You get to the top of the priority list quickly' bit?

30 **MR PATTERSON:** Yes. So it could be - it could well be that I didn't let - that we didn't have a proper understanding of the ways in which choice-based letting worked overseas. So, it wasn't entirely clear that a person - like that a person gets to the top of the list and then they, you know, are eligible for all of these houses and they get to choose one. The way that it read - or our reading of the report in fact was a different thing, whereby
35 a property is advertised and all those who are eligible may apply. And so - - -
-

40 **MR INNIS:** So your concern is that the provider of the property would have an opportunity to say, 'No to you', and 'Yes to you'?

MR PATTERSON: That's right. And that there's a - - -

MR INNIS: I understand that.

45 **MR PATTERSON:** Huge incentive there for them to take the less

complex person.

DR KING: Okay, now I understand where you're coming from. Thank you. Sorry, Sean, you wanted to - - -

5

MR INNIS: So just a couple of things, if I may. So you talked about a story of collaboration, and I think what I heard was government should fund organisations so that they're able to form collaborative partnerships, grease those wheels, if you like.

10

Can I ask a question about how the referral model works, and I'll start with a little story. So visited Homelessness Services as part of a former role and I asked them whether they were the coordinator of all services to, you know, this particular homeless person, and there were 11 services, or 12, I can't remember how many, and all of them said they were the coordinator and the other services were not. They were the referrer, effectively. Is that system working well? Is that coordination of care system working well, and is it clear who is the person that's ultimately responsible for making sure it really does come around the human - the end will be joined properly?

20

MR PATTERSON: Sure. So to talk about whether that system is working well is hard to talk about in ways that are sufficiently detailed. The answer being that some geographies work better than others. Each locality is its own service system, where it works differently. There are places where it's working well but if you're asking broadly is it working well, the answer is no. The reason for that is that it's not necessarily a funded role. It is a function of case management support at times, and so it, to my mind, would be incumbent on the case manager to be the person who is coordinating, but then that assumes that somebody is receiving case management support. So it's a complex question.

25

30

MR INNIS: I appreciate that and I didn't expect you to have a single answer. I just wanted to make sure that I had an appreciation of the dynamics from your perspective. It is complex. And I promise is the last question.

35

MR PATTERSON: I'm here to answer questions.

MR INNIS: I want to come back to the social housing dynamics and if we're looking at the system, should we have it in our minds that everyone who needs the extra support, the public housing support, is in public housing now or on a waiting list?

40

MR PATTERSON: Sorry, you're asking is that the current state?

45

MR INNIS: Yes.

MR PATTERSON: That is not the current state.

5 **MR INNIS:** So I'm just trying to reconcile that with some of our earlier conversation about the people who work in the private market now, not needing additional support, because not all of those people are homeless. I don't think we necessarily need to take that further.

10 **DR KING:** It's certainly been clarified though.

15 **MR PATTERSON:** Yes, I might want to clarify that. There isn't a suggestion that those who are in the private market don't need additional support. We are very supportive of additional support. We don't think it's appropriate to withdraw supports from those with higher - more complex, more enduring needs in order to fund those supports.

20 **MR INNIS:** So it's a triaging issue; it's making sure we're getting the right support to the right people that's at the heart of your concern?

20 **MR PATTERSON:** That's absolutely correct.

25 **MR INNIS:** I understand now, and sorry for taking so long to understand that point.

25 **MR PATTERSON:** It's great.

MR INNIS: Thank you.

30 **MR PATTERSON:** Thank you.

DR KING: Thank you Damien.

35 **MR PATTERSON:** Thank you so much.

DR KING: Our next participant is Little Haven Palliative Care. Sue, if you could formerly state your name and organisation for the transcript, and then if you would like to make some opening statements.

40 **MS MANTON:** Hi, I'm Sue Manton. I'm the business manager of Little Haven Palliative Care, a not-for-profit organisation in Gympie Queensland. Thank you.

45 **MR INNIS:** Can I say Sue, thank you so much for coming down and appearing in cold Melbourne.

MS MANTON: Yes, it is cold. Look, thank you. It is important for me to be here so I was happy – our board was very supportive of having a voice here.

5

MR INNIS: We appreciate it.

MS MANTON: And thank you for the opportunity to add my strident voice to the very welcome findings of the Human Services issue paper into end-of-life care. I come as the business manager of Little Haven. A service that's never turned away a patient in need. We've only ever expanded our boundaries, added more nursing services and staff and just cared for people.

I come as a board member of Palliative Care Queensland and most importantly, a recent consumer of palliative care services and aged care packages provided in metropolitan Brisbane for my mum who passed away last month, in her home of 60 years after being diagnosed with a brain tumour 21 months ago, and I apologise for getting - - -

DR KING: No, please. That's - - -

MS MANTON: I will get over that. Anyway, empowered by the findings of the Commission and enraged by my experiences with the clinical model of these well-resourced services, and bearing in mind over the last ten years our community has chipped in \$4.2 million for end-of-life care for Queensland Health to their \$1.8, I requested a meeting with Cameron Dick, the Minister for Health to discuss these issues, specifically, recognition for true community based model of care, the associated costs and benefits to the patient and the health system and the community.

30

More equitable funding for community palliative care, currently receiving only approximately 35 per cent of our annual budget in government funding. This funding gap as it widens is becoming unsustainable and to hoping to balance that share with community and government funding, and also shaping policy direction to roll out this demonstrated model into other rural and regional communities, thereby extending the reach and supported palliative care into more disadvantaged communities and bringing our care of the dying a little closer to that of other civilised countries in the western world.

40

The Health Minister refused this meeting instead sending me on an endless loop of consultations with various areas including the Community Funding Unit, the Sunshine Coast Hospital and Health Service and the Primary Health Network.

45

They all acknowledge the wonderful work we are doing, I am very disappointed to be informed there's no additional funding available and increasing funding for our model of palliative care is not on the Queensland Health radar at present. Is freeing up hospital beds also not on the agenda?
5 Currently Little Haven is caring for 72 palliative patients in the community at an approximate cost to Queensland Health of \$700 a day, that's total, not per patient.

Should just one of these patients not have access to community based
10 palliative care and end up in hospital, the cost would be upwards of \$1600 a day based on their modelling. Queensland Health have provided special project funding for Little Haven and five other charitable community-based care services for 15 years and they have all the stats and all the reports demonstrating the effectiveness of this model, providing gold standard
15 palliative care for thousands of Queenslanders. I would hope the community funding unit and policy unit would rejoice in the ongoing success of these true community based models.

Our service consistently sees 60 per cent of patients at home for end-of-life
20 and a further 24 per cent with less than five days hospitalisation because not everybody wants to die at home. Our service is highly regarded by referrers, patients, carers and the broader palliative care community. Given the older demographic of the Gympie region and the low socio-economic status of our area, we've served Queensland Health extremely well, and yet we are
25 starved of funding, not on the Queensland Health radar and not eligible to apply for funding under National Palliative Care Project Grants, currently only available to projects and services delivered on a national basis.

Instead, we're told to move away from our core principles of early access
30 to palliative care, shorten our boundaries and close our books at a specified number of admissions each month. We won't be doing that as we have a social contract with our community who have supported us so well for so long. Last year we cared for 221 palliative patients and provided bereavement support to 222 clients, demonstrating a consistent growth of
35 14 per cent per annum. In our community people know their end-of-life needs and wishes will be met by Little Haven.

The clinical direction palliative care is taking in Australia is the wrong
40 way, in my opinion, for the patient and for the health care system. Fully funded services laden with assessments, eligibility criteria, administrative costs are failing to deliver the hands-on care and 'how can we ease your burden' approach that's needed, and they will never meet the needs of the tsunami of palliative care admissions we are witnessing as our Baby Boomers move through the system.

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- My objective here today is to gain recognition for the work services like ours are doing at the coal face, to recognise our model of care and the possible societal benefits of having that rolled out into other areas, true community-based, rigid in community and supported from the community up, and to hopefully have some input in maybe palliative care being funded through aged care packages, and ensuring that smaller organisations like ours who are doing such a great job for the health care system are not left by the wayside in the competitive tendering process.
- 10 **DR KING:** Thank you very much for that.
- MR INNIS:** Thank you, Sue.
- 15 **DR KING:** You've actually clarified a couple of my earlier questions that I had on your submissions so to make it clear for the transcript, so when you refer to the 60 per cent dying at home and 24 per cent spending less than five days in hospital, that's five days at the end of life.
- MS MANTON:** Yes.
- 20 **DR KING:** So that was one thing I wasn't sure of.
- MS MANTON:** So some patients obviously want to die in hospital, they don't want to die at home and some people, you know, they are being cared for by their 87 year old wife and when they get to that very heavy stage, they need to come in.
- 25 **DR KING:** Do you find, do the conversations occur – do you find that you are able to facilitate those conversations to have those conversations with the individual? It's because there's often statistics thrown around, 70 per cent, I think it is, say they want to die at home, but they tend to be surveys of people not looking at death, if I can put it that way.
- 30 **MS MANTON:** Correct, yes.
- 35 **DR KING:** As I understand it, preferences change over time, you know when you see that there is a burden there, but not necessarily relieved, particularly if there isn't community-based palliative care there. How do you find those conversations go?
- 40 **MS MANTON:** Sure. So often, for a start, the conversations need to be held at an appropriate time. You know, it's not that one model suits all. You can sit down and do advanced care planning when you're not unwell, but sometimes when somebody has a diagnosis, that's harder because they think 'you're trying to knock me off' basically, you know, people don't want
- 45

to address those issues. It's actually harder at end-of-life.

5 But often patients will – you know, what they say when they're first admitted may not be what actually comes about because some people will be concerned that it will be too much of a burden for their family, and it's not until they're going through the process. In my own mother's case, she said 'Oh, no, I will go into hospital, it's too much for you to look after'. But as she went along and she saw that it just became part of our normal family life to be there and care for her, she didn't want to, and in those last couple
10 of days when I said, 'Mum, your disease has got to the point where you could go on IV antibiotics or we can just, you know, start to withdraw things'. And she made that choice herself, 'No, I want to stay here'. So that's what we did.

15 So that happens a lot of times, and a lot of older people don't think they'll be able to manage and they're surprised. I mean, what people do do to care for their loved ones is phenomenal, but having the support, knowing there's someone there 24 hours a day, you know, they can lift up the phone if they get concerned, that just helps alleviate it, and you know, we don't
20 overwhelm people at the beginning of the diseases trajectory by saying 'This is what's going to happen'. We just wait and as we see their care needs increasing, we will try and educate the family about what they might expect next so that things don't come as a surprise and they're not on the phone to the ambulance saying 'Help, this is happening', you know.

25 **DR KING:** Your submission, in the case of your mother, how that was done and using friends, family, social network to facilitate to be able to get that support network, I thought was fantastic. So well done. That was very good.

30 **MS MANTON:** You've got to hope you can look after your own mother when I've helped, you know – well, not really helped, but I've watched hundreds of people doing it for their loved ones before so.

35 **DR KING:** So there's a tension there from government and I think you partly touched on that, particularly in your presentation, that community-based organisations, I think only 35 per cent, I think it was, you said of your revenue comes from government, the rest is volunteer and fundraising and so on.

40 **MS MANTON:** Yes.

45 **DR KING:** So incredibly effective from the government, just a financial perspective from the government, as well as providing such an important service in the community. But at the same time very local in approach.

Whereas the government is there saying, 'Well, geez, it's hard to have the Gympie contract and Marysville, just south on the Mary River. I am not a Queenslander so I'm showing my ignorance.

5 **MS MANTON:** So in Queensland, there's Karuna and Cittamani which - - -

DR KING: So I would imagine the government saying 'Well, we've got thousands of contracts with these providers. How do we manage that?'
10 Have you got any thoughts on how the government's able to get that balance?

MS MANTON: They've got 15 years of knowing how they manage it because they've been managing ours. So we've been providing quarterly
15 reports. You know, they have all our statistics. They've got much better statistics on our end-of-life care than they have from their own services.

DR KING: Yes.

20 **MS MANTON:** So the model is there. It has been demonstrated to work, and I don't know from their administrative point of view how expensive it is for them to administer that, but I think basically what you need is a few passionate people in these communities and going out to places like, you know, the CWA or Rotaries and thinks like that, to get them off the ground
25 and running.

I've certainly put my hand-up to say that I would help them to roll out that model. I know because I communicate with other – you know, with the Roma District or the Gladstone District, and people that look at our
30 model and say 'We want it. We want it here', but they need seed funding to start. You know, they've got to have some funding for that to come off. What they are doing though is funding – so they're putting in through their own hospital and health services, a community based, you know, they'll have some connections out into the community.

35
Now, my experiences of that with my mother through Metro South Palliative Care was (a) it's difficult to get to because I have a belief that if somebody has a terminal diagnosis, then palliative care at that point is going to give them the best options, mainly – you know, in my mother's case there
40 was never a suggestion that she would have anything other than aggressive treatment from the health care professionals.

DR KING: Yes.

45 **MS MANTON:** They didn't take into consideration that at 80, she lived on

her own, and coming out of that hospital system, someone was going to have to be with her 24 hours a day, which is what happened. I believed that having the benefits of palliative care from the start were essential and I was an advocate for palliative care. I forced my foot in the door. But it was –
5 in front of my mother, at least four people made us say ‘Yes, mum has a three month diagnosis’ which actually panned out not to be the case and is often not the case.

10 **DR KING:** Yes.

MS MANTON: But you know, you're forced to say that because you have to meet that three month to fit the model, and I would take mum outside and say, ‘Mum, it's not really going to be like that, we just have to say that’, and it is distressing.

15 The other thing was, you know, I was pretty well resourced. I knew what I was doing. A lot of people don't and I was infuriated for other people that didn't know. But in my case, the only thing that I thought mum really needed, at that point, was I needed a bit of a back-up as a carer, and mum
20 was having difficulty getting in and out of a chair, and I thought that an electric lift chair would be a good – I probably put that in the submission already – but would be an ideal thing.

25 So three different health professionals came out to assess mum to see if that need was qualified, the OT came, the physio came and the specialist nurse came. They got her standing up and sitting down and yes, they agreed that she functionally needed it, but when they went back and ran it through their rugs and their peacocks and what-not, she missed out because she wasn't spending more than six hours a day during the day in bed, because
30 my mother was a social animal and she liked to be where the rest of us were.

They had chairs, but their modelling said that we weren't entitled to that chair, and fair enough, we went and bought her a chair. It was no big deal. Mum had private health cover and we paid for everything through the
35 system anyway. But what it did was, it made me feel like we weren't on the same team, you know. You want that warmth that palliative care should offer. So that you know if you're down and you do get down, you've got somewhere to go.

40 Basically, I felt that the – you know, the other thing that happened was the specialist came out, did an assessment, sat across probably as far away as that gentleman over there, and asked mum a few questions and then said – I said she had a GP appointment that afternoon because we were concerned about her swollen legs. She said, ‘I'll write a script now’ and
45 I said, ‘Oh, no, well, her GP's concerned about’ – because the GP had been

quite fundamental in her care, and it was like, 'No, he's worried about her renal function' so he didn't want to put her on the – you know, all these sorts of things.

5 But it's just that – there was no personal touch to that. It was just a clinical - - -

DR KING: A clinical service rather than - - -

10 **MS MANTON:** Yes, it was clinical service, they were ticking their boxes. They were doing their reports and I've never had a carer strain index done on me. I was very strained. Nobody ever asked me how I was going. You know, that's the difference in what we're doing and what they're doing so.

