Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

INQUIRY INTO INTRODUCING INFORMED USER CHOICE AND COMPETITION INTO HUMAN SERVICES

DR S KING, Presiding Commissioner
MR R SPENCER, Commissioner
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TRANSCRIPT OF PROCEEDINGS

359 CROWN STREET, SURRY HILLS, SYDNEY
ON MONDAY, 24 JULY 2017 AT 9.01 AM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR McMASTER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

DR McMASTER: Yes.

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

DR McMASTER: Yes.

DR KING: Coffs Harbour is an area - - -

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

DR KING: Please.

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

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

DR McMASTER: Yes.

DR KING: Or are there other barriers?

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

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

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

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

DR McMASTER: I like you clarifying.

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

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

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

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

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

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

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

DR KING: Thank you very much for that.

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

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

DR McMASTER: Yes.

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

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

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

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

DR KING: Thank you for that.

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

DR McMASTER: Yes.

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

DR McMASTER: Yes.

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

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

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

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

DR McMASTER: Yes.

MR SPENCER: Is that the local health district?

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

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

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

DR McMASTER: Yes.

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

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

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

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

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

MR SPENCER: Thank you.

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

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

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

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

DR McMASTER: That's right. It would.

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

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

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

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

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

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

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

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

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

DR McMASTER: Thank you very much.

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

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

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

MS MIRANDA: Kate Miranda with the Australian Dental Association New South Wales Branch.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR SIVANESWARAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR KING: A couple of other clarifications from the opening comments: firstly, let me stick with vouchers for a second. We've had it put to us – and it's reflected in the interim report – that the vouchers are too broadly defined, the services aren't well-defined and that you get, for want of a better word, overservicing in vouchers in the private sector. At the same time, we recognise your submission that vouchers enable consumer choice compared to a capitation-type model. How would you address this? If there is an issue here, would you see that the services and payments for patients under the vouchers should be more tightly defined? Do you think they're appropriately defined at the moment? What's your feedback on that?

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MS IRVING: I do want to comment on this suggestion that there's overservicing. I noted that was a point made in at least two submissions that you received. If we take dentistry out of the equation and we look at something much more simple like when I go to my mechanic or even if I talk about let's say a cardiac issue and I need a defibrillator. That might be a bit more closer to the thing. Actually, I've just had a hip replacement. I've just got back to work. Now, I went privately to have my hip done and my orthopaedic surgeon offered me a range of options, but he suggested a particular type of hip replacement, which is the ceramic hip replacement. That was the one that I chose, and so I'm lucky enough that I could afford to pay the difference of what my private health insurance covered. But I had the choice. I could have had the run-of-the-mill option or I could go with the ceramic one, which is the one that I did.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR KING: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

MR HARTLEY: Sure.

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

MR HARTLEY: Yes.

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

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

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

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

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

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

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

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

MR HARTLEY: Sure.

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

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

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

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

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

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

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

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

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

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

MR HARTLEY: Yes.

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

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

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

MR HARTLEY: Yes.

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

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

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

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

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

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

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

MR SPENCER: Thank you.

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

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

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

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

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

MR HARTLEY: Yes.

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

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

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

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

MS STAR: Yes.

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

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

DR KING: So 200,000 dwellings?

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

MR INNIS: Sure.

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

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

MR HARTLEY: Yes.

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

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

MR INNIS: Thank you.

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

SHORT ADJOURNMENT

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

MR SLABB: Good morning.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR SPENCER: Thanks, Greg.

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

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

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

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

MR SLABB: Thank you.

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

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

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

In our submission we did not support it largely because we feel that there needs to be more work on what are the implications of that. I guess I wanted to highlight that we do think that this is an interesting idea, but there are substantial concerns in the homelessness sector about what the implications are. I noticed that the Centre for Independent Studies put in a submission on this point as well, and their attitude was that there would be a substantial gap that would either require large increase of rents for some or large increases in government expenditure. We are obviously highly concerned about large increases in rents for low income earners, and so if there was further modelling, you talk about a high rent compensation, whether or not it's always high rents is an issue. It might simply be low incomes that causes the gap. So just further information on that might change the sector's mind, and I wanted to emphasise that.

The other thing that might need to be further explored in terms of the sector's attitude on it is the fact that the increased choice of going into the private rental market may not actually be there because of structural inequalities there. I believe Homelessness New South Wales has already spoken to this, but certainly in the area of youth homelessness we've had from the sector many examples of young people who have applied to multiple – and when I say "multiple", I'm talking 50 or even 100 – different rental properties and been knocked back every time. They can pay, but they can't get in. So the increased choice may not be quite as much as would be expected because of discrimination factors. So there would need to be some discussion of that and reform around that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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of the services and based on what it wants and based on the research on what sectors do what differently - coming to a conclusion about that. That may mean in some cases saying, "No, this tender is aimed at the community sector," or, indeed, "We feel this service should be provided in-house by government." These are all the same sorts of commissioning decisions that need to be made by any organisation, but where you refer to not discriminating against provider types, it gives the implication that it's never acceptable to ever limit it to a particular provider type, and I don't feel that's quite maybe what you guys meant and I don't think it's quite right.

MR INNIS: Chris, just following up on this point, I think we'd agree very strongly that what government should do is think very carefully about what attributes a provider has that will deliver the outcome sought.

MR STONE: Yes.

MR INNIS: Indeed, what our recommendations were intended to do was focus government much more strongly on that process of understanding what ingredients are needed for effectiveness, for service effectiveness.

MR STONE: Yes.

MR INNIS: The bit that I wonder about, though, is why you would translate that into a blanket for this type of service it's always this type of provider, because what we've seen is that even in the same area, providers vary a lot.

MR STONE: Yes.

MR INNIS: What we've proposed is effectively always go for the attributes and the expectation is some services will lend themselves more naturally to a high proportion of one type versus another. But I just don't understand why you would start with only this type of provider.

MR STONE: Sure. I think what it is that while there is a lot of variation within the sectors, there are certain inherent differences. So in the private sector there is a profit motivation, and that's an inherent part of the private sector. That's going to be a different set of motivations from the community.

MR INNIS: So where do you see the private sector as including NGOs?

MR STONE: Sorry, I'm not making a distinction - - -

DR KING: When you said the private sector, did you mean - - -

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

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

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

MR STONE: Absolutely, yes.

MR INNIS: Thank you.

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

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

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

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

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

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

MR STONE: Yes.

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

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

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

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MR STONE: Yes.

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

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

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

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

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

MR STONE: Yes.

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

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

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

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

MR STONE: Yes.

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

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

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

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

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

MR SPENCER: Thanks, Chris.

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

MR STONE: Yes.

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

MR STONE: Yes.

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

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

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

MR STONE: Right.

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

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

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

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

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

MR INNIS: Thank you.

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

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

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

LUNCHEON ADJOURNMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS WILLIAMS: The financial savings?

DR KING: The financial savings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS WILLIAMS: Yes.

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

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

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

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

MS WILLIAMS: Thank you so much for your time.

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

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

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

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

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

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

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

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

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

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

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

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Some other people are arguing that there should be a significant increase in the spending on social housing, particularly expanding the number of properties or the government subsidy. The submission argues that there are a number of things that could be done instead of doing that. One is relaxing planning laws to make building cheaper. I argue that concerns are raised about the financial stability of the sector and the broader reforms I'm talking about, including transferring of assets to the private sector to increase their scale efficiencies and the rent differentials, will help with that.