15 **DR KING:** So let's imagine that funding increases, the message comes back 'Look, we've heard you, Sue, we're going to increase State level or Federal level funding for this. We're going to select a provider for the Gympie region for community based palliative care, and now we're going to have a competitive tender for it'. What would be your views on that and
20 is it an appropriate way of doing it or not?

MS MANTON: So we have got a competitive tender arrangements in scripting, you know.

25 **DR KING:** Okay.

MS MANTON: So we get a project funding which is \$255,000 at the moment, and that is just, you know, it really came into play to care for 40 patients and it's doubled, it doubled with the introduction of the National
30 Health Reforms, but they don't really don't look at the numbers. So now we're caring for 220 patients, so it's obviously used up quite quickly. But there is the competitive tender for services which we do through the hospital and health service, to say 'Yes, we'll be a provider of scripted services', and we got that tender in the Gympie region.

35 The problem is that they don't keep their side of the bargain. So with 60 per cent of our referrals coming from the hospital and health service, if it went to any other provider, if it went to Blue Care or went to Silver Chain, Silver Chain's not in our area, but it is on the Sunshine Coast area. If it went
40 to those, they wouldn't accept them without funding, but for some reason because we're a not-for-profit and they know they have us over a barrel because we're compassionate, those patients come to us and we're only being scripted for that last week of life.

45 So when I've met with Queensland Health, all I'm asking for them to do,

which I think is reasonable, is to fund the admissions that they're sending to us through the health care system because we're alleviating that burden, but they're just saying, 'No, we don't have more than \$40,000 in scripting budget for the Gympie region'.

5

DR KING: So as long as the contracting is done properly and not, 'Well, here's an arbitrary cap and if you've spent the cap well, tough, you can' - - -

MS MANTON: That's right.

10

DR KING: Recognising that the funding has got to be there, then you don't have a problem with that sort of competitive tendering process.

MS MANTON: Only as I put in my comments to the draft Commission, in Metro North Hospital and Health Service District, they did that and Silver Chain got the contract over Karuna who had been in the district for a long time and you know, a similar organisation to us, and basically Silver Chain just has a much better administrative process, I guess, behind them, and a much higher profile. But they had no profile in Queensland at the time and it took them eight months to get up and running to fulfil that contract. Where, you know, Karuna had been doing it seamlessly before the hospital and health service was even into being.

I mean, I obviously have concerns about that. I think that is of concern, that the bigger services, and it surprises me that the bigger services like Blue Care and Silver Chain, who have not only that big, and they do wonderful work. I mean, we had Blue Care involved with Mum and they were very good, but they don't have the same - they have a lot more administrative processes behind them, too, in that they'll only give out their 24-hour number in the last week of life, or they won't see - in our region, about 40 per cent of our region doesn't have mobile phone coverage, so it automatically cuts Blue Care out of it because they won't go into areas without sealed roads of mobile phone coverage. You know, so there's those sorts of things.

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DR KING: The difference between real community versus community, what's called community.

MS MANTON: Yes, that's right, and I think that we need to drag resources out of the community, too. Like, I don't think that funding should be fully, you know, I think there's great value in the community getting behind care of the dying. It's the only way we're going to manage it, but it has to be equitable. So I think, like, I went on the Silver Chain website to see that, and they say, well, you know, they don't even accept donations for palliative care, so they would give it for other things, but I think that really being

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5 connected in the community is so important. I mean, we are able to - if somebody needs lifting up the stairs at home, we can ring the local butcher whose dad we've cared for to help that person get upstairs, and they know Little Haven and they would be happy to help us. So having that knowledge and that real community feel I think's really important.

10 **MR INNIS:** Thank you, and thank you for being so generous in what you have said. I want to reflect a couple of things before asking a question. So I think what I'm hearing is, there's a lot in the notion of care that is not about clinical or about administrative systems. That's a bit hard to put into formalised processes, but if you were to say that there was about the rebalancing that needed to be struck, it's on that personal psychosocial type care, so the care for the person and the care for the family, just as people, rather than the technical bits of care. So I think that's a message that I have
15 heard.

20 One of the things that I have wrestled with is the word 'palliative', so I was listening to your mum's story and there was an aggressive treatment phase of that story which, you know, most people who define 'palliative' would say, that's not palliative, but the care outside the hospital, it actually doesn't look much different except for when you get right to the end of life with prescribing.

25 I've heard that, and that's a hard one to wrestle with in a system, but I certainly heard that, and the big thing that I've heard is, there's a lot of magic in the very best localised service, and for what it's worth, something that we are struggling with is the difference between supporting the local where the magic exists and having a system where you don't - it's not determined by luck that you are dying in the place where there is a magic local service for that. We're looking at the nation as a whole and how you develop that
30 system, and you know, translating models is very difficult, so I wanted to let you know that we're really wrestling with those issues.

35 **MS MANTON:** Okay.

MR INNIS: Translating your service out, so you talked about, you know, going to other areas, are there ingredients locally that just need to be there, and if they're not there it can't work? Does that make sense?

40 **MS MANTON:** Yes.

MR INNIS: Can you talk a little bit about that?

45 **MS MANTON:** Okay.

MR INNIS: And you know, in my mind is, we're in Melbourne today. I'm off to a suburb in Melbourne. How do I make this work?

5 **MS MANTON:** Okay. First of all, I just want to go in the clinical side of it, and just to assure you that our nurses are great clinicians as well.

MR INNIS: I'm sure they are.

10 **MS MANTON:** And I think that that, even in the most, even the clinical models that we have, they're not - unless they're giving that 24/7 support where it's in the home, they're triaging patients into hospital. Like, if I rang the Metro South Palliative Care Service about Mum after hours, it would be, 'You need to go to QEII Hospital, blah, blah, blah', okay, which would be the case here, probably. Also palliative means to ease or soothe, so it's
15 part of the journey - - -

MR INNIS: I understand what the word means, but - - -

20 **MS MANTON:** Yeah, so I think in the community aspect of it, you know, there's communities everywhere that, you know, Gympie is not a unusual community. Sure, we've been there a long time, so we have a lot of history there, but I think community, I was able to - I found in my mum's case, in living in Salisbury, which is a very suburban part of Brisbane, that that aspect of community was there, you know, the neighbours that keep an eye
25 out for her and all that, you know, and it's a place that has a lot of young people moving into the area, but people came on board.

In talking to other services in Brisbane, I can't talk about Melbourne, but I know Eastern Palliative Care does a wonderful job down here too, but I
30 think, you know, community, there's community centres all throughout most major cities as well, so, you know there's people interested in, say, Mt Gravatt Community Centre or the Aged Care providers where you could put in this model of care at a more equitable share, I think. You know, it would be less effective - less expensive than the model that you're rolling
35 out at the moment.

I'm not sure about how it would work in the big cities. I feel like the big cities already have a good investment into palliative care services through the NGOs and also the hospital health services that are delivering it. They
40 just need to improve their game. They need to look at what the best models are of care and improve to meet those, but there's certainly loads of rural communities that have nothing. They don't have any access to it, so how it would work in a metropolitan city I'm not sure, but I think that they have the resources and they just need to stick to the standards of care that are
45 provided to Palliative Care Australia, but if you go to an Indigenous

community, you will find a passionate person who will take up the - take up the drive to get this up and running, so they would be more the areas that I have been targeting that we should be rolling something out to.

5 **MR INNIS:** Thank you.

DR KING: So just on that, because one of the statistics that we're aware of is, for example, Indigenous Australians, just simply don't accept or don't receive palliative care as much as non-Indigenous. There are differences
10 that seem to relate to linguistic background, ethnic background and so on. Now, is part of that around the Gympie area just reflecting that - well, why? Why is that, rather than trying to answer?

MS MANTON: We don't have a large Indigenous community there.
15 Certainly we've cared for Indigenous people and I think part of the main thing that steers most Aboriginals away from the health system is that they don't want to have their health care needs overtaken by the system. So when you can reassure them that you will meet their own community needs and values and culturally appropriate way of dealing with it, it's not different
20 from any other person that walks through our door. You know, we've got to respect their choices, support their decisions and provide our care accordingly.

DR KING: Thank you. Sorry, Sean.
25

MR INNIS: No, I had no other particular questions.

MS MANTON: Was that correct? Have I given you a broad enough summation of - - -
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MR INNIS: You have given us a wonderful set of issues for us to think about. We're not sure any report can solve them all, but I hope what you've seen is that the team and Steve and myself and Richard recognise that Australia has a long way to go on having a good care system for the end of
35 people's lives, and hopefully our recommendations can ensure the ball keeps rolling towards a much improved system.

MS MANTON: And I think my frustration is that nobody even comes and looks at our model, and you know, we're not getting - why aren't we getting
40 the people in universities coming up and looking at our model or saying, 'We don't have the money to do research into it, but, you know, we're happy for other people to do that'.

MR INNIS: One of the things, and this is now my hope for how things
45 will roll out, once you put a spotlight on things, people ask the question,

5 ‘Where is best practice?’, and in pursuing best practice, that is where you click in people very interested in the models on the ground and what they are delivering, et cetera, and you know, I'm sure it's a wonderful model and will come through as that, but you've got to get to the point where people are asking, ‘Well, what is best practice and how do we make sure that occurs everywhere?’. We're not quite there yet.

MS MANTON: Sure, yes.

10 **DR KING:** Also recognising what's best practice in one community may be different best practice - - -

MR INNIS: It may need to vary.

15 **MS MANTON:** Yes, sure. There would be aspects that they could take from, yes.

MR INNIS: Philosophy is learned from everyone.

20 **MS MANTON:** Yes, for sure.

DR KING: Thank you very much.

25 **MR INNIS:** Thank you, Sue.

DR KING: Thank you, Sue.

MS MANTON: All right. Thank you.

30 **DR KING:** Thank you very much. We will now break for lunch and if we can reconvene at 1.30. Thank you.

35 **LUNCHEON ADJOURNMENT** **[12.31 pm]**

RESUMED **[1.33 pm]**

40 **DR KING:** Let me formally reopen the hearings after the lunch break. The first organisation is the Hobart District Nursing Services, Ms Macgowan. If you would be able to state your name, organisation, just formally for the transcript, and then if you would like to make some opening comments.

MS MACGOWAN: I'm Kim Macgowan; I'm the Chief Executive of the Hobart District Nursing Service, Australia's second oldest nursing service behind the Royal District Service. So we celebrated our 120th birthday last year.

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In 2004 I made my way down to our nurses' work room to be confronted with a student nurse sobbing her eyes out, with a very senior community nurse standing beside her. They said to me that they had just made what would be the last visit to a client that we had had for some time and been palliating for many months. What made this visit difficult was that this old gentleman had for a long time been resolute that that he would not go to hospital and that he would die at home with his little dog, and he had no carers. I remind you this is 2004.

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If he'd been a veteran we could have cobbled together some care for him, if he had been on a disability pension we would have been able to access more. But he was on an old age pension, a Home and Community Care client, so therefore there was no access to any afterhours care, overnight care or anything else.

20

This student nurse sobbed even louder and said to me, 'But he'll die in pain'. So I took her in my arms and I said to her, 'Yes, he probably will die in pain, he may well die incontinent and he will die alone. But you know what, he'll be better off than most Australians, because he'll have died on his own terms in the place of his choosing'.

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That day I walked back to my office, determined that this had to change. So on that day I put a piece of butcher's paper on the back of my office door and I wrote 'hospice@HOME' on it. Then from there it took almost a decade before we could have the model of care funded. So while we tweaked it and played with it for a few years, and perfected it, we waited for funding. The funding came along in 2013, through the Better Access to Palliative Care, and so hospice@HOME was launched.

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I made a promise to the Tasmanian people that every Tasmanian would have access to equitable hospice care within their home. That meant I had to figure out a way to deliver care to not only urban and metropolitan, but also to the rural areas, and in Tasmania, the very rural and remote areas, the tops of mountains. And lots of people on the mainland don't realise how many small islands we have around the state that are well populated.

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That brings me to the first of the two points I want to make today. The hospice@HOME program has reached every single hamlet, mountain, island and valley in Tasmania; it is a true state-wide program. It has been equitable to every single Tasmanian that has been able to receive it, and it's

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been unique in that we didn't reinvent anything. What we did was use the services that were already available within communities; we focused on coordinating those services. So it was about not new services, it was as well as not instead of. So Hobart District Nursing didn't come riding in on their
5 big white bicycle and throw service delivery at these communities, we spent the time to use the services that were already there.

Within a very short time we stopped saying 'to die at home', we started saying 'to die within community'. Because for some people, going to their
10 local community hospital or nursing unit was where they preferred to die, but it was within community.

So the first point I want to make is this, the time for trials and pilots and testing models is over. Between Hobart District Nursing and many
15 other organisations around the country - we have to name Silver Chain and HammondCare, the work done by the Grattan Institute – the time for trials is over. The models are available now to the Australian public and those models now have to be funded and rolled out.

The second point I want to make is the confusion out in the community around the terminology: specialist palliative care, palliative care, end-of-life care. They confuse the public, they confuse governments, they
20 confuse everyone. Palliative care, if we're going to stick with that terminology, is an area of health that shouldn't have the boundaries of funding and age.
25

I can speak for Tasmania where the Tasmania Government still firmly believes that palliative care is the domain of the over-65s. All of us who are in this area of health know that that is not the case and that where you
30 have these boundaries set around us, that funding is doled out by age, then we can never deliver equitable palliative care to everyone.

So what I'm putting to the Productivity Commission and to everyone I speak to is that the time has come that palliative care be funded as a separate
35 area of health, that it be one of the target areas and that age and location shouldn't be a barrier to having equitable end-of-life care.

We've proven in the Hospice@HOME program there are savings to be made on all levels of the acute care system. Even in our own little state, in
40 three years we managed to save \$12.4 million out of the acute care budget. We could deliver Hospice@HOME for between 39 and 78 dollars a day. We have that wide span because it depends on what the government contributes as to what the cost will be. But if we only ever delivered it at \$78 a day, it's still a lot better to 15 to 1600 dollars a day for a hospital bed,
45 and that's a Tasmanian number.

5 So the most important thing we want to get across today is that the time has come for all of this to end. In the last Commonwealth budget there was money allocated to the Primary Health Networks, around \$8 million, and I met with the Primary Health Network straight away, so okay, 'What can we do with this money'. The second question I asked was, 'How long is this funding for', and the answer I got was, 'Oh well, it'll be treated like a pilot'.

10 I can't believe I'm hearing this. I've lost half my workforce because we are now down to the program has to end in December. We haven't been funded since June. So we've now had 2223 Tasmanians die at home, we have just over 200 people left in the program that we have to transition out by December. So in this forum I can say, if they don't die, then we have to find other services for them. But Hobart District Nursing has made a
15 commitment that we will keep them till death anyway.

But the notion that as of December – well, as of now - there are people who are going back into acute care to die. This morning the first news story of the day in Hobart was that there couldn't be an ambulance shift
20 changeover at 11 o'clock last night because all the ambulances were ramped at the hospital, so one shift couldn't take over to take up the next shift, and there is no doubt in my mind there would have been end-of-life patients in those ambulances, and that hasn't happened for three years, and in the few months since our program ended, the ambulances are now ramping again
25 with palliative patients.

DR KING: Thank you very much for that introduction. Can I follow it up, Kim, just on a couple of things that comes out of what you said there? So first off, so your funding has ceased and – rather than me trying to put words
30 in your mouth, can you explain your understanding of why the funding has ceased? Why didn't the funding continue? What happened?

MS MACGOWAN: I've done a lot of shoe leather and a lot of flights. From about the middle of the project – because for me this was always a pilot, and my job within this project was to ensure it was sustainable. So
35 our focus has always been on sustainability. I've got to say that as we came towards June of this year everywhere we took this model got the tick; the State Government ticked it off, the Commonwealth ticked it off. That was a \$35 million budget and we had an underspend of almost \$12 million, because we knew from the beginning that we didn't need all this money, so
40 we had this underspend.

So there was really no expectation for us that there wouldn't be something forthcoming, that model wouldn't be picked up. And we didn't even care
45 if it wasn't us, and I made that clear in politicians' offices, in government

offices. We don't care if it's not Hobart District Nursing, it's the model that's been proven and I'm important.

5 It was an absolute shock. We had a very late night and early morning around the budget, thinking it was – and we pored through to find that the Mersey Hospital money, there was a bit tacked on at the end, it was about \$6 million, and we thought 'well maybe that's ours', we can put packages together with \$6 million. Then that was halved, and then it was halved again. And I can tell you that we received \$500,000 per year for the next
10 three years to provide an afterhours information and call centre to the palliative patients of Tasmania. Where are the patients? It's over.

DR KING: So government has clearly, either explicitly or implicitly, made a judgment of priority. What have they said to you?
15

MS MACGOWAN: Nothing. The only explanation we've had from government this is a majority over 65s health domain and therefore the Commonwealth funds over 65s.

20 **DR KING:** So it's a Commonwealth-State dynamic?

MS MACGOWAN: It's a Commonwealth-State argument, if you like.

DR KING: When the Commonwealth comments, what do they say?
25

MS MACGOWAN: The state manager of the Commonwealth program for Tasmania spoke at our last function, our last launch, lauded the program, spoke of all of the stats, how we had come in so far under budget, met every target, and then silence. All of the Commonwealth health officials that I
30 meet with all say exactly the same thing, this has been amazing, it's given us exactly what we need.

Remembering too that we've run a research program alongside this for homelessness, dementia and people with mental illness, because they
35 became quite a specific area of need within the project, we realised that there was nothing to meet their needs, and they had specific needs. So all of that has been applauded. As you know we – or you may not know – we presented at the international conference in Montreal by invitation, we were overwhelmed with countries from all over the world saying, we never
40 thought of this.

Because I spent the whole time thinking this is so simple, why has anyone never thought of this. So yes, we heard nothing negative at all from any corner. The only feedback we get is that this is a Commonwealth
45 problem, and the Commonwealth say the state have to contribute.

But of course there's that kind of black hole between the two. And that's why I mention in my submission that there's this idea in Canberra that they already fund palliative care, but they don't. They fund specialist palliative care, and specialist palliative care is a consultation service only. There is no hands-on care delivered by specialist palliative care services. I don't intend that to be a criticism in any way, all of our services need to access specialist palliative care knowledge and expertise, but governments think they already fund it, and they don't.

DR KING: Thank you very much for that, and also, by the way, thank you for your comment on palliative, specialist community and end-of-life, you will notice that we chose end-of-life. So trying to choose the one with the broadest and least likely to fall into a particular clinical definition, for the reasons that you outlined.

MS MACGOWAN: Yes.

DR KING: The numbers that you present in your report, and you mentioned I think \$78 per day - - -

MS MACGOWAN: Yes, 39 to 78.

DR KING: Yes. Is it possible, and we don't need to do this now, but is it possible offline just to be able to get more details of how you came at the number? Also it may be we're not taking into account the 12 million underspend, I think you mentioned. Because we just had trouble replicating the numbers, so that would be good, so we're clearly just not doing something right. Also, you mentioned 12.4 million in acute savings, where was that number from? How did you come up with that?

MS MACGOWAN: We engaged KP Health and they undertook that work for us, because really, they were the only ones who could access the government sector health data. So they undertook that work. I'm more than happy to provide you with that.

DR KING: If you could, that would be fantastic.

MS MACGOWAN: Yes. I shall send you my very big box of data. The reason that issue between – and we were only saying \$39 a day for a long time. But there are two aspects of the program that we really – is really out of our control now. Equipment. Equipment was one of the key tenets to the success. We identified in the early developments of the model that one of the major reasons we were sending people to hospital was that we

couldn't access equipment, and people literally died before they would get a hospital bed delivered.

5 So when we set this up we said 'we will buy the equipment, we will put together a program to have that equipment delivered'. We set a task of within 24 hours, not only for delivery, but also for collection. Because it's a horrible thing to have a hospital bed sitting in the middle of a lounge room when someone's died.

10 Our equipment partner has not once ever not met that goal. Everyone has received their equipment in 24 hours. But the equipment scheme is part of the State Government, and so now all that equipment will go over to the State Government, which was one of the things we said at the beginning. But what that – yes, so with the State Government now managing
15 equipment, the cost will shift.

 The other area was the afterhours response. Whilst we developed the algorithms and we trained all of the staff, we used a commercial provider to actually do the 24 hour phone service. In a non-pilot environment you
20 wouldn't do that, because – we have our own RNs on call, but this was about – this was a testing environment to see how you could do this. And Government already pays for GPS system and we had to test that out. But you wouldn't do that in a non-pilot environment, you would certainly have your own staff on call.

25 **DR KING:** Thank you for that. So just coming back to the more general, as I understand the hospice@HOME program, you were able to roll it out very quickly.

30 **MS MACGOWAN:** Because it was a decade putting it together.

DR KING: On the ground, how did you do that? What were the challenges? Because obviously if there's an increase in funding where also – it's that transition time and things go wrong, we need to understand them.

35 **MS MACGOWAN:** My pleasure. So the model was absolutely – that had been refined and defined for a long time. We knew what we had to achieve, equipment, we had to stop people from actually picking up the phone and calling an ambulance, because if they call the ambulance, they have to go
40 to hospital, they don't come home again. We knew we had to achieve that. We had to do something about medication. So many of our patients were sent to hospital for the want of one extra little bit of medication.

45 There's no pharmacies open after 8 o'clock in Tasmania – I don't know about anywhere else. And even if you can get a GP to come to the house,

he can't access the drugs he needs. So the development of the 'Just in case box', which is now in every home of the hospice clients.

5 So we had all the elements there, everything was ready to go. The key to the roll out was that we organised a forum in the centre of Tasmania, a town called Campbelltown, which is smack in the middle of Tasmania, and we worked really hard at marketing to get everyone who was involved in palliative care to that forum.

10 To go back a step, when we were asked by the Commonwealth what palliative care might look like, long before the funding was ever released we were part of some discussions, and I suppose the fire in our belly came from the fact that we were in this forum listening to the State Government tell the Commonwealth representatives that the State Government were the
15 only provider of palliative care. In that room were district nursing services, there were residential aged care services; there were little community groups, who we were all – who did they think delivered the medications and cleaned up and – not the state services. So that was the fire in the belly came from.

20 So then, when we put the call out that any service in Tasmania delivering end-of-life care to meet in Campbelltown, everyone came. From there we put together a communications strategy, in that room on that day. So the communication was the key to it.

25 We ended up partnering with 67 service providers across Tasmania, and with full contractual obligations. In fact we are now doing contracts for the next six months, because it's been kind of bit of piece by piece. But that's been the key to it. The constant communication, the communication
30 strategies that we've used, with stakeholder forums, with making sure that the information is two-way, it's getting right down to the bottom and right to the top.

35 The other success of that roll out was that we guaranteed training and education. So one of the big pluses of the hospice@HOME project has been that Tasmania now has a phenomenally well trained end-of-life care workforce. You know, support workers, who previously their only role in end-of-life was to maybe help the nurse shower the patient. Those support
40 workers are now the people who are in the home at end-of-life, supporting the families and doing all those tasks. That's a complete turnaround to the previous situation.

45 So really good communication strategy, putting everyone in the one room, and I suppose – and painting a vision of what this could be like if we all work together.

Those stakeholder forums, we hold them every three months, and there is not one that I don't end up choked up, because in that room are our direct competitors. At least half the service providers in that room compete with us for every bit of work in Tasmania, and yet we come into that room and there's no competition for hospice@HOME. We work absolutely collaboratively. We share information and we don't poach each other's work. And it seems to be like this bubble has wrapped around the – the wrap around packages, for the service providers as well. It's buy-in, it's what it is.

I'm not so naïve to think that there's been an awful lot of money go into their coffers as well, yes.

DR KING: No. But if we're looking at rolling out appropriate end-of-life care across Australia, so is your sort of model, which is almost a central coordinating agency - - -

MS MACGOWAN: It is.

DR KING: Do you see that model – I guess what are the strengths and weaknesses you can see there, and what sort of split up? So Tasmania, in hindsight, should you have done north and south? Or is Tasmania about the right size, but if you hit somewhere like Victoria, that would just be too big? So I'm trying to understand that.

MS MACGOWAN: Yes. I get exactly what you're saying, and I've thought about this a lot. And when you think about half a million people in Tasmania, honestly, I don't think you could do it for many more than half a million. Half a million delivering around about 1000 packages a year, if that's going to be your core model or – and then you cookie cut that. So six agencies for three million, that's the way I thought of it.

I'm about to tell you how I think it should be done, and I have been criticised for it. But I believe that this should be delivered in a gateway type of model, where you have a palliative gateway that's doing all the care coordination, accessing the service providers and coordinating the service providers in a single access point, much like we've done with disability and a bit like the My Aged Care websites and call centres.

But I think it does need to be a gateway model. I've always believed that they should – that these packages should become like the fifth package like we have in aged care, four packages. I've thought they should become the fifth package. But in saying that, palliative patients can't wait on a waiting list and they don't want to be directing the care, they don't want to

be handling the money and sourcing the providers. So in a tweak of that gateway would also be the fund holder, and the extension of the coordination to coordinating the providers as well, not just the clients themselves.

5

I also believe that there needs to be a co-payment for the packages. It doesn't need to be a lot of money, but it does need to be a co-payment. I think one of the things that has affected all of us within the program is that we have cared for the very, very poor and very, very destitute - like my man
10 - along with the very, very rich, and people who could have easily contributed to their health care. But because the hospice@HOME pilot was that no one would pay, and that's exactly as it should have been, but looking back on it now, there were certainly opportunities for some co-payment. Again, much like an aged care package, where there's a means testing or
15 whatever.

MR INNIS: Do you think people would see that as reasonable?

MS MACGOWAN: I do. The reason I do is the number of our clients that
20 have struggled with the fact that they've paid us nothing, they can't get their head around the fact 'But what do I pay for this?'. In saying that, the Australian Government or the Department of Health has to have discussions with private insurers. Remember, we've kept people out of acute care; we've also kept people out of private hospitals.

25

A palliative patient or a medical patient is the worst kind of patient for a private hospital; it doesn't make them any money. They want the really complicated orthopaedic or neurosurgery or whatever. So we have freed up
30 beds for the very expensive surgical stuff as well. That's been an offshoot of it.

There is currently very, very limited access to Australians to access private health funds if they're palliative. They can access payment for a community palliative nurse, and it's extremely complicated. I don't shy
35 away from anything, but I threw my hands in the air. I even went to the point where I thought, okay, we will put every one of our registered nurses through the private health insurers' system to be accredited, to be able to then collect fees from people who are with Bupa or St Luke's or Medicare. It was impossible. It was impossible to do. The accreditation process for a
40 group of nurses - if you were a sole practising nurse, nurse practitioner, you might get through it, but it was impossible to do.

MR INNIS: Thank you. One of the things you said a little earlier was 'we've got to cut through the crap', if I may put it that way, and we've got
45 two levels of government very heavily involved. So if we're going to make

someone accountable, who is it? I've got too many instructions from the teams.

5 **DR KING:** We have this sort of thing here that says - - -

MR INNIS: Speak up, you must.

DR KING: And it's now down on the transcript.

10 **MS MACGOWAN:** I'm really impressed that the New South Wales Government has thrown \$100 million at palliative care for their state. I think they've got it, I think they've realised what the savings can be.

15 **MR INNIS:** So should it be a state responsibility?

MS MACGOWAN: It should be a state responsibility, there's no question about that.

20 **MR INNIS:** And how do we then handle the link to aged care? How would you suggest that be handled?

MS MACGOWAN: I think it needs to be through the packages. I think it's logical that if someone's already – you know, we've got - - -

25 **MR INNIS:** So the deal with the Commonwealth is to do would be through the packages on aged care.

30 **MS MACGOWAN:** Through the packages. And even if it's that – it's a top up to it. So we have supplements now for dementia and for – even if it's a top up, but effectively that's where it's got to be. But the state governments, they have to take charge of this. Because in one of my exchanges with Minister Ferguson Tasmania, we got to the point where he said that the State Government really didn't see their role in this, and that the funding was Commonwealth funding, I just asked him for the savings.
35 I said, 'Fair enough, you just give me back the savings and I'll run the packages', but that's never going to happen.

40 No, it's a State Government responsibility. Andrew Wilkie is this week – he's got himself a bit hot under the collar because he got BAPC funding for Tasmania originally, and only yesterday I prepared some documents for him for the next question time because of the fact that there was no funding and that the state – and he has said in his work that this is a State Government responsibility now.

MR INNIS: Thank you. One final question from me, it comes back to something that Stephen asked. So we're conscious that we're going to make recommendations for the country as a whole, it's important for us to understand to whom we're pitching those recommendations. On your
5 evidence it sounds like Tasmania was well prepared for a rapid rollout because there was a lot of pre-work done. How do you put consumer protection arrangements around this? Because we've seen in Human Services some areas where rapid rollouts have not worked terribly well.

MS MACGOWAN: Along with the – well, there was stakeholders, I said the word. The stakeholder forums and the stakeholder communications strategy, the Tasmanian people were a stakeholder, and so the advertising that we developed for the Tasmanian people - which was full-on media, TV, newspapers, the works – we told them what their rights were, we told them
15 they had a right to die at home and this is how you contact us to access the care.

So there was no hiding behind eligibility or this was the right of every Tasmania who met the eligibility, which was the simple, world-wide, if you
20 expect this person to not be alive in 12 months, that was the only eligibility, had to be Tasmanian, and we weren't allowed to offer it to people in residential aged care, obviously.

So having your population as one of your major stakeholders, and being
25 open and transparent with what they're entitled to, keeps everybody honest. And also we developed really robust complaints processes. I think if I had my time over again, I would have put together a community advisory group that had some teeth. But given the time – and remembering too, the election happened when we were given this money, so we were behind the eight ball
30 really, we had six months lag before the money came through.

So then we had to prioritise what we would do. If I had my time over again, I'd have had a state-wide community advisory group that had no industry or government reps near it, who would also meet in the middle of
35 Tasmania every three months, and put the money to that so as you would enable them to be able to do that.

I'm very conscious of the time. The other real battle for us was to cut through and keep the conversation away from euthanasia, and that was a
40 constant battle for the whole four years. One media outlet in Tasmania doesn't get near my office now, they edited my comments and made it sound as though we were in favour of euthanasia, and Hobart District Nursing's position has always been we support the choices of our patients and clients, we don't hasten death and we don't prolong life. That's as

simple as that. So that really took some of the time that took some hard work.

5 Remembering too that we had a group of politicians who were very vocal about the euthanasia bill, and of course it's just gone through and been tossed out. So maybe all the talk around euthanasia is what piqued the Tasmanian public, and they unwittingly then were facing this discussion being had in public; palliative care, euthanasia. And interestingly, everyone was supporting palliative care.