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

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

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

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

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DR KING: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR POTTER: No, I'm not.

DR KING: Okay, that's fine.

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

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

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

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

MR POTTER: Yes.

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

MR POTTER: Indeed, yes.

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

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

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

DR KING: That's fine, thank you.

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

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

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

MR INNIS: Please jump in, Richard.

MR SPENCER: Sure.

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

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

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

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MR POTTER: Quite likely. Sorry, to be clear, I'm saying that it needs to remain in social housing. Governments can choose whatever caveats they want, but my preferred model would not be saying it has to be a particular type of social housing provider; it could be anybody.

MR INNIS: I understand that.

MR POTTER: So you don't do the caveat on terms of the provider; you do it in terms of the lease.

MR INNIS: The caveat is on the tenant?

MR POTTER: Yes. The tenants of these properties would be social housing tenants.

MR INNIS: I understand. Just to clarify: in your submission the sense I got was you didn't necessarily feel either for new properties or for subsidies to tenants there was a need for a significant increase. In fact, the tenor of your submission was that planning and other things which the Commission has often spoken about would help with supply and that's a better path. Is that the position, that there's not a need for any sort of injection?

MR POTTER: Yes, that would be a fair interpretation. I guess there might be a need if you implemented these types of reforms, particularly the transfer of assets. If you did the major transfer of assets and then you found you still had a problem, you might look at that again. But I think the key thing here is to do the reform of the sector and then determine whether you need to be injecting more funds once you've done that reform. It's too early to say what reform of the sector will actually do to the efficiency of the sector and whether it will still need a major injection of funds or not,

MR INNIS: I think I probably need to understand why you think our recommendations could result in such large rent increases. Our recommendation is quite clear that existing tenants would be grand fathered at least for a 10-year period and that the reforms would only apply to new tenants.

MR POTTER: Yes.

MR INNIS: Those new tenants are operating in the private market right now, so it's not clear to me why there's an assumption that rents would increase.

MR POTTER: Well, they would increase by that amount, but the question is whether it's actually going to have an adverse impact.

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MR INNIS: Sorry, how are they increasing?

MR POTTER: Well, for a new tenant, the rents will increase compared to the current situation.

MR INNIS: Not for that tenant.

MR POTTER: Yes, that's right.

MR INNIS: The new tenant wouldn't be paying more money necessarily.

MR POTTER: Not paying more money necessarily, but they will be paying more - - -

MR INNIS: They will be receiving a higher subsidy than they are today?

MR POTTER: Yes. Well, after 10 years this problem will occur.

MR INNIS: Certainly there's a transition issue.

MR POTTER: At $40,000 a year – that's the worst case, I should point out – increase in 10 years is still - - -

MR INNIS: Where is that property?

MR POTTER: You have to go to the IPART submission which I referred to in my submission. They don't say specifically which property they're talking about; they said there's some particular property in Sydney where the market rent is that amount. It's all in the IPART submission.

MR INNIS: Thank you.

MR POTTER: But they don't say where it is.

MR INNIS: A final question: I heard earlier that, in theory, you thought the reform package that the Commission has put forward is good, but you worry about the fact that it might not be picked up in practice.

MR POTTER: Yes, I think that would be fair.

MR INNIS: Is that a political problem or is it a technical problem – ie, is there a practical barrier to implementing it, or is it political?

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

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

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

MR INNIS: Final question, I promise.

MR POTTER: You can keep going.

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

MR POTTER: No. But they've neither said that they haven't supported it. Actually, I have received some correspondence from several state governments saying, "We're broadly moving in that direction." But I think that was probably more responding to the choice part of it than the rent differential part of it. I actually think that those two really go together. I mentioned this in my submission: IPART in New South Wales is recommending you give choice only without the rent differentials, and I'm concerned that that may not work because you'll actually end up with excess demand for the good properties and insufficient demand for the bad properties.

MR INNIS: Thank you.

DR KING: Thank you very much, Mr Potter.

MR POTTER: Thank you.

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

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

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

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

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

DR KING: Yes, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR SPENCER: Thank you.

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

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

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

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

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

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

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

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

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

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

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

DR KING: Thank you very much.

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

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

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DR LENARD: Andrea Lenard.

DR TAM: And I'm Patrick Tam.

DR KING: Welcome.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR TALIANA: Absolutely.

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

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

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

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

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

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

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

MR INNIS: Yes, of course.

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

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

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

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

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

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

DR LENARD: Definitely.

MR INNIS: Thank you.

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

DR KING: Thank you.

MR SPENCER: That's a very good example.

DR KING: Thank you very much.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR SPENCER: That's fine, thank you.

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

DR KING: Thank you, Mr Lobb.

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

MATTER ADJOURNED AT 3.03 PM

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Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

INQUIRY INTO INTRODUCING INFORMED USER CHOICE AND COMPETITION INTO HUMAN SERVICES

DR S KING, Commissioner
MR S INNIS, Special Adviser

TRANSCRIPT OF PROCEEDINGS

AT CANBERRA
ON TUESDAY, 25 JULY 2017 AT 9.01 AM

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DR KING: Okay, let's get started. So good morning and welcome to the public hearings for the Productivity Commission Inquiry into Introducing Informed User Choice and Competition into Human Services. My name is Stephen King, and I am one of the commissioners on this inquiry. Sean Innis, on my left, is special advisor on the inquiry.

I would like to begin by acknowledging the traditional custodians of the land on which we meet today. I would also like to pay my respects to elders past and present.

The Commission was requested by the Australian Government to undertake this inquiry in April 2016. The inquiry was to be undertaken in two stages, the first stage 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 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 Commission's draft recommendations for each of the services.

We have talked with 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 500 submissions over the course of the inquiry.

We are grateful to all the organisations and individuals that have taken the time to prepare submissions and/or appear at these hearings. This is the second public hearing for this inquiry. First hearing was conducted yesterday in Sydney. Following this hearing, hearings will also be held in Melbourne and Perth. We will then be working towards completing a final report, having considered all the evidence presented at the hearings and in submissions, as well as other informal discussions.

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

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The purpose of these hearings is to facilitate public scrutiny of the Commission's work and to get feedback on the draft report. We like to conduct all hearings in a reasonably informal manner, but I remind participants that a full transcript is being taken, and that is what the microphones for, and not for amplification. Just on that, if I could ask participants when speaking, including us, to make sure we speak up, just so that everybody can hear.

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

Transcript will be made available to participants, and will be available from the Commission's website following the hearings. Submissions are also available on the website. For any media attending today, some general rules apply. Please see one of our staff for a handout which explains those rules.

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 will hear a warning alarm. Please listen for instructions over the PA from the warden. Follow the exit signs to the front door of the hotel, and assemble on the grass area in front of the hotel. Lifts will not be used. Please follow the instructions of the floor warden at all times. If you believe you would need assistance, it is important that you advise wardens, who will make arrangements for you.

Participants are invited to make some opening remarks of no more than five minutes. Keeping the opening remarks brief will allow us the opportunity to discuss the participant's submissions in greater detail.

First off I would like to welcome Liz Callaghan from Palliative Care Australia, and just for the transcript if you could state your name and organisation and then - - -

MS CALLAGHAN: Liz Callaghan, CEO, Palliative Care Australia. Thank you, Commissioner.'

DR KING: And please.

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MS CALLAGHAN: Thank you. So thank you for the opportunity to speak with you today. As you know from our submission, PCA is the national peak body for palliative care, and work towards ensuring access to high quality end-of-life care for all. The draft report into introducing competition and informed user choice into human services contains five recommendations relating to end-of-life care, which are strongly endorsed by PCA.