10 But I can't think of anything other than to say that it's engagement, it's that really hard work on engagement and stakeholder communication. We really didn't come across any area of the project that could have been rorted or – actually saying that, there is a danger that service providers - - -

15 **MR INNIS:** We're less concerned about rorting and more concerned about the quality of care.

20 **MS MACGOWAN:** Yes. There will always be service providers who will try and offload their patients to you, but see; in our project they couldn't deliver an inferior standard of care. They were being paid by the hour and you would think, well, they could do nothing for that if they wanted. But because of our coordination process, with having registered nurses overseeing coordination, then there was constant reassessment. And there was a service provider in Tasmania that we refused to do business with, because their standard of care, they would not meet what our standards were. They wouldn't have their staff trained appropriately and they wouldn't meet the standard. So we kept increasing the scrutiny and then said, 'No, we won't do business with you'.

30 **MR INNIS:** Thank you.

DR KING: Thank you very much, Kim, it's been fantastic.

35 **MS MACGOWAN:** Thank you.

MR INNIS: Thanks, Kim. And thanks for coming up.

40 **DR KING:** Our next participant organisation is the Victorian Aboriginal Community Controlled Health Organisation. And Ms Tunny and Ms Neville?

MS TUNNY: Yes, that's correct.

DR KING: Would you please state your names and the organisation that you represent for the transcript and the room, if you would like to make some introductory comments.

5 **MS NEVILLE:** My name is – do I need to speak into this?

DR KING: Yes, they're for the transcript.

10 **MS NEVILLE:** My name is Alisoun Neville; I work for the Victorian Aboriginal Community Controlled Health Organisation.

MS TUNNY: My name is Noeleen Tunny and I also work for the Victorian Aboriginal Community Controlled Health Organisation.

15 **MS NEVILLE:** I'd like to start by acknowledging the Kulin Nation, it's the traditional owners of the land on which we meet, and to pay my respects to elders past and present.

20 So the Victorian Aboriginal Community Controlled Health Organisation, or VACCHO, is the peak body for Aboriginal health and wellbeing in Victoria, and also represents Aboriginal community controlled organisations, which I'll refer to as ACCOs, in Victoria. And I will just mention that they're called different things in different states, but - - -

25 **MR INNIS:** I've always used ACCHO, do I need to change?

MS NEVILLE: We used to use ACCHO, so yes.

30 **MR INNIS:** I'm not up with the times.

35 **MS NEVILLE:** We've moved to ACCOs, but ACCHOs is fine. The role of VACCHO is to build the capacity of our members and to advocate for issues on their behalf. Our member ACCOs have a cooperative membership structure and offer a range of services to their local communities, including but not limited to primary health services. Other services vary across the members, but will often include housing, justice, child and family, social and emotional wellbeing, aged care and disability services.

40 ACCOs have a proud history as sustainable grassroots organisations that assist in building community capacity for self-determination, and community control is a practical expression of self-determination. Notions about the roles and responsibilities of individuals, consumers and service providers must be considered in the cultural context and cannot be
45 translated directly from western models and concepts.

5 So VACCHO is concerned that a one size fits all approach to competition, contestability and user choice in human services will undermine formal commitments and specific measures to achieve health and other outcomes for Aboriginal peoples. VACCHO agrees with the ACOSS that the current focus on competition can obscure the lack of adequate funding for services and, in isolation, will not address funding inadequacy or accessibility issues.

10 VACCHO does not believe that without special measures to provide a safety net, marketization will provide for the needs of Aboriginal people or that they will be in a position as individual consumers to shape how those needs are met. Open markets will simply not deliver the services needed to help address the gross inequity in health outcomes.

15 Reforms in the area of aged care and disability offer some cautionary learnings for future reform. For example, standardised one size fits all assessment processes do present barriers for access for Aboriginal people. Likewise, the National Disability Insurance Agency has to date relatively
20 focused its attention on outcomes for Aboriginal people in remote areas, especially the trial site of Barkly, without equivalent strategies to address comparable challenge in rural and urban settings.

25 This inquiry recognises that equity is one of the components of effectiveness. VACCHO agrees with this but notes that equity of access to services itself requires special measures and cannot be achieved by offering the same service to all people. To support users to exercise informed user choice where individual entitlement schemes are introduced, ACCOs should be funded to facilitate equitable access to quality. This should
30 include funding for cultural support officers, outreach, culturally safe assessment planning and reviews, as well as support coordination and system navigation. Investment is also needed in community engagement and awareness strategies that ensure Aboriginal people understand their rights and entitlements.

35 VACCHO is also concerned that the Productivity Commission's proposed move to market rents for social housing tenants and increased contestability in the selection of housing providers will disproportionately impact on Aboriginal people. Almost one-quarter of Aboriginal people live
40 in social housing. In addition, housing provided by ACCOs often carries a range of cultural and other benefits which may not be taken into account in the design of measures to increase contestability. These include community connection and access to a range of health and community services.

- 5 So any understanding of user choice must take into account the unique cultural, social and health needs of Aboriginal people and the right to choose an Aboriginal organisation, and there is a preference among Aboriginal people for Aboriginal organisation. ACCOs are the dominant choice of Aboriginal people in all geographic areas in which they're located, and many Aboriginal people travel considerable distance to access them, often bypassing mainstream services to do so. It doesn't mean they're the only choice, but they are the dominant choice.
- 10 VACCHO challenges the finding by the Productivity Commission that social capital benefits are not exclusive to one type of provider and asserts that the community controlled sector provides unique benefits that cannot be delivered by government mainstream, not-for-profit or for-profit providers.
- 15 The issues paper does point out that where user choice is not feasible or desirable, there may be other options for empowering users, such as governments and providers taking greater consideration of user preferences in decision making. VACCHO recommends that all levels of government
- 20 take into account the preferences of many Aboriginal people for community controlled organisations and ensure policies and programs support access to this choice.
- 25 As an example, the National Disability Insurance Scheme emphasises choice and control for the individual, and while it's legislated to take culture into account, it has no investment in the viability and sustainability of organisations, which has implications for the capacity of member ACCOs to offer the unique service model and/or a culturally safe service.
- 30 Aboriginal people are more likely to present with complex and chronic needs, in addition, for many mainstream service providers Aboriginal peoples' cultural needs increase the complexity of quality service delivery. In the absence of block funding there may be low incentives or insufficient funding levels or profit margins for non-Aboriginal providers to offer high
- 35 quality and culturally safe services to these populations.
- 40 Aboriginal organisations are accountable to their communities, which provides natural incentives to respond to complex or emerging need. However, if Aboriginal organisations cannot establish financial viability under the pricing models available, an example of that is the NDIS price guide where there's set prices, this leaves the market chronically under serviced.
- 45 Informed user choice will only contribute to the development of responsive and appropriate markets where users are sufficiently empowered

to actively shape the service response, placing pressure on providers to understand and meet their needs. Aboriginal people, in contrast, are often deeply disempowered, especially in mainstream settings, and face unique and complex barriers to access. If the market does not provide, the safety of block grant funding and other measures is required.

So VACCHO asks for significant caution in the introduction of any measures aimed at greater competition, contestability and informed user choice, and for the mandatory inclusion and adequate funding for special measures to mitigate the negative impacts on Aboriginal people in remote, rural and urban areas. Improvements in the quality, range and funding of human services are better achieved by economies of scale through funding of the holistic service models that encompass a broad range of human services.

Where individualised funding is introduced: include targeted funding for culturally significant items required to meet the needs of Aboriginal people - and one example of that is providing cultural support through the assessment process so they even get through the gateways that we've mentioned before; providing funding for the social determinants of health that take into account evidence about the systemic and structural factors, producing ongoing disadvantage; provide funding on the basis of need, based on a cost benefit analysis and social insurance approach that recognises the long term economic benefits of effective intervention; collaborative needs-based planning and allocation of resources; adequate resourcing and support to enable Aboriginal community participation in co-design of any reform to ensure it's effective in meeting the needs of service users; an evaluation and monitoring framework that's adopted by Commonwealth and State and Territory Governments and provides rigorous quality and outcome benchmarks based on empirical evidence about the needs and circumstances of Aboriginal people; and accountability for outcomes through appropriate establishment and monitoring of KPIs. Thank you.

DR KING: A couple of areas I want to pick up, just to clarify, to make sure that I'm clear on. You stated that VACCHO didn't support our finding that social capital benefits are not exclusive to one type of provider. I guess what we tried to do is to say – generally through the report, which is obviously a range of services, that the government should be sensitive in its approach to the different motivations, the different incentives facing different organisations. So it shouldn't simply say, well, not that group, or always this group. But it should actually say well, horses for courses. But different services need different groups in different settings.

So I wanted to get your view on whether you're happy with that or you do feel that there are particular services where it is only an Aboriginal community controlled group that would be appropriate. I've got two parts, so let me do that first one. So just your feedback on that.

5

MS NEVILLE: Sure. And I might throw to Noeleen, you may know better than me about the Victorian Government's policy preferring Aboriginal organisations as well. But the quick point I would make is that the benefits are exclusive to Aboriginal organisations, they offer unique benefits and that that should always be taken into account. So the wording is saying that, you know, a provider does not offer benefits, that they're not unique to one organisation, there are unique benefits that need to be considered.

10

So where that is properly taken into account, then that should always be the first port of call for looking at whether those unique benefits can – are the best to be accessed in that circumstance, and that's your first port of call, and have a very good reason for not accessing those benefits.

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MR INNIS: And just to confirm, we've heard some arguments that not-for-profits generally have these benefits, I think what you're saying is that you need to look beyond that to actually – a deeper understanding of the organisation and its attributes, and in this case the connection to Aboriginal people and their community control.

20

MS NEVILLE: And self-determination, that it's absolutely fundamental to self-determination and so that's why it should absolutely always be, in every circumstance, the first port of call.

25

MR INNIS: Thank you. I just wanted to make sure I understood.

30

MS NEVILLE: Yes.

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DR KING: So the second part of my question was our draft recommendation 8.4, which is in the context of human services in remote Indigenous communities, I guess what we tried to do there is take into account factors to try and capture the benefits in particular that Aboriginal controlled organisations could bring, but sometimes also other groups can bring. So the four points there: culturally appropriate service provision; community engagement and governance; collaboration and coordination with existing service providers and community bodies; and employment and training of local and/or Indigenous staff. And so they were sort of the four aspects that we picked.

40

Is there anything obvious that we've missed there? Are you happy with that approach that we've taken there to try and capture the distinctions so that

45

government does take into account these important attributes? So in particular have we missed anything, is there something wrong with the approach we've taken?

5 **MS TUNNY:** I think the approach that you're taking is definitely on the right track. I guess what we noticed, particularly from a Victorian perspective, is that the benefits of community control seems to be only recognised in the context of rural and far remote communities and ignores the fact that many of the same difficulties are experienced by Aboriginal
10 people in regional and in fact in metropolitan settings, and our introduction referred specifically to people who will travel large distances and bypass mainstream service providers in order to get a service provider that they trust. This is across the board; it's not unique to remote areas.

15 Often times we hear, the necessity of taking recourse to community controlled organisations in remote areas, because of the specific and unique culture of the people and also because of the thin markets that they experience. There doesn't seem to be recognition of the fact that Aboriginal people have a unique culture and a unique approach to service provision,
20 even in metropolitan areas, and even where English isn't someone's fifth language.

 So that's what we'd like to focus on, and the fact that if you're talking about Victoria in particular, you have small dispersed populations of
25 Aboriginal people who experience thin markets, regardless of whether there are other mainstream providers available to service the need.

DR KING: Recognise all of that.

30 **MS TUNNY:** Yes.

DR KING: I guess the task that we were faced with was of course not looking at all of human services but picking parts we thought were, if you like, most urgent for reform. So we did focus on remote Indigenous
35 services, and it may be that all Indigenous services, in hindsight, would have been a better grouping. But we are where we are.

 It would be very helpful to us, however, to be able to feed into our final report, where the sorts of recommendations that we're making for remote
40 Indigenous communities could be extended or that it's put to us and argued to us that it's not just remote communities, that these same reforms, these same issues are critical in rural and in urban settings. So I guess more of a request than anything else, if you're able to look at our recommendations in particular the remote Indigenous part of the report and can provide us with
45 some assistance, to be able to say it has been put to us, it's been argued that

these are more general and the government should be thinking more generally, that would be very helpful.

5 **MS TUNNY:** Can I give you an off the cuff example, as we said?

DR KING: Please.

10 **MS TUNNY:** If you take a look at your own reports on government services over the last few years, Aboriginal people are under-represented as recipients of aged care assessments, at a national level and in every state and territory jurisdiction. So even if you look at Victoria where the figures paint a picture of a population who are better served than their Indigenous counterparts in other states, they are still below, you know, per head of eligible population, the numbers for assessments received per thousand, are
15 less than both CALD populations and mainstream populations. So there's a quick example, off the cuff.

MR INNIS: Thank you.

20 **MS NEVILLE:** Well, I guess I just wanted to comment that I might need your comments on what the final recommendations were, because our concern with the first report - - -

25 **DR KING:** These are the draft recommendations.

MS NEVILLE: Sure. So I might get you to repeat those in a moment. Because we're particularly concerned about the family and community grants and the potential of informed user choice and client directed care being introduced in the family and community grants. So I have to confess,
30 I'm a little bit - - -

DR KING: Yes, it's really for the - the remote Indigenous specific ones are in chapter 8.

35 **MS NEVILLE:** Yes, sure, so I'm not completely – could you just - - -

MR INNIS: So I might ask the question another way, and then we're happy to talk a little bit about the family and community grants and what was behind what we're trying to do.
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MS NEVILLE: Yes.

MR INNIS: The question for me is this issue is in front of governments every day. Governments are making decisions on who to trust to deliver services or facilitate access to services every day. Is the issue that they
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5 don't understand the needs of the group and what it takes to facilitate appropriate access, or is this just a straight funding issue? Or is there something else? So what's the thing that's – you know, we're making these decisions every day, who does what? So help me explain what we can advise government that changes the dynamic in the direction that you seek.

10 **MS NEVILLE:** I think it would be good to give the Victorian Government's current policy on self-determination as an example, because that is shifting things here.

15 **MS TUNNY:** Within the Department of Health and Human Services in Victoria, they are looking at their, I guess, procurement practices in relation to Aboriginal people, and as part of their focus on self-determination they are now determining with DHHS that if a particular stream of resources is intended to provide services for Aboriginal people, that the preferred provider shall be the Aboriginal organisation in the catchment under scrutiny, and if it should be that it's decided not to award or not to allocate the funding to the Aboriginal organisation, there actually has to be an explicit reason why you would choose a mainstream organisation that doesn't have cultural connections over the Aboriginal organisation and there has been sign-off at I think secretary level as to providing the rationale for allocating money to a mainstream organisation.

25 **MR INNIS:** It puts an onus and burden on those organisations to be ready for the delivery task. Is the government supporting that in any way?

30 **MS TUNNY:** The Victorian Government? Are you asking whether that's part of their procedure now? Yes, it is. But the issue is we have a number of Aboriginal Community Controlled Organisations that are subject to multiple accreditations that have proved their capacity in a variety of different ways and the issue is for those organisations that have proved that they have the strength to actually deliver the service and provide the oversight required, why wouldn't you allocate funding to those organisations?

35 In fact, that's basically the policy and procedure. If an organisation has the capacity to provide the service, then why wouldn't you allocate funding to them?

40 **MR INNIS:** It sounds like a first choice - - -

MS TUNNY: Like a preferred provider.

45 **MR INNIS:** Thank you. Coming back to the broader families and communities approach we've taken, one of the things that we've sought to

do is avoid very simple prescriptions and marketizations, so I think that was a concern you expressed at the beginning.

MS TUNNY: Yes.

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MR INNIS: In fact, I hope we are quite clear in that area of the report that we don't think - - -

MS NEVILLE: Yes, we were relieved to read that in the draft report.

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MR INNIS: I just wanted to confirm that because if we weren't clear, I'd like to make us clear. Part of where we were trying to help was to say actually government should look very, very carefully at the attributes of providers to make sure that they will deliver the outcomes needed. For particular client groups, be it Aboriginal or be it a newly-arrived humanitarian migrant, there are certain organisations that are going to be better at it. That was an intent at least.

15

Can I come to your concern about market rents and noting the high proportion of Aboriginal people in social housing – I think, from memory, about 9 or 10 per cent of all Aboriginal people live in New South Wales social housing. I'm drawing that from the past. So it is a very important service. It also means that there's a lot of people outside social housing who are renting in markets. I guess one of the issues that we were trying to do is actually give people eligible for financial assistance more choice about where they live.

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That 25 per cent who are living in public and social housing, if they had more financial resources, do you think they would be able to choose – they could choose to live in social housing or they could choose to live in the private market.

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MS NEVILLE: I suppose the concerns would be about the level – and, again, this is not my area of expertise – but the level of increase to Commonwealth rent assistance that's mentioned compared to the security of tenure that they currently get and the affordability that they currently get in social housing would potentially significantly - - -

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MR INNIS: It's more than just the money, it's security of tenure.

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MS NEVILLE: Yes, but also the money as well.

MS TUNNY: Certainly the money and the security of tenure. If you're looking at ACCO-provided social housing, you're also looking at that broader range of access to services of community outreach and health

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services that are entailed in that.

MR INNIS: I understand. I'm assuming the ACCO model isn't intended to house every Aboriginal person.

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MS TUNNY: No. It's vulnerable members of community.

DR KING: Just on that, our recommendation, when we're looking at the social housing, is to separate it off to the additional support services that are needed for any tenants in social housing from, if I can say, the actual asset management landlord type of approach. Part of our logic behind that is because currently there are many people eligible for social housing who simply aren't in social housing. So we see no reason why they shouldn't also be able to access these services. Would that work for Indigenous services for Indigenous Australians so that there could be a separation of – you mentioned that one of the benefits of ACCOs where their community housing provider is also providing those services, do you think it would be reasonable to say, 'Well, you could have those separate?' so it may be that those services are provided to Indigenous people needing those services regardless, in a sense, of where they happen to be housed?

MS TUNNY: It's the aim of our members to provide wrap-around services to their communities and to address community needs. If somebody does not have a requirement for housing but they have a requirement for a variety of other services, they do receive that as a wrap-around regardless. But it's the, I guess, capacity to provide services to the person in context so that the person who requires the housing and the rest have that most neatly wrapped around them.

When you consider, I guess, the vulnerability of the people who are occupying those social housing places, actually being able to wrap the services and the housing in context together is a benefit to those clients.

MS NEVILLE: I just want to say we do – I mean, this may be obvious but we do support an increase in Commonwealth rent assistance for those not in social housing. It's just we would like to keep the affordability for those in social housing.

MR INNIS: And we've done two things that I hope helps. One is for existing tenants. We've grandfathered those arrangements for a minimum of 10 years to provide a very long period of certainty. We've got an additional payment that we've recommended, which we probably haven't explained well enough, for high-needs clients. These are clients who have a need to live somewhere that's more expensive than their rent fund, their assistance fund gives you. That can be varied, depending on the person's

needs.

5 For someone who has a real need to live in this area and these areas of Melbourne, for example, that would be much, much higher than in another part of the state. Those sorts of measures would help?

10 **MS NEVILLE:** It would help, but I suppose it depends on – the devil is in the detail in that and what kind of need to live in – it might be their need to live in community, but will you recognise that? Fitzroy is a great example. It's a very expensive area but it is a really important place for Aboriginal people culturally. But, yes, it's without knowing the detail of how that would be assessed and also how people would get access to it through the assessment process as well.

15 **MR INNIS:** Our intention is to leave state governments with some flexibility there. But I think the message we're hearing is we need to explain more on how it could work.

20 **MS NEVILLE:** Yes.

MR INNIS: Thank you from me.

25 **DR KING:** Thank you very much, it's been very useful. Our next organisation is COTA Australia. Welcome, Ian. If you could be able to just your name and organisation for the transcript and then if you've got any introductory remarks.

30 **MR YATES:** Ian Yates, Chief Executive of COTA Australia. Yes, I do have a few remarks and then happy to be open to discussion. We certainly appreciate the opportunity to talk with you. Perhaps I'll just apologise that our response to your draft report in writing was very brief, in the nature of a two-page letter. I won't begin to tell you how many inquiry and other submissions we're finishing in the current two-week period at the moment; a very large number, including yours and some others of yours and several
35 parliamentary inquiries and some others.

MR INNIS: I think we can all record that everyone in this room is busy.

40 **MR YATES:** Yes, just finalising submissions at the same time as being busy is a challenge. Look, we really welcome the draft report. There's obviously a great deal of thought and work gone behind it. It's, for PC reports, relatively slim; 48 pages, having memorably waded through a number of others that were many multiples of that number of pages. I particularly welcome the point that you've made that the key issue is
45 actually the effectiveness of services or, as we would say, what's being

achieved, what are the outcomes, and that competition and contestability are, if they're applicable, means to an end and may, therefore, not be the appropriate means in some context.

5 I do, indeed, having just listened to the ACCO presentation that's obviously clearly an area where that might be the case. I also welcome the focus in a couple of places – and I want to talk about this later – on informed choice, that a competitive requirement actually requires people having capacity to take advantage of it. And I will probably return to that. And on
10 tailored solutions for each area. So you can't just kind of take the approach, which there was some nervousness in our organisation in terms of the first paper, the discussion or issues paper, about that if you just marketise everything, everything will be fine. I think it's clear that that's not where you've got to in the draft report.

15 I just really for the record want to applaud a few things. I want to applaud your comments on page 11 that the fact that many people, unless things change, will die in a place that does not reflect their values and choices is not acceptable. We would urge you to hold the course on that in
20 a final report. It is really a very poor thing for a country like ours that so many people are unable to die in the place and in the kind of context that they would want to.

I also applaud your opening remarks in the comment in the social
25 housing to say that the social housing system is broken. We've been saying that the broad public or social housing system is broken for a long time and the nature of housing systems is that's not always immediately obvious. In our particular case, it's clear that older Australians who used to have it as a very significant safety net in terms of later life housing stopped going
30 through the front door a long time ago, but that got masked by the fact that very significant numbers of people in public housing are older, either because they were older and moved in and have lived a long time or have stayed in it, which may not be a good thing.

35 Just really strongly support your recommendation that CRA should be increased, Commonwealth Rent Assistance, and would note that the Palmer Review of pensions in 2008/2009, which led to the increase in single pension, pointed to the inadequacy of CRA. That's quite a while ago now and it's not been addressed. A number of commentators have said if want
40 to do something in the social security space that's well-targeted and isn't a huge amount of money compared to other things, that's what you should do.

45 Then, finally, while I'm handing out these really (indistinct), to really thank you for the comment that in the dental health services are, that unlike

some other parts of the health system, governments have paid scant attention to public dental services. They have paid scant attention. Indeed, I think it's fair to say that they've been the subject in some occasions of cost shifting, that they've not been given priority at all. They really are a very poor cousin in the system and most of the health system wouldn't even recognise them as part of it. Yet we know that dental and oral health is critically important.

Indeed, for older people it's a very significant issue and it's one of the bigger issues for older Australians of limited means in retirement, that they just can't access it. As you succinctly, although a bit more gently, put, if you have a preventative services that has waiting lists in excess of three years it's kind of a contradiction in terms. So I really welcome that.

A few qualifications and without commenting on every recommendation, because I'm not going to. There's a lot of them that we haven't considered carefully. Just in terms of a couple of comments. I would exercise a note of caution where you note that the sector complains about having to do tenders instead of their real work. I would comment that within our overall caveat that you don't force competitive or contestability on everybody just for the sake of it, that it is something, an exercise that can force providers to rethink what they're about, how they're doing it, what alternative ways there might be of doing it and to have to look over their shoulder or sideways at what someone else might be able to do.

We have sometimes had a bit of a soft sector that hasn't – and the whole notion of you are doing good can become an excuse for not doing it the best way. All of us have to go out and find resources for what we do. Having to tender – well, competition can be a challenge, but it should be. It needs to be consumer-driven, and that's a discipline that a lot of human services haven't had.

A comment to the degree that you change the environment to a greater degree of competition or greater market – and I want to talk about this in the aged care context as an illustration in a while. Some people equate that with the word 'deregulation'. We would just like to make sure that that's not and that clearly – in the aged care space, for example, while reforms, we hope, are headed in the direction of even greater consumer choice and control in a more market-like provision of services, that it's absolutely essential that a quality regime is maintained.

Quality regimes exist in quite a lot of markets. In fact, they're probably the rule rather than the exception. We're surrounded here by lots of restaurants and eateries that are subject to quality controls that we'd all be

disturbed about if they weren't there. That's certainly the case in aged care and should be the case generally.

5 This is not a big thing, but I just note in terms of my earlier comment about tendering, also a note of caution about long contract periods. I understand the rationale. But you have to think how you did that without it introducing a degree of complacency for a fair whack of that period. I have not widely consulted on this, but intuitively seven years seems a bit long to me. Five would probably be more acceptable.

10 I have to say that actually it would be good – mostly government has in recent times done something in a three, four or five year space. It would actually be helpful if they consistently did that rather than then they run out of it so they extend you for 12 months or six months. That is really – I mean, it is worth drawing attention to that being poor behaviour, because it really – that's when you actually lose a lot of your staff, when you actually don't know how long and whether there's a potential.

20 And really support your comments about tendering and giving greater notice, more length of time, a rolling schedule of tendering. That's a professional way, I think, to go about it. A couple of small things. At recommendation 43 you talk about introducing advanced care planning as part of the 75-plus health check or a condition of it. Wouldn't oppose that; would support that. If we could think of a mechanism for raising that much earlier, that would also be helpful because there are a lot of people for whom that's an issue before 75.

30 Your recommendation about residential aged care providers doing the advanced care planning in the first couple of months, I'm not sure if you've had feedback from the aged care providers PEACH, but I suspect they might query that and whether that's the best place to do it, whether it ought to be raised during the aged care assessment process as a question in that process. When people are actually being, in effect, triaged into the system to raise that as an issue of whether they have advanced care plans and, indeed, whether they have medical powers of attorney and other things in place.

40 Having said all that, I've just got two other bits of introductory comment. I've raised this before. I just want to put it on the record that we do have a really major regret that you didn't choose aged care as one of the components. In terms of informal discussion with the Commission about that, it's clear that part of the component was a sense that aged care was on the way and it might be useful to do it in other places.

45 Unfortunately, while it's on the way, and certainly some of the kind of positive changes that you point to for other sectors have recently been

introduced for homecare packages, homecare packages are the smallest part of the aged care system. I just would say that it's far from a done deal in the rest of that system. Commonwealth Home Support Program, which is where the big individual numbers are, has already been delayed from 2018 to 2020 in terms of bringing that into the packaging system, which would then give greater consumer control.

Bringing that into residential care is not by any means a done deal. We're all waiting to see what the legislated review that was in the Living Longer Living Better legislation says that's being done by David Tune. Some of us have a sense that – well, certainly the matter will be addressed because it's required to be addressed. But the Tune review goes to the federal minister next Tuesday and will be released not later than 14 September, so we'll see.

But I just would note that I have actually heard some of the continuing doubters in our system make the point that the Productivity Commission didn't choose aged care for its inquiry and therefore obviously didn't think it was necessarily the most appropriate for greater control. Whereas we argue that in the aged care system, in particular putting the homecare package or, in current terminology, the bed licence – you wouldn't call it that but a residential care package – in the hands of the consumer does two things.

One is it enables consumer choice in a real way. You can (a) interview where you want to go and (b) you can decide to move if you're not happy. But the actually much more profound thing it does is remove government-mandated restraint of trade, basically. It says if you're a good provider with a waiting list down the street and you've not been able to offer your service out there anymore than the packages you've got, if the package is in the hands of the consumer, you can.

That means, in fact, in terms of quality that I have no doubt over time the poorer ones will disappear. In fact, we're already seeing some signs of that. Now, there are other dangers in the system, but I think if we have the kind of quality regime that I talked about, that's important. But the final point in my introductory comments is to go back to the point that you made about the need for informed choice and informed and capable consumers with capacity.

In the aged care reform process we continue to be concerned that the conditions of having well-informed consumers with capacity are not met for significant segments of the consumer or customer base. There are a whole lot of vulnerable groups for whom these changes are a challenge and,

indeed, the colleagues before me would argue some of the new regime just does not work particularly in remote Indigenous communities.

5 COTA put together a proposal for what we were calling a consumer support platform; and I'll explain what that is. I just would note that that's now been picked up, firstly, by all our colleague consumer organisations in the National Aged Care Alliance and then just now signed off the whole of the National Aged Care Alliance. I will send you that paper by the end of this week.

10 What it argues is the reason we called it a platform – and now we don't call it a platform because apparently all the IT people think that means an IT thing, so it's now called a set of integrated consumer supports. The reason for that is to say these different components, that I'll talk about, ought not exist as isolated programs, but actually be linked together and have embedded in them information sharing and evaluation. And you make a comment in this paper about evaluation needs to be built in to the design and not something you do later on, having forgotten to do base-level data, et cetera.

20 So that we learn about the customer experience in a much more systematic way. You'd have agreed data requirements common across the system and gather information about people. We argue for a mix of things like what we'll call the system navigators helping some people through. Now, sometimes the system navigators just needed to get the lie of the land. The nature of aged care is it doesn't tend to be a repeat business. You don't get to practice using it lots of times and it's a complex system for everybody.

30 I only half-jokingly made the point that we started to get real traction in aged care reform when very senior bureaucrats had to find aged care for their parents and found that it was a challenging experience. Sometimes it's just getting the lie of the land, but for other people it's actually being available at different key turning points or transition points in the system.

35 Also system wranglers, a term that our colleague, Minister Ken Wyatt, is quite fond of. System wranglers help actually link what's happening in aged care with other parts of the system. Quite frequently you're dealing with the interconnects with the health system as well. They don't always work very well. But also other things like peer education, so that's older people providing education to other older people about how the system works. It's information dissemination and engagement.

40 Peer-to-peer support, there are plenty of people out there in receipt of some form of homecare who are still active and involved in community and

would be keen to be mentors of new recipients of the system. That needs organising. Outreach, so that if, for example, you're talking about Indigenous community, that you've got people in those communities who know how you can reach out of that community into the aged care system – different context – in a safe way.

Advocacy services, they're there and they're being further developed, but need to be linked in to all those other things. And there are more supports. But it's actually about having a range of supports for people who can help them use the system, which is actually, in the end, in the system's interest as well to be used efficiently rather than have people not knowing what's happening.