Distinctions in your draft report between palliative care and end-of-life care will need to be drawn, however. The chapter is titled "Caring for people at the end of life", yet refers to palliative care throughout. This is consistent with the view that at times these terms are used interchangeably.

In this short statement I would like to draw your attention to some of the work PCA have undertaken since we last spoke with the Commission. Yesterday we released a series of seven economic research notes relating to palliative and end-of-life care. These include summaries of latest research and case studies relating to the economic value of palliative care and end-of-life care; the economic benefits of home-based palliative care and end-of-life care; the economic benefits of palliative care and end-of-life care in hospitals, in residential aged care settings; the economic benefits of integrating palliative care and end-of-life care into chronic disease management; the economic benefits of early access to palliative care and end-of-life care; and the financial costs to families caring for family members receiving palliative care and end-of-life care.

I have hard copies of those which I am happy to leave with you today. They are also on our website. PCA have also developed a set of principles for palliative care and end-of-life care in residential aged care. This was released during Palliative Care Week in May this year, and the principles are a collaboration by PCA, Alzheimer's Australia, COTA, the Aged and Community Services Australia, Leading Aged Services Australia, Catholic Health Australia, and the Aged Care Guild, to present a united commitment in recognising the diverse needs of residential aged care consumers, families, carers, aged care staff and service providers in providing palliative care and end-of-life care. And we believe the principles go some way in addressing some of the items in your report, and think they are a good match.

PCA, along with Professor Jennifer Tieman from Flinders University and Professor Deborah Parker from UTS, have also drafted a palliative care and end-of-life care road map for suggested inclusion in the aged care road map, because that has been omitted from the aged care road map. Both these pieces of work call for end-of-life care to be recognised as core

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business for aged care services, which is consistent with your recommendations.

Finally, PCA are currently undertaking two important pieces of work. One is the revision of specialist palliative care standards. This work is important because the palliative care sector believes there is a minimum set of standards that needs to be applied to delivery of specialist palliative care services in order for them to be known as palliative care services.

This work will complement the standards work undertaken by the Safety and Quality Commission. So they have done - they are complementary, not duplicative, and a review of these standards will be completed by the end of this year.

And secondly, a revision of two key planning documents in palliative care, "A guide to palliative care service development: population based approach" and "Palliative care service provision in Australia: a planning guide". Both documents were developed in 2005 and are long overdue for revision.

One of the key outputs from this work will be a set of definitive definitions of what constitutes end-of-life care, palliative care, primary palliative care, et cetera. These definitions will be incorporated into the revision of the national palliative care strategy, also due for finalisation by the end of the year.

And just finally, another piece of work you may not be aware of. Last week one of our members, Palliative Care Victoria, released a policy proposal in Australia for financing palliative care in Victoria. So they estimate that there is a need for an annual additional $65 million of funding for services in Victoria, and this is based on a survey of the sector and includes funding for structural adjustment, including incremental community awareness and capacity.

What this recent work shows is that 60 per cent of palliative care consultancy services currently cannot meet the demand in Victoria. So that is the end of my remarks. Thank you.

DR KING: Thank you. Actually, I just would like to start actually at the end there, with the work of Palliative Care Victoria. Two things that that highlights, from my perspective. First off, so 65 million is their estimate of the shortfall?

MS CALLAGHAN: Yes.

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DR KING: Do you know if other organisations or other data is available around Australia or in other states in Australia as to the shortfall that is needed? Numbers are always very useful when putting a proposal.

MS CALLAGHAN: Yes. This is, to my knowledge, is the most recent work that has been undertaken, and it was a survey of services, so estimating how many people they are turning away, what the demand is. So it was based on that survey work, but also, I guess, a development of a strategy as well, going forwards, looking at what needs to happen. I have got a breakdown of that funding, if you are interested?

DR KING: Presumably it is on their website?

MS CALLAGHAN: It is on their website.

DR KING: Yes, so no, that is fine. We will follow that up, so thank you for providing it. The other part that your comments there highlighted, so 60 per cent of palliative care services can't meet demand?

MS CALLAGHAN: Yes.

DR KING: One of the things that has been put to us is that there is a shortfall in palliative care specialists, and there is really two points that I would like to get your views on. Firstly that shortfall, especially in specialist palliative doctors and palliative nurses, but also there seems to be a slight tension between some of the submissions put to us between the role of the generalists - so a generalist GP who may have some small palliative training versus a palliative care specialist, and the different roles that they play. Where do you see workforce shortfalls, if you do see any? Where do you think the emphasis should be, and how should the government be balancing the workforce requirements of the specialists, the generalists, and also the community: the families, the carers, the community organisations?

MS CALLAGHAN: I think it is fairly obvious that palliative care specialists can't - medical specialists can't care for every person that is dying in Australia. It would just be impossible. The workforce planning in Australia was being undertaken by Health Workforce Australia. That has been disbanded. It has gone back into the Department of Health.

And many years ago AMWAC, so the Australian Medical Workforce Advisory Committee, did a lot of work around workforce planning for specialist palliative medicine. That was many, many years ago, actually, around 2005, which is why we are updating this guide for palliative care service development and the planning guide, because within that is a workforce planning component to that work.

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I think what needs to happen is a very clear understanding of what service models - so you can do workforce planning, but if you don't understand what the service model is and what you are trying to achieve, you can't do workforce planning ahead of that service planning.

And so I guess the complexity in that relates to state and territory jurisdictions do that service planning generally, and yet the Commonwealth fund and direct funding for workforce training positions.

There are instances of palliative care specialists who complete their training who can't get the work that they're looking for, because - and that relates to state and territory health departments not creating positions for them.

So that is the complexity around that, I guess, or the curiousness, but I mean, clearly there is only - I think the latest AIHW data, and I would have to check this, it was 193 specialists. The latest tranche has taken them up - it's up to over 200, 204 specialists across Australia.

Clearly there are pockets of inequitable access across the country. Now, the question is do you need a palliative care specialist for the complex care? I think where we will be heading with the work that we are currently doing is that we would be advocating for upskilling general practice. Not everyone needs specialist palliative care. Many people die in residential aged care without needing palliative care support. It really is around complex family issues, the psychosocial/spiritual support. In a perfect world, everyone would have access to that, but there are financial constraints clearly.

That is why the standards work is really important as well. So there needs to be a level of - a standard of care. So I think all of those bits of the jigsaw will come together to create, I guess, a way forward that articulates a better model for end-of-life care across the country.

I think there isn't a community based model of care across the country, and that - I mean, that is picked up in your report, so I think it is not easy to answer that question. I think we still need to look at data.

But there is also - you know, there is still - it still is not mandatory to look at - to undertake palliative care or end-of-life care learning as an undergraduate for both nursing and medical. Yes, so it is not mandatory across the country, so you can get - - -

DR KING: Even as a GP?

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MS CALLAGHAN: Yes.

DR KING: Okay.

MS CALLAGHAN: So you can - a colleague of mine is a general practitioner. She went through her GP training very recently and didn't have anything on end-of-life care or palliative care. So unless you go looking for it, you can get through your training without reaching it. So I think there are some structural issues that need to change. That is why I think there is a whole lot of building blocks we need to put in place. Yes. That is - - -

DR KING: Thank you. Just also on the - you mentioned seven research notes as well as that Victorian work that has come out.

MS CALLAGHAN: Yes. Yes.

DR KING: And you're also updating the standard on providing quality palliative care.

MS CALLAGHAN: Yes.

DR KING: I guess, given this work that is going on - so this is a very general level question - do you think that our recommendations should say, "Look, you really need to look at our work here. That needs some nuancing, that needs fundamental change"? Any thoughts on, you know, if you had the pen in your hand and could go, "Look, you know, scrub out that, put this in"? Just from the recent work and the work that is going on. So in a sense, we want to make sure our recommendations are as close to the cutting edge and up to date as possible.

MS CALLAGHAN: Yes, well, I think the work on the standards is very important, because I think there are sort of community based services out in the community saying that they offer palliative care services, and they're personal care services, and they are not necessarily palliative care.

So it might - in the holistic sense. And it is not connected to a consultancy service or a general practice that has an interest in palliative care. So I think that is why standards are important, because they are a minimum - and what we are working on, and we had - I was in Sydney yesterday for a meeting relating to the standards. There is a minimum set of standards, and these are process standards that we think services should be able to offer to be able to say that they are delivering palliative care.

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There are also aspirational standards within that, because there are higher-performing - you know, in the old terminology, level 3 services that undertake research. They do education, all that sort of stuff. So there is a mix there. But there should definitely be an understanding of what you are paying for.

So if you are paying for palliative care services, you need to, I think, meet a minimum set of standards. And this is something I have discussed with a couple of health insurers as well, because health insurance is interested in getting in this space, and I am sure you will have talked to many of them, but I think they really need to understand what they are buying, because it is more than a lit candle and a doona, which is what is often offered in residential aged care, for example.

DR KING: Yes.

MS CALLAGHAN: And we had examples of that yesterday, so - so I think the standards work is really important, and I think the updating the guide to palliative care service development and the population planning guides are really important, because jurisdictions have used them to plan for their services.

So they are so out of date. They were last done in 2005, so clearly lots of things have changed. The context in which we are living in has changed, even in that period of time. So I think we need to do that work, and I think if that could be incorporated into your final report that would be good.

We are looking at finishing that work by the end of the year, which might not meet your timelines, but we will have progressed a fair way, actually, with that work.

DR KING: Thank you. And if we are able to liaise with you on that work - - -

MS CALLAGHAN: Absolutely, yes.

DR KING: Yes. You mentioned funding, and there was an increase in the funding of the recent federal budget, greater choice for at home palliative care budget measure, so $8.3 million over three years.

MS CALLAGHAN: Yes.

DR KING: So given the $65 million you mentioned before from Victoria, it might put some perspective on it. Two things, I guess, about that. Do you see that sort of budget approach - more than just the amount of money,

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but the actual approach taken through those - that funding announcement, which seems to, at least from my perspective, seems to have little funding for direct service provision. It relies significantly on the primary health networks. Do you think that is an appropriate way of enhancing delivery of palliative care services? If so, what role do you see for the primary health networks playing, and how do they fit into this system? And if not, how would you like to see it done?

MS CALLAGHAN: PCA are very supportive of that budget initiative actually. And you are correct, it is not for direct services, and it is a small amount of money in the scheme of things. However, it is for a trial of ten sites, and at the heart of that announcement is, I guess, an intention to look at coordination of care.

So we have a fragmented health system, we know that, and particularly in end-of-life care, those fragmentations can be very pronounced if they are not managed well, so we have long said, you know, having a navigator in a system would be a great thing.

So primary health networks, I guess, provide that opportunity of - and I think that funding for the trials I imagine will be used to bring service providers within their primary health network catchment to develop a health pathway for end-of-life care and palliative care.

And I have spoken to a number of PHNs who haven't even commenced thinking about end-of-life care work. They want to do it, but they know, you know - they don't know where to start, basically. So this is a bit of an injection of funding to help coordinate and bring services together.

So you can identify in catchment areas who are the GPs who are interested in delivering palliative - who are the GPs that would actually go to someone's home out of hours and provide care? Who are the pharmacists? Pharmacy plays a really key role in the community at end of life, because often, particularly in rural areas, often they are the ones who can support the GP in prescribing, so if you have complexity around your pain and symptom management you often need to change drugs and all that sort of thing. It is quite complex. It is not for everybody, so this is not every case, but there are many, many instances of people - and we hear all the time of people having poor deaths, dying in pain, their symptoms not being well-managed.

So this is why we need a system that can deal with this. So I think the PHNs coming together to develop those health pathways is a fantastic start, because it is in primary care where people can miss out on accessing any sort of service for end-of-life care.

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You are very well looked after, usually, if you are part of an out-patient kind of appointment with medical specialists, say, renal, heart failure, that type of thing. You can be. There is opportunity there, so you are more likely to be, and particularly if you have got access to in-patient palliative care units or hospices or community-based services.

But those primary health networks have 100 per cent coverage across Australia, so they do have a role in looking at what is in their network and trying to coordinate and get people to work together and take ownership so that when - I mean, I would love to see when someone is recognised as with a life limiting illness and they are approaching the end of their life, that actually it is some kind of urgency. It is a priority. It is something that needs to be responded to. It is not urgent in the sense of a medical emergency, but it is urgent for that person. You only die once, and that family only experiences that once, and it is really important and you don't get that chance again.

DR KING: Yes.

MS CALLAGHAN: Yes, so that's - so I'm actually quite hopeful that this initiative - I can see that is how it could work, and it would be fantastic if it could be rolled out nationally. Because I think the primary health network CEOs that I have spoken to are really keen to bring that - bring those bits of the sector together and identify who can support people in their community, particularly with a complex chronic illness.

So I'm hopeful that it will do something, yes.

DR KING: Yes. Okay, so the idea of the PHNs as a navigator, I can see the appeal of that, particularly with the primary care. I guess my initial reaction is to question whether that is going to work in the coordination of the hospital care, and do you think that's an issue? I mean, we do tend to have this division in Australia between the primary and the tertiary.

MS CALLAGHAN: Absolutely.

DR KING: And yes, how could that be dealt with, you know, through a navigator or - you know?

MS CALLAGHAN: Yes, yes, I think you're right, and I think - I think that is where some of the difficulty is, and that is where the value of a model like Silver Chain is good, because it is outside of that health system. And I think hospitals - and it is just the nature of hospitals, they like to suck up everything around them and bring them. That is the metaphor. They are

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like a vacuum. And don't outward look into the community as much as they possibly could.

So I don't know that primary health networks will be able to change that, necessarily. I really think it is about the hospitals looking out. Everyone looks in to the hospital, but you know, the reverse is not happening. So how do you do that? I think navigators within the hospitals as well.

So some relationship there. And it is difficult, because we have a fragmented system. It is funded - and that is where the funding differences come into play, and what is a quid pro quo? So I think in residential aged care, for example, if you were to have state funded services, say palliative care services that are part of a consultancy service within a hospital in-reaching to residential aged care, not in a formal sense where you have a, you know, an agreement where money changes hands, but it is an understanding that by doing that they are avoiding hospital admissions, you know?

So that kind of - and you know, whether that can happen in the bilateral negotiations, I think there is possibility there. I think that would be the mechanism. I would be looking at trying to do that. So having some KPIs for state and territories around that outreach into the community, in order to avoid hospitalisations.

DR KING: Sorry, actually you've reminded me of something, just to skip back, and apologies, because this isn't your work, it is the Victorian palliative care work.

MS CALLAGHAN: Yes.

DR KING: The $65 million, did they look at any chance - and I suspect the answer is no - but did they look at the potential savings in reduced hospitalisation from increased palliative care?