I'll give you a bit of an example of that. We don't know all the detail yet, but introducing the new homecare packages system which now, of course, has a national queue and as they're available out they go – and that when it first started a lot of people were kind of a bit bemused because suddenly the supply went dry. But, of course, consumers might take a little while to work out what they're doing. In fact, there were more consumers taking longer than people had anticipated. The department, commendably, did a sample survey out to about 500, if my memory is correct, to see what was needed.

One of the things they found, of course, is that some of their communications weren't all that clear to the people. It met the bureaucratic requirements but people didn't actually understand what they had to do as a result of the letter, but also because some people were just struggling with the system as a whole. My point would be contact with the system navigators is actually going to speed up how the whole system works. We'll send you that paper in the coming days because I think, although its content is specific to aged care, some of the principles in it are probably more generally amenable. I'll stop there.

DR KING: Ian, before we start on the questions, I think there's one thing you mentioned, and that was an impression that might be there that we didn't choose aged care because we didn't think the types (indistinct) that the Commission has previously advocated are a priority. I'd just like to confirm on record that is not our view.

MR YATES: That would be great and it would be great if there was another way to do that so we can be really clear to people about that.

DR KING: I just want to clarify a couple of things also from your opening comments. With regards to the advanced care plans, you noted that it would be good if they were done earlier than the 75-plus health check. I guess we

picked the 75-plus health check as being that's – you sort of need an event to tie them to.

MR YATES: Sure.

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DR KING: Have you any thoughts on how you'd bring them in earlier? Is there an equivalent earlier event that you could tie them to or some other way that you could get them? Because we agree that it would be fantastic to bring it back and to make sure these are some things that are done earlier in people's lives.

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MR YATES: I mean, there's nothing that one has that's kind of totally comprehensive because not everybody has the 75-plus health check. But I might take that on notice and shoot in something. There are, for example, other packages of supports that people can get access. For example, these are somewhat controversial, better access to mental health services program. There are a number of those kind of contexts where it might be appropriate, but I'll take that on notice and come back to you.

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But I think underlying what you're saying is we really need to find ways to bring this more to people's attention and point out the benefits of it; we would agree.

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DR KING: I guess similarly with the residential aged care, so at the moment we've said well, within the first two months, and you suggested – well, I wasn't quite sure if you were putting your views or paraphrasing the views of the residential aged care groups. But you saw that as perhaps not being the right time or quite the right recommendations. Do you mind just expanding on that?

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MR YATES: I would just say that in discussions in a variety of forums and contexts there are different views about where it's appropriate and whose responsibility it is. Is it actually the facility's responsibility or is it the individual's and families'? I think, again, the need to encourage it is important. Everybody has to go through an aged care assessment if they want to access the system and it seems an appropriate place at least to raise it as this is – not that you have to do it as a requirement, but that this is something that there might be good (indistinct) value for doing.

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I might add in parentheses it would really be helpful if the states and territories could all get together and agree on a common approach in these and related areas because you can't do one national explanation or promotion of it because it varies. It's something that the Australian Law Reform Commission's Elder Abuse report has drawn attention to.

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5 **DR KING:** Thank you. That's a fantastic segue into the area I wanted to touch on next, which is with regards to events planning and, in a sense, issues facing older Australians in general. What are the barriers to facilitating knowledge, consumer knowledge, of the services available of things like advanced care plans? It's one of those areas where I was quite astonished at the statistics that we saw, have seen on, the lack of advanced care plans. The role of a body like COTA to help facilitate education, for want of a better word, information, communication, what are the barriers there at the moment? How can those barriers be lowered?

10 **MR YATES:** A variety of ways. One is, as I said, to actually have a consistent approach to it nationally. I mean, I do think the fact that it's different means you can't – if you're a body like COTA and you talk about it you have to say – if we put an article in a magazine you've got to either make it at a higher level than it applies in every jurisdiction or you've got to caveat it heavily.

20 Secondly, even when they exist, they tend to be somewhat more complicated than – I mean, people find them complicated. Thirdly, there's never been a great deal of promotion of them. I guess if you had an MBS item number for it for the GPs you'd probably get them all to do something about it. But then you would need something common that they all had to do. Certainly that's an area of contact.

25 These things are multifaceted and culturally engrained. We don't actually like to talk and think about ageing and end-of-life. In this country we avoid talking about the fact that we're going to die. Mostly we end up doing so, but we don't want to talk about it much - - -

30 **DR KING:** The example is where we - - -

35 **MR YATES:** Apparently there was one. All of those things combine, I think, to the fact that we're not very successful at it. I think (a) standardising the approaches so that what you're doing is clear, people understand what is clear and what the benefits would be. But secondly, I do think the medical profession as a whole has a responsibility to do some of the educating. I think some of them are ambivalent about it because, notwithstanding that we are seeing shifts in this, it's still generally the culture that the doctor knows best really. So how could you make a plan in advance?

40 Thirdly, it's an issue that even generationally people will have trouble talking about. In some families they don't, but in others it's something that you really avoid talking about. Significant amount of difficulty with them from what we have heard anecdotally is, indeed, with children of the person

who's made the plan who then don't actually want it to be followed because they want to keep mum or dad alive beyond normal (indistinct).

5 In fact, one of the comments I was going to make in regard to palliative care in your paper was that one of the things we have to do is convince – for the people who die in a hospital is convince those doctors that they should stop doing heroic medicine and let the people go home and die, which is what they're going to do within a very short period of time anyway.

10 **DR KING:** Or die in a longer time if they're allowed to go home.

MR YATES: Well, indeed, it's certainly better. So all of those things I think are part of it. This is a bit of a tangential comment, but just to make it, part of having a more informed aged care constituency is actually having
15 more public currency and discussion about aged care choices and so on. We have seen with the 27 February change in homecare package system, which is when overnight they went from being owned by providers to being owned by the consumers, for the months leading up to that and since more advertising of aged care than we've seen in the whole of the rest of my time
20 in the ageing space.

Getting that kind of competitiveness out into the public space raises potential for discussion in a – not in an ashamed or hiding behind – we only talk about that behind closed doors. Why? Because there are people out
25 there saying, 'Come to us. It will be a good thing for your life to come to us.' If we had that happening in residential care as well, because most people actually think aged care equals a nursing home, that that would significantly change the discussion.

30 Whether that flows on into advanced care or not, but I'm illustrating that we need to find ways to get the public discourse going. Another might be actually using champions, key public figures who are actually part of a campaign to talk about advanced care planning, if you actually had a product that they could promote anywhere in Australia. And getting the
35 product right is, I think, really important.

MR INNIS: In a sense there is a sequence that probably needs to be gone through.

40 **MR YATES:** Yes. We are certainly hoping that the excellent report from the Australian Law Reform Commission on Elder Abuse will encourage the Commonwealth to put a bit of legwork into trying to get the states to come up with model legislation across a range of those areas, which we managed to do in other areas of public policy that probably don't have quite as much
45 human consequence. If we can licence tradespeople on model legislation

around the country, why can't we get advanced care planning and power of attorney right?

5 **MR INNIS:** I'm raising this to get a reaction. In other areas – and I'm thinking specifically of people going into aged care facilities where they don't end up with advanced care plan – is there merit in having a standard of care or almost a default to apply in those circumstances, noting that that is, by far, a second or even third best situation so that there is at least a certainty of what support needs to be put around a person?

10 **MR YATES:** I see the logic of the argument. I guess what I would want to say is that what is really important is the person wants to do it. So it's about – if the requirement is on the proviso and there's pressure for them to do it, do you actually get the outcome that you want, which is the ownership of it by the person who's thought the issue through, rather than well, I've got to give an answer. Indeed, you would find in practice you'd find shortcuts. 'Do you want A, B or C?' 'I want you to go away. I'll take A.'

20 I think that's the issue. I think that we've actually – this, in the end, ought to be about people understanding that this is them taking power over what's going to happen and then owing it and thinking and working that through, rather than making it, as it might be seen, as something else that the provider has to tick and isn't getting paid for. Like if you paid them for it.

25 **MR INNIS:** I understand the power of money in these systems. It leads me to another thing you've raised that I particularly want to focus around, the end-of-life set of recommendations. We are conscious across all of these areas that there have been many failures of government stewardship. In end-of-life care we are recommending a very significant increase in services, service availability and emphasis. I guess I'm interested in your views about what stewardship needs to be put around that and what consumer protections might be appropriate for that in taking our recommendations forward.

35 **MR YATES:** I thought that what you wrote in the draft report was really good in it points out how come we have a high quality palliative care service in this country but it only reaches a certain number of people? I mean, one of the jokes in our sector, sick jokes in our sector, is if you want to die well, get cancer, because with cancer you generally get good palliative care. Yet lots of people get to die not well and against their wishes.

40 Let me take one segment of that. In terms of the residential aged care system, you correctly point out that it's very patchy in how well palliative care happens and that one of the real tragedies are the number of people

5 who close to death are shoved in an ambulance and sent to a hospital. Even if the residential care facility mightn't have been their strongest preference, I'm sure it would have been their preference if they'd been living there for a while than being chuffed off to lights and blinking things and tubes and whatever.

10 One of our views would be that palliative care should be funded as palliative care in whatever setting it happens. It shouldn't be bundled in to what a provider needs to do within a bundle of services. It actually ought to be funded as palliative care in any setting. Yes, there has to be biting the bullet too, that that money is worth spending in any context. I suspect – and I think you made this point – that good palliative care and a changed culture of that last end-of-life, what you do, medical intervention, is not only a better outcome, it's actually going to be cheaper, because we spend a lot of money as a country on the very last stages of people's lives.

20 If nothing else, we could talk to our colleagues in finance about the cost savings of doing it properly. I mean, it is clear what people's preferences are. The reasons that doesn't happen are not all system failure. They are also things to do with families and so on. But, again, the decision by say a spouse to have the partner die at home, which may be a challenge to them, is, nevertheless, more likely to be acceptable if there's a good support system of palliative care around.

25 I think it is about talking about it as part of the phases of life and the end-of-life phase and, really, as an entitlement that people have, like they have an entitlement to be admitted and treated in emergency if they have an accident or a heart attack.

30 **MR INNIS:** I am conscious of time. Can I ask one more question?

DR KING: Sure.

35 **MR INNIS:** For a system really to work you've got to have someone leading. We've had a number of participants provide evidence that there is confusion between state and federal governments about who's responsible for palliative care. Do we leave that as what seems to be an awkward shared responsibility or should someone, one level of government, take responsibility for this working with the others? If so, who?

40 **MR YATES:** Basic consumer and good public policy response says it should be very clear who's responsible. The delivery is obviously going to happen at a jurisdictional level, at a state or territory level. I don't know that a snappy answer from me about who ought to be responsible, but I've
45 no question it needs to be clear one or other level is responsible for ensuring

the funding is there and, if it's there, that it's used appropriately. We wouldn't have any trouble, from where we sit, with that being a federal responsibility. But there might be other arguments.

5 **MR INNIS:** I understand.

MR YATES: I suspect in terms of really if you were going to make this a significant push rather than this kind of incremental chipping away at a major problem, and given the fact that we are talking about residential aged
10 care as a significant component of it, that the federal level is the area in which you would get more traction if they were prepared to bite the bullet and do it.

15 Then in the process of doing that, they can sort out the financial trade-offs in terms of what's there now. I understand that's complex and murky. Sitting on the private health ministerial advisory committee and looking at private health insurance, the complexities of trade-offs between Commonwealth and state shifts.

20 **MR INNIS:** If not the murkiness.

MR YATES: Well, and the financial transfers, yes. It's an area that at some point we're going to need some real leadership to grapple with because we're not getting good health outcomes out of it.

25 **DR KING:** Thank you very much, Ian.

MR YATES: Thank you.

30 **DR KING:** I'll just take a break for afternoon tea. If we can just make it 15 minutes until 3.30. Thank you.

35 **ADJOURNED** [3.16 pm]

RESUMED [3.32 pm]

40 **DR KING:** Would you be able to state your name and organisation for the transcript and then if you'd like to make any opening remarks.

MS BARTEL: Great, thank you for having us. My name Rebecca Bartel.
45 I come to you with a new hat. I've been previously in front of you guys as the executive director of the Australian Centre for Health Research. Today

though I'm here as the – I have a new role as the executive lead for Deakin University's new Institute for Healthcare Transformation. I'd also like to introduce my colleague.

5 **MR MARTIN:** My name is Peter Martin. I'm at Deakin University's Faculty of Health as a – in a new role as professor of clinical communication and end-of-life care. Thank you.

10 **MS BARTEL:** Peter is also a palliative care physician, which is very useful. I really just wanted to open by telling you a little bit about the new institute and some of the work that Deakin University are bravely going in to. The new institute for healthcare transformation has initially been set up for less than a fortnight to accelerate the translation of existing evidence and emerging evidence into practical solutions to improve health outcomes
15 and end-of-life care.

It's telling that end-of-life care is important to Deakin University. They believe it's a public health and a health system problem, with the main challenges being the need for better information on quality end-of-life care but also better communication in end-of-life care. Deakin actually believe
20 this is so important, such an important area, that they're really prepared to invest in this over the next significant period.

This year alone two professorial positions have started. They've
25 opened a new centre, which Peter is the director of, and a new institute, which I'm the executive lead on. There's potentially two more professorial roles to come and this will be an important future space.

I think when it comes to the report, I really need to congratulate
30 everyone involved. I think you've done a fantastic job on the end-of-life care section. There were three things that we thought through a slightly new gaze that we wanted to raise with you specifically today, those three things being: shared decision-making, being absolutely critical for informed choice; how important conversations are as a part of advanced
35 care planning and that advanced care planning is actually a process, not just a document; and also about funding conversations around end-of-life and end-of-life care. They're the three kind of critical - - -

40 **MR MARTIN:** Public awareness.

MS BARTEL: Yes, public awareness as part of the advanced care
45 planning conversations. I would like to just get Peter initially to start talking about shared decision-making and the importance of shared decision-making within advanced care planning.

MR MARTIN: Thanks, Rebecca. As I say, I've been a palliative physician/clinician for the last 25 years. During that time – and a clinician for 30 years. It is, in fact, my 30-year anniversary. But I guess over 25 years of that time I've been involved in clinical communication education.

5 As a gradual awareness, the centre has been created essentially because we see that the missing part on health is the conversations – in fact, whether you read the literature or whether, as we did at Barwon Health, engaged our own consumers in end-of-life care, the thing they said that was most evident to all of them as consumers was the complete avoidance of

10 appropriate complex conversations around end-of-life.

I guess the bit I wanted to add to the advanced care planning is that while it's a critical component, it's completely predicated on two things. One is all the conversations that precede it having to have appropriate

15 conversations. The other assumption is that the clinicians that are having them have the requisite skills to have the right conversations. If you don't have those two things, the end point actually doesn't achieve the outcomes you want. I think that's the bit of the missing piece of the puzzle, as far as we're concerned, that there's an assumption, despite 40 years' evidence to

20 the contrary, that the clinicians have those skills.

There is a tonne of evidence to suggest we don't have those skills in a uniformed way. We know what the scales are and we know how to teach them, but it hasn't made it into practice. My other hat is as chair of the

25 policy and practice group for the International Association of Communication in Healthcare. They also recognise that we know what and how but we haven't got it in clinical health organisations. That means there's a whole pile of downstream outcomes we're not achieving.

For me, why did I move into this space? Because I was fed up picking up the pieces downstream for patients and families that should have been fixed upstream. So I decided I needed to do something about it. Also, in Australia if you do want to work in this space there's very, very limited opportunities to do anything about it and certainly very limited investment

30 in doing it. There's a few pockets, but it's tiny. I think I'll just stop there. Our centre is really trying to drive person-centred care. Obviously my particular interest is clinical communication and getting those clinicians to acquire those skills.