MS CALLAGHAN: No. No, I don't - - -

DR KING: That's all right. If - or if you're not sure, well, we can look it up.

MS CALLAGHAN: Yes. I don't believe they did. Some work that we have done has tried to look at that as well.

DR KING: Okay.

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MS CALLAGHAN: I think we provided a report, yes, last year. It is hard to do that, yes. You can make assumptions. Are they correct? I am not sure. Yes. Yes.

DR KING: That is fine. Just a couple of other things I wanted to cover off. You mentioned your recent research note which was looking at families and carers.

MS CALLAGHAN: Yes.

DR KING: And your submission highlights important support for families and carers. Not an area we cover off in great detail in our draft report, so I was very keen to hear from you what you think needs to be done there.

MS CALLAGHAN: Yes, so in - I mean, your report makes reference to the fact 70 per cent of Australians want to die at home, and, you know, very few are doing that. I think that is about choice, actually. So people may want to die at home, but actually at the end of - when it gets to the pointy end they may not want to, so I think we have to have a system that offers choice.

So I think - and we use that statistic, 70 per cent want to die - but you know, actually, it is about choice in places. So part of that, so going back to your question, is the care in people's home, so if you were to care for someone, it does create - there is a financial impact on families, and I - and this has not really been quantified.

It is there. I mean, I think Deloittes did a study for Carers Australia I think last year. They do it every couple of years, and it was in the billions of dollars in terms of the savings. But for this particular issue, I think, you know, there is cost shifting that happens, and the burden lands on families. And there are lots of out of pocket costs as well for families who are caring for people at home.

I mean, I know I did that when I cared for my mum. You do. But it's - so it's people who can afford to do that, so again it's inequitably distributed, I suppose, so yes, I think there is an impact, but I think it's - and it's substantial, but it hasn't been quantified.

DR KING: True. Well, it is monetary, time - - -

MS CALLAGHAN: Absolutely, yes. And then it is also, you know, grief afterwards as well.

DR KING: Yes.

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MS CALLAGHAN: And that - and I mean, there is different research, and our briefing paper picks up some of it, but there is research around if you have cared for someone and it has been particularly difficult for a long period of time and you're an older carer, your length of life is probably shortened by doing that. You know, so there is - you know, there is lots of impact.

DR KING: Just - okay. Because we know choice of where you would like to die changes as your death approaches.

MS CALLAGHAN: Absolutely.

DR KING: And I guess the wisdom, conventional wisdom, around that is that, well, as a person who is dying sees the burden that is then placed on their loved ones who are acting as carers, that that is one of the drivers behind, for example, maybe they should go into a specialist facility, into a hospital, whatever.

Has - I mean, one - do you think that is a correct view of it? And secondly, has anyone done work on, well, if you provide - again, you provide more support for the in-home care or care in a residential aged facility, maybe in-home care for the informal carers, that that would also lead to a better death and lead to less burden on the hospital system. Has anyone looked sort of formally at that?

MS CALLAGHAN: Yes, I think there has been bits and pieces, and I think we mentioned some of the research in here. Yes, it has just gone what I was going to say, actually. Sorry. I think they have looked at it. But I think the - particularly towards the end of life, if there can be respite offered to carers in-home, just to sleep, or, you know, that can assist and alleviate the stress.

I think there is evidence that if you are well-supported and you are well-supported both by your informal network - so if people are able to come in and assess, and this is where the Compassionate Communities movement, which we support, some of comes to light, actually. Where you can - most people want to care for each other, and we never ask. We don't ask people to help us in this caring role because people might ask you twice or three times, and after the third time you say no, they stop asking and cross the street so you don't have to help.

But if we were able to, I guess, mobilise that informal network that everyone has, and everybody can have a network, and then there is volunteers on top of that, people can be better supported to provide that care

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in-home, before you even get into the paid bit of the formal networks that can help.

So I think there is quite a bit to be done within the community at the - like a community development level, I guess, around mobilising communities to care for each other. And that is some of the work that we are doing as well. It just eases the burden, relieves the stress, reduces the cost, and is overall a better experience.

And there is some work done by - and I'm sorry, I don't have it in front of me - but Dr Julian Able from the NHS in the UK implemented a Compassionate Communities approach in his - he's a palliative care specialist, works for a trust, but in the community with a GP trust. And they put in a community development worker that basically connected people with their informal network of care, and then identified formal bits where that was required, and over a period of time they had - because people were able to be better supported at home, they had quite a significant reduction in hospital admissions within that area, and they did a control with it.

So it was - yes, it was for people with three or more chronic conditions, their rate of hospitalisations had reduced very significantly. So I think there is bits and pieces that it is a bit of the building blocks, so I think there is not one simple answer, and there is a whole lot. There is a kind of a bottom up from community, and then there is, you know, some levers from the top.

MR INNIS: Sure. So thank you, and thank you for the contributions you have made to the inquiry so far.

MS CALLAGHAN: That is all right.

MR INNIS: Listening to your evidence and thinking about the submissions we have received, it strikes me that we focus on the areas where people die, the locations. So the hospital, the aged care facility or the home. And that we are trying to build a system where people have more choice around those three major settings.

And as you say, it is a bit disconnected, and in our report we make quite a - say some strong things about government stewardship and governments needing to be stewards of human service systems, and I guess my question is, looking across those settings and thinking about someone who is steward of palliative end-of-life care in Australia, are we good enough? Is government performing that role well enough? Are there some things that governments need to do to position themselves to perform that stewardship role better?

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MS CALLAGHAN: I don't think governments are doing a good enough job. I will have to be honest. And that is both level of - or three levels of government, local government as well. And I - but I think we are at an interesting time, because I think governments are now realising the importance of looking at end-of-life care and palliative care. You know, ten years ago maybe not, and for palliative care it is a relatively new specialist service. It is only about 20 years old or so.

And so I think - I think governments have come late to the plate, if you like, and now we are scrambling to try and set a model, and what you have got is many different models, and so then very many different end of life experiences for Australians. It really depends where you live, and - as to what type of care you will get at the end of your life, which is, you know, not a fair go for all.

So I think what can governments do? I think they are trying to look at this in a systems view, and you know, you could argue that end-of-life care doesn't fit easily within - it is hard to place it within there, so if you are looking at health or human - it is hard to actually position it somewhere, because it touches - it can touch across so much of the human services space.

So that is a difficulty, I suppose. I think we just have to - what I would like to see is that prioritisation, some sort of acceptance that actually end-of-life care, it is different, because you get one go at it. It is - and it needs a different prioritisation.

And part of that is that community awareness. We can't even spell palliative care. People don't know - you know, they think it's euthanasia or they think you want to keep people alive forever. People don't even understand what it is. So there is a huge gap in terms of health literacy around this issue. We are very reluctant to talk about death and dying, although once you find people who are kind of interested you can't shut them up, because it's kind of like an exciting thing.

So I think governments should support what is happening at a community grass roots level, and allow that to happen, those conversations to happen. Because I think what has happened in the past is if a community mobilises, and Australians say, "Hey, we want to have something different for our end of life," governments will listen and things will change.

MR INNIS: So I understand that, and I understand that is part of the advocacy and lobbying path - - -

MS CALLAGHAN: Yes.

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MR INNIS: - - - towards a good system.

MS CALLAGHAN: Yes.

MR INNIS: But I guess my question is, it looks like we've got lots of people responsible or at least partly responsible - - -

MS CALLAGHAN: And then no one having overall responsibility?