40 But sadly, you're talking about behaviour change and behaviour change does not happen with documents and PowerPoints. The methodology to change clinician behaviour is (indistinct) but we do know how to do it.

DR KING: Can I follow up on that because – there's a number of ways

45 that we could go in terms of improving clinician skills at having those

5 conversations. So I'd like to start on the clinician side then. I'd like to come back, Rebecca, to something that you had on the Medicare side. Starting off on the skill side, it can be introduced into curriculum back in medical school. That's fine, as long as you're happy to take the next 40 years for it to permeate through.

10 There's a range of points, I guess, of interaction with the medical system that conversations could be introduced at. I guess actually I've put those slightly in the wrong order. I'd like to understand better where you see the points of context. Is it GPs? Is it – the GP refers off to a specialised palliative care nurse, for example. And you mentioned conversations leading up to an advanced care plan. Is it that there is – how are they instigated as – because there has to be a conversation to start the conversation, if I can put it that way.

15 **MR MARTIN:** Sure.

20 **DR KING:** How do you see that working? Again, who are the medical professions? Finally, coming back to the training, you can introduce it into the courses, but that's a very slow way. How do you get the information out there? That may be different if you say well, it should be a specialist palliative nurse, because that then can be additional training. If it's through GPs, how do GPs get the training? So all of those questions I'd like to put before you.

25 **MR MARTIN:** I'll try and remember them all. The first thing I just wanted to go back, while we've made a pretty good effort of getting into universities, the evidence is absolutely clear that as soon as they go out they will tail off and role model the people they're watching. So the issue is even if you get them to a very high standard, whether it be nursing, physiotherapy, medicine, if you get them to a high standard when they leave university, the evidence is absolutely clear that it tails off because of the (indistinct).

35 **MR INNIS:** Sorry to jump in on that to make your responding to Steven's questions harder, does that mean we need to focus much more about the organisations where these – the settings in which these things take place, so the hospital, the GP clinic, the aged care facility.

40 **MR MARTIN:** The simple answer is yes. They're interdependent. So if you don't give them a good baseline, then you're starting off against it. If you don't reinforce – and it's Helical learning. So as you get into the context of becoming a GP, then you know what the new challenges are. Then you can add those core process skills. The good news is those skills are translated across a lot of different areas. So the same skills of

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remembering questions and responding to cues is spotted across multiple areas and it's transferred where it's in a team environment as a GP, it's a practice nurse, community nurse, and you can use them in multiple areas where you're talking about shared decision-making, motivational interviewing, lifestyle modification or end-of-life conversations.

However, you're right, the bad news is you can't just set and forget. You've got to do it and then you've got to work out – the evidence is roughly probably about every three to five years that you will actually get Helical learning, but otherwise you'll get tail off. That's in crude terms. I think that's the first thing. I'm just saying that's the basis of it, that it's not about where we get them and it's about embedding them with all those other points.

I think the other part is that yes, there's probably some critical points where you get the maximum bang for your buck, if you will, in the system. But the reality is patients tend to ask the questions of the people that they trust. I think the more you can embed it generally, the more likely you are for somebody to give a cue. If you respond to that, it's at that moment for that person at that time. Having said that, if the oncologist hasn't had a prognostic discussion or avoids it, if the surgeon doesn't put up all the options or if somebody doesn't respond, we know from the evidence is that if people are given the opportunity and they don't respond they don't do it – maybe do it once or twice but then they stop giving the opportunities.

Yes, I think it needs to be multifaceted, targeted, but you've got to start somewhere. I would think that primary care is one of the important settings to do it. Then I think it's about a model – one of the models we've looked at is identifying high-risk groups, basically high risk of one-year mortality, and then integrating both the process and the system. That's what usually happens, but we've integrated (indistinct) skills to make the clinicians confident to have the tough conversations.

Because when I train them actually most of them want to, but they avoid them because they don't have the confidence – because they don't have the competence to have the tough conversations. Once you give them the kind of skills, my view is that most of them are very willing to have that and that patients are – they tell us they want to have them, but obviously in a very supportive individualised manner.

DR KING: Is that lack of confidence in their own skills right the way from the specialist oncologist right the way through the system down to the GP?

MR MARTIN: As an educator, I say from the first-year medical students and first-year nurses right up to the head of department of surgery,

oncology. Whilst they all have different learning points, it's right across the board. Even though there's a normative distribution of ability, the evidence shows that you shift everybody to the right. In fact, if anything, the people who struggle a bit more tend to get more benefit.

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DR KING: You mentioned the oncologist, for example, having the conversation. But my reaction is well, from what you've said before about the importance of conversations leading up to an advanced care process it's sort of too late by that stage. You would want the advanced care – the thinking, the discussions about advanced care planning to occur much earlier on. Well, (1) is that right and (2) how would you see that then going? From the clinical perspective, where does that occur?

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MR MARTIN: I'd agree that elective conversations are better than crisis-driven conversations, absolutely. However, I think there are – it's like just-in-time teaching. I think there are just-in-time conversations when people have new points in their illness where it focuses their mind on, 'I probably do need to think about this.' The value of that, it adds context. So I agree you don't want that in the very last weeks or a few months of life. But I think there are times when the nature of their illness changes – disease recurrence, when its treatment has been maximised. There are still one, two, three years down the track.

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I think it also depends on where those points occur. Sometimes that will be in the specialist rooms, sometimes with a community palliative care nurse or a community nurse and sometimes with the GP. But I think you're right. Crisis-driven decisions are difficult. It's being proactive but at timely points where there's a real willingness to consider the options.

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DR KING: I'm just wondering if there's a bit of a juxtaposition there, that timely points – so you've got a diagnosis of adult onset diabetes, therefore your life expectancy is reduced, we should talk about advanced care plan. I'm just wondering if that would be the right point or that could have an opposite effect where a patient sort of says, 'Oh God, I'm going to die,' and you're telling me – I'm just wondering about that messaging, because I guess I've been thinking about it from almost the opposite. You'll see that in our recommendations where we sort of say well, you almost want to take it – this is just part of normal – everyone dies, so we do the 75-plus health check, which may be too late.

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But we've sort of tried to take an alternative approach of saying actually, it's nothing to do with what particular disease you have now.

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MR MARTIN: It's not about you, it's about a point in time in your life and everyone goes through it. So we're trying to make it easier by doing

that part. I agree it should be ubiquitous and I think it's an evolving dynamic thing that you start the conversation. But I do think if you don't evolve it in the context of how the health is changing you will end up with a smorgasbord of document that actually does not always reflect their
5 changing values and goals and preference in the context of the current health situation.

MS BARTEL: And potentially risking a checkbox kind of approach.

10 **DR KING:** I see where you're coming from. It's actually that - - -

MR MARTIN: It might start off generic and then as it changes it'd get more and more specific to the context of their current situation.

15 **DR KING:** I understand now.

MR MARTIN: I'm not sure if I've forgotten any of your other questions. I hope that's answered some of them.

20 **DR KING:** That's actually – I think you've covered off on really what I was after. Rebecca, can I come back to the payment side? In your ACHR paper you referred to that (indistinct) would be desirable to have a Medicare item number for advanced care planning.

25 **MS BARTEL:** For conversations.

DR KING: I guess two things. How would see that – would you see that as being mainly a GP thing or would it be broader than that? Secondly, particularly the GP level, there's already flexibility in appointment lengths
30 and charging. I wonder why do you need a separate item number for advanced care planning.

MS BARTEL: I've grappled with this quite a bit because there's no doubt GPs are doing this and pulling together a range of different item numbers
35 and consultation lengths to have these conversations, and particularly the good ones who really feel that they have identified a key moment where it's important to have those conversations. I'm absolutely sure – and that should not change in those circumstances.

40 I guess my biggest concern is when I've spent quite a bit of time talking with general practitioners about end-of-life care. It's amazing to me how disinterested in having these discussions they are. They feel undertrained. They don't feel confident. They avoid it. They seem to avoid it at all costs. They're very happy to refer patients to a specialist, kind of hoping that that
45 specialist will have that conversation.

5 I guess part of my drive for having some kind of item number or clear remuneration process is to draw attention to the importance of end-of-life care conversations as part of caring for somebody as they age or as they get terminally ill or have a chronic condition; that it's part of the continuum of life. I guess it's about being able to as much re-establish the importance of that advanced care planning process within the life of a general practitioner.

10 **DR KING:** Create a focus point rather than - - -

MS BARTEL: Correct. I guess part of that is repackaging it and re-pitching it and reselling it as part of a proper series of reforms or suite of reforms that can really – because we've got to start impacting the system on numerous levels to create change. I guess it's a way of bringing focus and attention.

20 **MR INNIS:** Can I ask a question about this? As in many parts of public policy, you can sort of see if we could just get here it would be so much better. What you describe really resonates in terms of the best possible approach to communicating in something that's a very real part of human existence. What's the best next thing – I'm now stepping back into well, I'm starting here. What's the next best thing the Commission could recommend to government to at least get the ball rolling?

25 **MS BARTEL:** I'd say two things. Can I jump in? Do you mind if I jump in there?

MR MARTIN: Please.

30 **MS BARTEL:** I think focusing on shared decision-making is absolutely critical to build those skills and train our medical workforce. I love the idea of end-of-life care nurses. I think that's a fantastic idea. But having people that have the competence and capacity to start the ball rolling to create the skill base to be able to have those conversations. Then on the other side, we need a national conversation about death and dying. We need to make it okay for people to talk about it, think about it.

40 At ACHR we undertook the largest survey about attitudes to end-of-life care. I've sent you this as a confidential document, again last night, too. But the numbers aren't quite validated and we're in the process of validating a few, so I just didn't want it in the public realm. But no matter which way we split the data, we had 3000 responses within a three-week period. We were completely overwhelmed. Age groups from 16 to 94. No matter which way we sliced the data – religion, nationality, place of birth, life

status, disease status – 89 per cent of Australians want to talk about death and dying more than they currently do. And that was across the board.

5 They just didn't feel like they had the capacity or the skills to be able to do it. Out of that 89 per cent, about 61 per cent believed that they had had conversations with their loved ones about death and dying. But when you actually drill down further on that they've maybe selected a decision-maker who could speak for them if they were terminally ill or unable to speak. They talked about whether they wanted to be buried or cremated, 10 but that was it. They hadn't told this person what to say, what they wanted, nothing like that, but that was the extent of their conversation.

15 Partly the problem with plans and this whole concept that we should be having conversations about death and dying is people don't know what to talk about. They don't really know what's involved. They're so far removed from that experience. Unless they've had a loved one die within the last five years, they really don't understand what their options are.

20 The other thing the survey showed is that people want to have this conversation with their families before they have it with a medical practitioner. If we can encourage that kind of family conversation, an internal – it doesn't have to necessarily related, but encourage those conversations that starts to get the ball rolling to then go and seek further conversations with a medical professional.

25 **DR KING:** Apologies because I cannot remember the name of the organisation. Sean might be able to remember from earlier on - - -

MS BARTEL: The current one, the Institute for Healthcare - - -

30 **DR KING:** Sorry, no, your one I can remember. This is one we talked to earlier in the week who had run seminars, for example, 10 things to know before you go.

35 **MS BARTEL:** Groundswell.

DR KING: Thank you, yes. I'm not sure how familiar you are with the work, but I suspect very familiar, given that you're able to remember - - -

40 **MS BARTEL:** Yes.

DR KING: How do you think about that sort of approach? Is that something that would help - - -

45 **MS BARTEL:** I've been to some of their seminars and the seminars are

terrific. They're very informative. I'm trying to be very careful how I say this. But my personal opinion is that's a great approach for some people. It's certainly not the right approach to others. They talk about – as part of the course they also talk about like green ways to die and mushroom soups and a range of different things. They make death and dying interesting and many things to think about.

DR KING: They didn't talk about those.

MS BARTEL: It certainly wouldn't be for everybody.

DR KING: If you were thinking about it, it's for one cohort or grouping.

MS BARTEL: Correct, and an important one.

DR KING: The Australian system is not - - -

MS BARTEL: Yes, that's right. We launched a program in my previous organisation and I've moved this across to Deakin to build on it called Death over Dinner. I don't know if you've heard about it.

DR KING: Yes.

MS BARTEL: It's a program that basically started in the States and now half a million people go through. We've had 49,000 go through in the last eight months in Australia. We really capitalised on media. We had Ben Lee the singer championing it. We had The Project championing it. We really tried to push it through popularity and some kind of key Australian figures. That's been incredibly successful just as a tool to start conversation and get people in their homes talking about issues around death and dying. That's been helpful too.

But Palliative Care Australia have some great tools. We need all of those tools. We can't just have - - -

MR MARTIN: A one size fits all.

MS BARTEL: That's right. It's not going to be a one size fits all approach.

MR MARTIN: Do you mind if I respond to your question of the one thing to get going. I've just come from an international visit where they've been doing this for 10 years. I think one of the things is actually have an exemplar where you can see the downstream outcomes when you do embed shared decision-making at an evidence based pool of organisation level. We haven't got many of those exemplars here. Actually to see the benefits

to patients, the families and, frankly, the health system, it's only when you put it in the real world. At the minute we're not putting it in the real world.

5 I think some exemplars where you could actually see if you put it at a whole of organisation, whole of community level, where you've got some integrated systems and see the downstream effects would be a really interesting space because it also speaks to connections in ways that maybe some other initiatives don't. I think that's one of the things that's considered what might incentivise people to do that and how would you do that.
10

MR INNIS: In our system, just taking this a bit further, I hope, you might create that exemplar around a primary health network or in concert with the local hospital district – the names change a bit across the country – but it's that sort of concept.
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MR MARTIN: It's integrated because they are interdependent. But I think whether people have done it, I think the outcomes speak to the clinicians but also give us some real tangible benefits to make it worth the while to make the decision-makers think - - -
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MS BARTEL: Barwon Health have done a great job of that.

MR MARTIN: They've done some, but when you see it's embedded at a regional level for whole of community for 10 years, then it's gets really interesting.
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MR INNIS: We'll test this notion with our colleague who chairs a PHN.

MR MARTIN: I look forward to it. That's one of the things I think would be really worth considering, as well as these kind of broader initiatives.
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DR KING: I've just got one more, if I could. It is on the navigation side for the families and the patients at end-of-life. We've heard big differences between states, big differences over time in the same state just on the ability to navigate end-of-life services. It's been put to us that perhaps there could be a role for a navigator in that space.
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MS BARTEL: I'm really pleased, I had a whole section on this all chopped out. We sort of initially talked about it in the first meeting last year. The clinicians at the table at this particular meeting would really try to dissuade you from that approach because it was a – nurse resources were so scarce and that it would leave a lot of services stuck. I don't agree with that view. I think having someone to help navigate that system is incredibly important.
40
45 There are some great international examples of transition care projects

where you actually get coordinators and almost sort of coaches they call themselves, but they're mostly allied health professionals, that help you navigate sort of from an acute care environment into a community environment and then support you within that environment.

5

There's some really interesting models sort of starting to germinate that are very similar to maternal health groups, you know, when you leave hospital with a baby and you kind of get positioned in a group and you have a carer that looks after a particular group for a period of time. Some innovative sort of projects that could be quite cost-effective. I could see that's also where insurers could also feel like they could participate more in this space as well.

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DR KING: I'm going to say it's not quite like that, it's quite different to that. But the hospice@HOME that was in Tasmania, how close do you think that sort of model – well, is that the sort of model you think is a good one or is that one of many?