MR INNIS: No one - which means no one is responsible. Is that a fair assessment or not?

MS CALLAGHAN: It is, but it also is not a surprise because of what I said before. It touches across so many bits and pieces. So you could take an approach where you say, okay, the federal government is completely responsible for end-of-life care, as they are for aged care.

Now I don't think that would work, really, because, you know, four out of five deaths are from a chronic illness, where it's not a surprise where someone dies. They could benefit from palliative care and end-of-life care.

That is the main business of the state and territory hospitals. So I don't see how you could do that. So - - -

MR INNIS: You mentioned PHNs earlier.

MS CALLAGHAN: Yes.

MR INNIS: Do the PHNs provide the best spot in which to do the planning and the on-the-ground stewardship?

MS CALLAGHAN: I think so, because I think they are responsible for population-based planning, and they are - yes, they are. They are supposed to bring in those - - -

MR INNIS: And consumer protection?

MS CALLAGHAN: Well, I think - I think those PHNs need to have things like community councils and involved in that planning. So is that what you mean?

MR INNIS: Well, we are talking about people who are very vulnerable, both potentially financially.

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MS CALLAGHAN: Yes.

MR INNIS: I am a little less worried about that, but certainly emotionally and physically, so my question is, are PHNs the right place to put the responsibility for ensuring that standards are being met?

MS CALLAGHAN: Yes. I am not - yes, I am not sure that that would be the right place.

MR INNIS: If not?

MS CALLAGHAN: I don't know, Sean.

MR INNIS: What might be?

MS CALLAGHAN: Yes. I don't know. I'd have to get back to you on that one. I - nothing comes - - -

MR INNIS: No, that's fair.

MS CALLAGHAN: - - - you know, obviously to the top of mind. I think - and why wouldn't I think the PHNs would be the right spot? Because I think they are just doing so much. Yes.

MR INNIS: I'm not suggesting. That's a genuine question.

MS CALLAGHAN: Yes. And - yes, I don't know where that would sit, but it needs to sit somewhere. Yes, I think you are right, that - yes.

MR INNIS: And so final question from me, our report hopefully makes a contribution to something that is very important, but I don't think we are pretending that it is the end of the journey. So what else might be needed? I hear the ground up story, but for something to really work the ground up has to meet something. So what should governments do?

MS CALLAGHAN: Well, I think - I think government is already looking at this at the COAG level, so I think that is really encouraging, and - because I think it is at that level that government needs to come together and set that priority around end-of-life care.

Yes, I think - I think it is getting agreement between states and territories and the Commonwealth to prioritise end-of-life care and look at - so the national palliative care strategy, which will be released at the end of the year, will have, for the first time in many years, KPIs. So a bit of a stick for states and territories. It was a strategy that sat on a shelf since 2010

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with no KPIs, no monitoring, no evaluation, so there was no need - there was no leadership by the Commonwealth.

I think the Commonwealth has recognised they need to provide that, and they also need to insert in their bilateral agreements some sort of performance indicators around access to services for people in the community.

So I think governments are coming at this now, and I think they are thinking it through carefully, is probably a way to put it. Yes. They are - what is it? Hurrying without haste or something like that, or you know, going slowly with haste, something like - you know. So I think they are seeing that it is an issue, and I think your report really assists with that. So thank you for doing it, and if I can say, thank you for having - holding that round table that you did hold on end-of-life care, and I guess for listening to what was talked about in that round table, and it was so fantastic to see this report. It was great. Everyone - the sector is very pleased, so thank you.

MR INNIS: Thank you.

MS CALLAGHAN: Yes, okay, thanks.

DR KING: Thanks. The next participant is Catholic Social Services Australia. We have got Mr Zabar and Chastel.

MS DE CHASTEL: Yes, that is right, okay.

DR KING: Castel or Chastel?

MS DE CHASTEL: De Chastel.

DR KING: Chastel. I think I - - -

MS DE CHASTEL: It's very Anglicised.

DR KING: - - - mixed up your name in the first one.

MS DE CHASTEL: Yes, that is all right.

DR KING: Welcome, so again, and just apologies to the audience, I do notice that this is a rather echoey room, and whenever anyone walks 100 metres away on the wooden floorboards that you can hear it in here, so - - -

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MR ZABAR: It's charming.

MS DE CHASTEL: I wish the fireplace was in here, though.

DR KING: Yes, that would also - I wasn't going to comment on - somebody said that Australian houses are like tents, basically. They have insulated walls, and this is a very nice tent. If, for just the record, you would be able to state your names and your organisation, and then just some introductory comments.

MR ZABAR: Cool. Joe Zabar, from Catholic Social Services Australia.

MS DE CHASTEL: Liz de Chastel, a director of social policy at Catholic Social Services Australia.

MR ZABAR: Well, thanks for the opportunity to present at the hearing. I'll make a few opening remarks, which are informed by the experience of our Catholic social service providers. Our focus will be on two issues, the grants area and social housing, so that is where our comments will sit.

We want to acknowledge the enormity of the task undertaken by the commission and commend you on your draft report. It was a big job, and I think to get as far as you did I think it needs to be acknowledged. The report provides some very helpful analysis of key issues and some interesting ways forward, and I think there is things there that we could take up.

We have approached this report from the view that human services are both a universal entitlement and a social safety net, able to be accessed by anyone, especially those with complex needs, and we start from the position that our human services system must prioritise the dignity of the individual over administrative efficiency. And I think that for us is the key in all the commentary that we are making.

As you have seen, we have made a fairly detailed submission which builds upon the issues that we have raised in earlier submission to this inquiry. So I thought I would just quickly go through and highlight some of the things that we - in relation to the grants and family and community services, we view many of the recommendations in this area as positive, albeit ambitious.

While we acknowledge the importance of coordination between the different levels of government in the identification and implementation of family and community service programs, we also believe that proper engagement with providers remains pivotal to the success or otherwise of these programs.

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Where we do differ from the Commission is that we don't agree that governments should be blind to the organisational type in the provision of social services. We are not arguing that for-profits should be excluded from family and community services sector, but rather that governments consider carefully any distortive effect that for-profits can have on a monopsony market, and how that may impact on services, especially on the most vulnerable in our society.

In our initial submission to this inquiry, we raised concerns about for-profit providers in monopsony markets, noting how their operating models further fragment the service system through their pursuit of profit-yielding activities and regions.

We agree that outcome measures and outputs can be helpful indicators of user well-being and program success, and while we welcome this outcome framework, we also note pursuing it with a degree of caution, and there are two things we have raised.

The first is that the measures must be developed as part of a negotiation process, rather than simply imposed. The second is that until we have a mature and robust outcomes framework, governments should avoid moving to outcome performance payments.

We commend the Commission for its acknowledgement of the importance of relational contracting and funding flexibility in the delivery of family and community services. We believe there are some difficulties in pursuing some elements of this agenda, namely around the government-centric accountability requirements of our current ministerial and budgetary mechanisms, and to this end we have proposed that all future grant-based family and community service programs contain a flexible ancillary services fund which is available to support the funding of services which assist clients to overcome barriers which might otherwise inhibit their ability to access and succeed in the program. And we have done some detailed commentary about it in our sub.

In relation to social housing, social housing traditionally provides a housing safety net for low income and vulnerable families and individuals with complex needs. We support the Commission's view that our social housing system is broken. The shared view of CSSA members is that there is a massive under-supply of social housing stock, and that fixing the social housing system is complex and responses need to be wide-ranging.

Our key concern with the Commission's findings in this area is the underpinning assumption that the private rental market can simply be

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equated to social housing. Social housing, in our view, serves a different purpose to that of the private rental market. Social housing provides vulnerable households with housing certainty that the private market cannot.

Now, while some of the measures in this report will better support vulnerable households in the private market, for example the tenancy services, they will not overcome many of the social, institutional, financial or regulatory barriers to eligible social housing tenants.

There are questions also as to the adequacy of the 15 per cent increase to CRA, but also the possible upward flow-on effects on rent prices. We are troubled by the prospects of funding for the increase of CRA coming at the expense of further investment in social housing infrastructure which has already been identified as inadequate.

We would also draw the Commission's attention to our concern for existing public tenants who live in locations which have high private market rents, but who have deep connections to their community and place, and are impacted by recommendation 5.2.

The recommendations made in relation to social housing are significant, both from a social policy and budget perspective. Accordingly, we would encourage the Commission to make available the financial modelling used to arrive to the various recommendations made with respect to social housing.

This would provide a better understanding of how the Commission has reached its views, and offer the sector the opportunity to help further refine some of the recommendations in the report. My colleague Liz and I are happy to take any questions.

DR KING: Thank you very much. Thank you also for - it was a very comprehensive submission, so I would like to touch on, in my comments, some of the things that you have raised, but I will not cover every area in your submission. But really to clarify some of your comments and make sure that I understand them.

Just to start off, you started your comments on the organisational type, and recognise that you have made that point in a number of submissions, as have others, and it was put to us yesterday that perhaps we needed more clarity in what we were thinking as well in this area, in that the way the recommendation is put at the moment with a double negative in there does not make quite clear the nuancing, but is perhaps in the text clear, which is that we do not see government simply saying, "Well, everybody is equal

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putting the tender," but rather that the government recognises different organisations have different objectives, have different capabilities, and that it is horses for courses.

So given that background, do you see - I guess two parts. Firstly, there are a range of organisational types which are not simply governments or NGOs. There are cooperatives, there are sole traders, there are small partnerships, there are large partnerships as well, as well as more formal corporate for-profit organisational structures.

So firstly, do you think there is a role for those other forms of non-government or non-government but non-profit-maximising, if I can put it that way, or nuanced objective organisations? Co-ops are the obvious example, which are acting for their members.

And secondly, on the actual for-profit, on the corporates, do you see that there can be situations where the profit incentives and the incentives from government actually do align, and an example that was put to us was the - not relevant for the services we are looking here, but in incarceration. It has been put to us in one of our earlier forums that in Western Australia the private for-profit operator there actually was operating far better and producing better results for the prisoners in recidivism and the government objectives than the government one.

So two parts to that question. Other organisational forms, what is your view on that? And do you actually see any role for the not-for-profit - for the for-profits, or do you simply say they shouldn't be in this space?

MR ZABAR: Yes, after - look, it all - I think it all goes down to what you see as human services and its purpose, right? Now, the problem that we have always had with the - sort of what I call the faux commoditisation of services is that we are trying to create a market for some purpose. And that purpose might be genuine in its desire to make it more efficient or more effective.

Now, there is a presumption in all of this, is that there are certain groupings that are more efficient and more effective, which will go to that second point. I think it is contestable that the private sector is any more efficient or any more effective than any other grouping. But the concern that I have always had about the private sector in the sort of traditional social services space is that we have seen the fragmentation happen because they chase yield, right? They chase an investment return.

DR KING: For-profit? The for-profit?

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MR ZABAR: For-profit, I meant, yes, sorry. I will start with part B first, then I will come to A, because A is a little bit less difficult for me to work through, because I think it is probably easier. But on that issue there, we have seen it in ageing, we have seen it in other places.

What happens is, is that there is - people in the for-profit space have to make a return on investment, right? So that is their purpose. That is their mission. So from our perspective it's what we've seen is that, okay, so what they then do is they try to further fragment the market. And when I was working for another organisations years ago, this was quite apparent in aged care, right? Absolutely apparent.

What was happening is, the leafier suburbs where you could do certain things and you could get a better return, they would go in. What that meant was that the less - the more complex areas or the less commercially viable areas are left to the others.

Now, the problem then comes is, if you are missional based, it does not mean that you are going to run at a loss. You can't. You actually can't run at a loss. So we often used to have this cross-subsidisation arrangement.

So as you fragment the market, you start to split. You start to split out, and you say, "Okay, well, I will pursue this," and that means that there is less money. The second part to that, which is again, if you give - if the government gives $100 to a for-profit to deliver a service, you know that part of that $100 has to go back into some sort of shareholder return.

In our system, it is probably not quite like that, because that $100 gets applied back into the missional purpose, which then spreads out more to the community, and I think that is the difference that I am talking about when you start having the debate around the privates - the for-profits versus the not-for-profits.

Going back now to your first question about is there room for groupings like mutuals, I think there is. There is. So long as it is around mission and it is around purpose and not being distracted by the profit motive. Because if they are there to provide a community purpose, well, fine. And what will happen is you will have that reinvestment and hopefully they will have some continuity of service and the like.

So it is not that we are - and we are not actually opposed to the private sector entry. We are just saying that if you are going to create an environment that allows that to happen, just make sure that there is not a distortion that occurs by doing so. That is our message. It is not an

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exclusiveness. It is just be mindful of what distortions could occur. That is the issue for us.

MS DE CHASTEL: I think some of the work we are doing in the NDIS space at the moment also highlights that our members are telling us that a lot of the for-profits are taking the high-end services where there is good returns. Some of the more complex, you know, cases that require a lot of wrap-around services, they are falling through the gaps, and our members are actually having to pick those sort of services up, so that is probably what Joe is saying, that they will pick out the bits that are really good profits, but in terms of the more complex harder sort of cases they won't get involved in that so much. So a lot of our services are picking up those sort of gaps in the market at the moment.

Definitely in the social housing space, we would see a market for the for-profits and the not-for-profits, but as Joe said, they provide different services, and often the faith providers actually deal with very complex types of families and individuals operating in public housing or social housing as well, so yes.

MR INNIS: Thank you for that. I just want to follow up on a couple of aspects, and confirm something from our perspective. So in family and community services we were very clear we weren't creating a market. We weren't putting money in the hands of consumers, we weren't getting them to buy product. So we weren't creating a market in the traditional sense.

Second thing I just want to confirm is, the model that you undertake, the service model, does include cross-subsidisation from easier, better off clients to poorer clients. I just want to confirm that's part of - - -

MR ZABAR: It's not - well, the cross-subsidisation could occur by activity, or it could occur by virtue of other funding. So for example, money from the church system. So when I speak of cross-subsidisation, it's not merely on a service stream. It could be - and it could be joining up. I mean, that is one of the benefits, yes.

MR INNIS: I understand.

MS DE CHASTEL: The other aspect is the huge volunteer base as well that our members have access to, which are often used in these type of services as well.

DR KING: So one of the recommendations we do make is government be much conscious of the full cost of service delivery for the types of client that are being serviced, and pay that full cost. Would that assist your service

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to provide better services to people, rather than worrying about all the money at the back end?

So we are saying government should meet the full cost of the needs of the clients.

MR ZABAR: The principle has to be right. I mean, yes, meet the full cost. The question will be, as we have seen with some of the areas around NDIS, where it becomes contestable is what is the full cost and what is the actual cost. And I think that has always been the difficulty in a monopsony, because at the end of the day the government will often set the price - well, in most cases of a monopsony it will.