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MS BARTEL: I'm such a big believer in the hospice@HOME project. I think it's fantastic. I think obviously there were some critical funding concerns that came out of that, being that it was way too expensive ultimately to be able to implement. While there were cost savings in certain jurisdictions, there were certainly much more bigger expenses in others. So that's something that has to be ratified and the federated health system will make that complex, there's absolutely no doubt about that.

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Another good hospice is the home kind of project though that runs out of Cabrini, which I think you guys are already familiar with, in Victoria and they – you're admitted as a – Cabrini is a private hospital. You're admitted into that service, but they effectively look after you at home. That sort of covers off some other cost issues that might be around. But it has some funding challenges.

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Private health insurers don't recognise any other model currently, except for that one that's quite unique. That was set up as a board relationship through my last organisation, a board conversation. So it would be great to model that and expand something like that because it is cost-effective and it doesn't seem to put additional burden on any particular jurisdiction. But, yes, look, I do think there are great community benefits to that model of the hospice in the home in Tasmania.

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DR KING: Thank you very much.

MS BARTEL: Thank you.

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DR KING: Next participant is the Australian Association of Social Workers. So would you pop down the front, thank you?

MR INNIS: Peter, thank you very much.

5 **DR KING:** I'm sorry; we haven't had a chance to introduce ourselves, Stephen King, Sean Innis.

MS SMITH: I'm Cindy Smith.

10 **MS SCARFE:** I'm Angela Scarfe.

DR KING: I just noticed we had down Sebastian here, I assume neither of you were Sebastian.

15 **MS SCARFE:** No, that's right. So Cindy's the CEO and I'm the professional officer.

DR KING: Thank you.

20 **MS SMITH:** Should just qualify that, acting CEO.

MS SCARFE: I beg your pardon.

25 **DR KING:** Now, before we start your presentation, would you be able to - the mics are purely for the transcript rather than amplification, would you be able to state your names and your organisation formally for the transcript, and then if you'd like to make some opening comments.

30 **MS SMITH:** Thank you. So my name is Cindy Smith, for the Australian Association of Social Workers.

MS SCARFE: And I'm Angela Scarfe for the Australian Association of Social Workers.

35 **MS SMITH:** So thank you, and first we'd like to thank you for the opportunity to present our evidence to you, and we know it's a long day for you, so equally, thank you. So the Australian Association of Social Workers is a professional body of social workers representing more than

40 10,000 social workers – I think we're about close to 10,500 throughout Australia. We're a self-regulated profession, so members are not required to join us, but we're very happy to say that 10,500 have joined us.

45 We set the benchmark for professional education and practising social work and we advocate on matters of human rights, social inclusion and

discrimination. Professional social workers consider the relationship between the biological, psychological and social factors and how they impact on the client and family's health, wellbeing and their development.

5 Social workers practice in numerous fields, including mental health, disability, family violence, health, family and community services and housing, just to name a few - policy, Department of Premier and Cabinet, we're all over the place, but we do work directly with the services that are mentioned in the Productivity Commission review, including working with
10 diverse communities.

Although social workers operate across the whole of society, our commitment to human rights requires that we pay particular attention to the needs of those most vulnerable. Social workers have a longstanding
15 commitment to improve the quality, effectiveness and equity and accountability of human services. Social workers have the knowledge and skills needed to participate, if not lead, the extra tasks that the stewardship role demands from the human services sector and government.

20 The concept of stewardship as the role of government, as described in the report, stands in contrast to the way that previous governments have conducted their role. To fulfil this role adequately we require a profound cultural change in the way that governments understand the components of effective human services and relate to the community services
25 organisations.

While we welcome any opportunity for improvements in the lives of vulnerable people, we approach the proposed reforms with caution. We have observed decades of underfunding for the sector, in recent years the
30 language of the marketplace has been used to justify decreases in resources which, from our members' experience, compromised the quality of services they feel that they can deliver. We recall multiple incidences where structural reforms have been accompanied by a decrease in funding, rather than an increase, especially at the transition periods, impacting again on
35 service users.

In conclusion, given social workers' direct experience with past policy decisions, we look forward to working with the commission and the government to ensure that this report does not become a vehicle for
40 perpetuating existing problems.

DR KING: Thank you.

MR INNIS: Thank you.
45

DR KING: Can I just start off, we're really asking you to expand on the issues of stewardship and culture that you've raised, and it is one of the things that is obviously a concern to us so we can put forward stewardship recommendations, but if the culture of the parties implementing those recommendations aren't appropriate, then we may not get the outcomes that we'll be hoping for.

It's been put to us by others that the risk-averse culture of Government is going to lead to a micromanagement, a lack of ability to allow professionals to act professionally, if I can put it that way. So as a simple example, we've suggested in family and community services, longer contract lengths to allow for more nuanced, more relational approaches to be used. And it's been suggested, well, that's fine, except Government isn't up to it, they don't have the culture, they don't have the right approach.

You mentioned Government culture, is that what you were getting at or is it something different? And where do you see that feeding into the sort of recommendations that we're making?

MS SMITH: I think it is Government culture. So I think it's important to also – just to say to you, so my experience is I've worked as a team leader in out-of-home care, so working very closely with ministerial briefings, critical incidents, 24 hour notice if something goes wrong. So very much as an area of service delivery it's quite micromanaged, and arguably, quite rightly so in some areas.

I've also worked as a branch manager and a general manager in community health for 12 years, so worked very much at the coal face with the mental health reforms in Victoria. I've worked across service provision when Partners in Recovery came in, and when I read your report or read this report, I was saying to Angela, everywhere I just went, yes, yes, yes, fantastic, bring it on, this is fantastic.

I do come very much from a management model of looking for accountability, looking for transparency, and I do believe that within the report it talks about competition, and I think there's an element – I think there is a place for that, certainly it's my belief, because I have seen organisations that have been block funded for a long time, and we know what happens when they've tried to go into NDIS, or with the mental health reform, a lot of organisations have really struggled within that environment.

So most of the things or just about all of the things in there I was very, very happy to read. Coming from someone who has had to write a tender in one month and bring 25 services together to sign up to a consortium because it was going to present very well – and Services Connect is a good

example of that – Partners in Recovery had duplication of service. So most of the examples that you have in the – or the points now I could have a real life example for how that's worked.

5 But where we're a little bit cautious is, it just depends on, we have seen the Government, the culture of Government, whether it's out-of-home care, because they're quite risk averse, especially in social work it's risk averse, if something happens in out-of-home care or something like that, it's usually the social worker that is named at the front of the paper. So we're
10 quite risk averse of that as well. But it's the culture of Government; it's also the culture of those organisations, those big organisations that have become solely reliant on those Government contracts.

15 I've worked with big religious organisations where I have never worked in such a punitive environment in my life. But because they are equally risk averse, and no one wants to be shamed and named in any of those reports. So the whole culture going down is quite risk averse. How that's changed, obviously it's a huge job, but it does need changing, and I certainly think that the report is heading in absolutely the right direction.
20 Just that it's a cautionary note from us.

MR INNIS: Thank you. May I ask a question about how do we help change the environment you've just talked about? And one of the things we hope will make a difference is if we can get people focused on the
25 outcomes for individuals and broaden that out so we're always looking at, well, how are we delivering for people, those individual issues that do emerge and we need to try and avoid them if possible and when they do emerge, fix them. But is that a potential benefit going down that path that might help?

30 **MS SMITH:** I think what comes to mind from someone – so I've been on a board for five or six years with an organisation and a graduate of the Australian Institute of Company Directors – watching what's happened within the – so the health sector with the – and now we've seen Stephen
35 Duckett's report around revised accreditation and looking at that.

But certainly for me, governance of the board members and actually direct accountability, I think that there's a – if I think about community health and I think about organisations where I've worked where we've had
40 five CEOs in seven years, and we've built a GP super clinic in amongst it, and the missing link there it seems to me is the accountability of board members through, because they have a very – the membership often of those organisations are not very evolved and they're not very engaged with the service so it really is an area that very much lacks stewardship. Certainly a
45 lot of community health do it well, but certainly there's a struggle with those

board areas and the governance, which was picked up by Stephen Duckett in the reports when he went through and checked actually what people had identified as their core competencies to what was actually revealed as core competencies.

5

That has been seen as being a real issue in how those organisations are governed from the head down. Secondly is the accreditation cycle or the credentialing cycle. Most organisations, you know how to get through those processes. One of the things that Stephen Duckett again has – he has recommended is that it's not a three year accreditation process, that actually you have expert teams that come in at different periods of time, whether it's around clinical care or whether it's around governance or whether – so organisations are on their toes a little bit about – and then boards are held accountable, senior managers are held – and I say this as a board member and as a senior executive.

15

But I think there's – in a lot of organisations it's just completely missing or it's easy to be moved – it's easy to – what's my words that I want to say here? It's easy for it to be passed through the accreditation process, really without the substance there.

20

MS SCARFE: You were also asking about outcomes, and I might, if you don't mind, just reflect a bit also on – my last job was with the peak body of the child and family welfare organisations in Victoria, and they worked on outcomes a lot, and I know in your report you cite all the examples. And they found that it was very difficult to make the jump between outcomes for an individual that you're working with to systemic outcomes.

25

You talk about the role of stewardship is setting outcomes for the sector, and so you would be aware that there's a beautiful tool that's been developed in America, services buy it for an awful lot of money, it's called the Outcomes Star, and it's a really easy visual way for a service user to plot how they're going in their life against a whole lot of dimensions. It's not translatable, it's lots of scalable up to system level outcomes, and lots of people in the sector tried really hard to do that and then the Victorian Government ended up saying that that was not possible.

30

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In the meantime what happened in Victoria was that the legislation that changed Child and Family Services in 2005, the Children Youth and Families Act was introduced, which stated clearly that the rights of the child, the best interests of the child were the decision – the basis for all the decision making, and that was what you would – so that in a way gave an outcome. That was due to our status as signatories to the United Nations Convention on the Rights of the Child, and that then helped a lot of services like the ones that we all worked in organise its work accordingly.

40

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5 In my talking to social workers in those organisations, they noticed a huge difference in the interface between state-funded services and federal-funded service, because having that outcome, the best interests of the child, enabled a whole lot of other things to fall into place in your work with a family in a way that it didn't when you were running a Federal Government-funded service.

10 Again in your report you talk about different service levels and how they do or they don't match at the level of an individual family. So the fact that Victoria mandated - in the Child Safety Act 2006 it supports the Children Youth and Family Act and says that everything else that a service does has to back up the interests of the child in the same way as the Children Youth and Family Act.

15 So things like family gambling services, if they were state-funded, you could call on this outcomes framework and say, well, your gambling is compromising the interests of your child. But if you were operating it with Federal funding money you didn't have the same leverage to say. So you're right, a clear statement of outcomes on the part of Government is really, really important for the quality of what happens for that child.

20 But in Victoria we were helped with our signatory to the United Nations and that definition of the best interests of the child. But where you're talking about the whole of the human services sector, it's much harder to come up with the same succinct statement that everyone will buy into.

MR INNIS: If this is an unfair question, please just tell me.

30 **MS SCARFE:** We'll tell you.

MR INNIS: So we're always wrestling with the responsibilities at the Commonwealth or the Federal level and the State level. You've got to bring it together somehow, and in terms of defining outcomes, do you think we should start with State and the Commonwealth jumping on board, or do you think the Federal Government should – you know, around the individual model. Is there a starting point or do we just need to sort of take the best we can and evolve it?

40 **MS SCARFE:** Because there's also local government.

MS SMITH: I was going to say, municipal health plans come to mind.

45 **MR INNIS:** We're well aware - - -

MS SMITH: For me, I mean, yes, it starts with that municipal health plan and then it's a State.

MR INNIS: Okay.

5

MS SMITH: I mean, it's interesting for that municipal health plan, I've long – again, a lot of my experience around in the City of Hume, working in a very vulnerable community in Melbourne, but I always lament when every time that we worked with three community health centres that represented very vulnerable communities, growth areas, huge growth areas, linked to two hospitals, and I was in the area for 12 years, so what I watched very closely was every time we lost a CEO, how we would go back.

10

So when the northern hospital CEO would – they would have a change in CEO, our partnership arrangements with them, I'm working within a preventative health care space, you knew it was going to go back 12 months. And why those CEOs, if the State Government is funding all of them, which largely there's a lot of funding that go – link their KPIs, link the social indicators, link the impacts that you want, because it was all very much dependent on the personality in the roles.

15

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So you do all that work at the local level, coming up with – that organisation I mentioned before, or the conversation with Services Connect, we had 25 services that were prepared to come together very quickly to work with the new initiative. So at the local level with a lot of the services there's lots of goodwill, but you get a key position in a local area like that change, and you're 12 months behind. And you know in the City of Hume, you just can't afford that, you just cannot afford that. But that's what happened with (indistinct), and if I looked at one of my organisations, five CEOs in seven years.

25

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We have a very vulnerable community, high obesity rates, high unemployment rates, huge disconnections, and what do we do? We build another prison and another Court there. That's what we do. So we've got to link the outcomes that we want through those services, I think, and put the outcomes where the – or the measures where the measures need to be, where the real accountability is.

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MR INNIS: So just to confirm, you're really reinforcing the importance of locational planning and locational connection and design.

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MS SMITH: Yes.

MR INNIS: Thank you.

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DR KING: So just one final issue for me and a slightly different tack. I'm not sure if you heard the conversation that we had just at the end of the last session on end-of-life, and I note your submission talks about social workers and potential for an enhanced role in end-of-life services. Can you
5 expand on that a little bit? And if you didn't hear the previous conversation, I'll just summarise it very quickly.

We were talking about perhaps the potential for a navigator for assistance to work through the system. Is that one of the potential roles for
10 a specialist social worker?

MS SMITH: Absolutely. So we already do that role in – so social work is a four year degree, and within that we do case management, advocacy referrals, direct counselling – unlike some of the others, we are actually
15 qualified direct counsellors, so we have a whole range of that. If your wheels, you know, the hub and spoke sort of approach, where social workers come in, work with the family or work with an individual, work with the community in some areas where there's particular vulnerabilities, and work across referral services to PHNs to hospitals. So very much they
20 can be central within that.

Again, I will pick up a comment of the previous presenters around there needing to be – we have 2000 accredited mental health social workers that can bulk bill through Medicare, they're more flexible in their service
25 design, they're more flexible in the areas that they work, because often they're private practice, but there would need to be a Medicare specific number for them.

DR KING: But you could do that same sort of model but in end-of-life
30 care.

MS SMITH: Absolutely.

DR KING: Thank you. That's all from me.
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MR INNIS: I didn't have any more questions; I just want to make sure that you've covered off all the issues that you would like to raise today.

MS SMITH: Yes.
40

MR INNIS: Thank you.

DR KING: Thank you very much. Apologies for being at the end of the
45 day.

MS SMITH: No, thank you for a great report.

MR INNIS: Thank you.

5 **DR KING:** Ladies and gentlemen, that concludes today's scheduled
proceedings. For the record, is there anyone else who wants to appear today
before the Commission? I'm looking at the three staff members who are in
the room and wondering if they – no. In that case, I will adjourn these
proceedings, we will resume tomorrow afternoon at 1 pm in this same
10 location to complete our hearings here in Melbourne. So thank you very
much.

MR INNIS: Thank you.

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**MATTER ADJOURNED AT 4.24 pm UNTIL
FRIDAY, 28 JULY 2017 AT 1 pm**