So if it is setting the price, what is it using to set that price? And that is the issue. So is it using its own modelling, is it using what it thinks, is it using a unit price based on this locality? I mean, there is real complexity. You go out in the bush and there is a whole swagger of issues that come into play versus doing - - -

DR KING: As we have.

MR ZABAR: Yes. So you - so the question of - so the principle - you are right. The principle is correct. As long as it is funded, the question will be is what is that funding model that is used to determine the price? And I think that is where it becomes contestable. Most of, you know, colleagues of ours in the public service will argue that they do do their best to work it out, but you know, there are assumptions and presumptions that underpin all of that modelling, and some of that is right and some of it is less right, and so that is the question around it - but the principle, more than happy to go with that.

MS DE CHASTEL: And I think we are seeing in the NDIS space where the pricing has been set, as Joe said, through a whole lot of modelling which is not always transparent, and I think your Commission's latest report actually recommends that that be put into an independent pricing authority, to actually really make that process transparent, have better consultation with providers, to actually understand the real costs.

Because often in the rural and regional areas, for example, those costs are massive in terms of travel and staffing, and they are not factored into that modelling, which is often universal modelling, it is not location-specific.

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So I mean, I think if the NDIS is looked at as a model, having that independent pricing, we would probably support that if it is open, transparent, and there is consultation with the sector in doing that.

MR INNIS: And just to confirm, the concern about the B question is really about for-profits coming in and effectively cherry-picking, is the language? That's the concern?

MS DE CHASTEL: Yes, that is what is happening in the NDIS as well.

MR ZABAR: And that is the fundamental concern. It is the cherry-picking, but it is the impact of that cherry-picking.

MR INNIS: Because that cherry-picking would lessen your ability to cross-subsidise?

MR ZABAR: Well, that is one of the elements, but also it further fragments the system. So if you pick up - for example, you could cherry-pick on a locality, for example, or you could cherry-pick on a service stream.

Now, if the private sector cherry-pick a particular service stream, then the capacity to join up that service with other things might be impaired. Now, I'm not - I don't have any evidence to say that is what is happening, but that is all I am getting at. The extension is beyond just, you know, we don't get access therefore we can't cross-subsidise.

The question that sits out there at the moment is, if you cherry-pick to the point of exclusion then it might be much harder to do the wrap-around, and I think that is one of the key issues that we have been concerned about, is how do you create wrap-around as the system becomes more fragmented?

Because the people that need support need holistic support, not bits and pieces. Someone has got to pull it together.

MR INNIS: And I know what you mean by that. I just want to ask - - -

MS DE CHASTEL: Can I just add to that? One of the other issues, I think, and that is that we find that with for-profits often there is a much bigger scale in their services, so they can do state-based funding, for example, or even national, and some of our members are actually then having, like, subcontracting to those for-profits.

So - and I think the danger of that model is that you lose the diversity of the type of services, and what we are finding is that place-based services

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are much better positioned to actually understand the local community and the needs of the local community. So the larger-scale for-profits probably can't really perform that role as well as the smaller-scale ones. Sorry, yes.

MR INNIS: So the recommendation we have made is really directed at encouraging governments to focus much more strongly on the attributes that matter to outcomes for people. I am hearing that some of the attributes that really matter include the ability to connect services - - -

MS DE CHASTEL: Yes.

MR INNIS: - - - up, and we would agree, and that is one of the attributes we would argue government should look for, especially for vulnerable clients who have multiple needs. So it would - that - if governments could do that well, would that help?

MR ZABAR: Yes. I mean - I mean, we supported that recommendation about the sort of - the better mapping, but as we said in our submission, when that got put forward as a proposition all of a sudden we had other concerns that were coming into play. Now - well, you were around, you know what that was about. And so for me, that is the question. And that is, I think, part of the dilemma that this report has, is that there is an assumption that this could well, amongst all the various levels of government, to actually come together, and we know that that is tough.

And so - but the principle is absolutely spot on. That better coordination, whether it is at a government level or at a provider level, there has got to be the capacity at the provider level to do that. So that is the question, is whether it is best served there or at another level. But certainly place-based, and the work that Liz has done prior to Dropping Off The Edge and all that - all those indicators are saying place-based is the way to go, therefore locality and therefore having that system on the ground is actually the most effective way, but it is about how do you coordinate that in a way that is effective for everyone?

DR KING: Can I just follow up on that, actually, two points that you made just at the end there? Firstly on the place-based, because in your submission you point out that there appears to be a trend to contracts being awarded to large organisations, contracts covering large areas. Do you see the main cost of that type of approach being that there is less of a place-based service delivery? What do you see as the cost of doing that? How does it affect service users?

I take it that you view that in the negative, so I guess I just wanted a bit more there, to understand.

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MR ZABAR: Well, I mean, I will just - - -

MS DE CHASTEL: Yes, go first.

MR ZABAR: The big issue for me is that it depends what's driving that decision to do it, right? And that is what we have said in our submission. If you, as a government agency, are encouraging this collaboration and cooperation just so that you have got one entry point for a contract and you outsource the management, the risk, and everything else to that lead provider, if that is your motive then we have got it all wrong.

That is my point. That is the key point. If, however, in doing that mechanism you are doing it because you think there is a better outcome available for the end group, that is fine too. But there are some issues that come with that model, and that is - and Liz will be able to sort of explain more, but it is - there are effectively two parts to this.

One is that you are vulnerable to what we call the cookie model because, "Oh, it works in Ballarat, and therefore it is going to work in the Northern Territory," so they have a uniformity which then gets back to unit price et cetera.

And the second is you might actually undermine the diversity of the sector, because place-based arrangements might be more - you know, one particular area might require a unique set of skills or unique set of contributions which a cookie-cutter model might not be able to deliver.

So I am happy for Liz to add to that.

MS DE CHASTEL: Yes, no, I agree with that. I mean, some of the work we did in Dropping Off The Edge showed that the communities of disadvantage were all different. So they had different indicators of disadvantage going on. They are not the same, even though there is an expectation, I think, by government that all communities of disadvantage have got the same problems. They don't.

And I think the advantage of our type of services is that they work very closely with the community. They have been there for, you know, 30, 40 years in these communities. They know all the people in their own communities, how to, you know, as Joe said, link up with other services. They can report back to government. They are trusted in their own community. They have got those relationships.

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And to have an impact to change that community or to improve the lives of those people, having those sort of attributes I think is really important, which I don't think you can bring from a, you know, state-wide one service provider understanding the intricacies of those, you know, communities and regions.

DR KING: Okay. I just want to challenge part of that, because there is a slight inconsistency there, I would have thought, but I would have thought it is groups like Catholic Social Services Australia who have best understanding of who are the small organisations, the smaller groups on the ground, who can deliver place-based solutions.

MS DE CHASTEL: Yes. Yes, yes.

DR KING: I would have thought even state governments are very poorly placed - - -

MS DE CHASTEL: Yes, no, that's what I was saying, sorry, yes.

DR KING: Yes, so doesn't that then suggest that an improved way of contracting, which may also be cheaper for the government and bureaucracy - - -

MS DE CHASTEL: Yes.

DR KING: - - - but as long as there's time, as long as the funding is there, it may also be better for users, is to have larger contracts to perhaps an NGO, a not for profit such as Catholic Social Services, who then can subcontract, for want of a better word, down to the relevant organisations.

It is because - it is not clear to me that your - the problem you have with these contracts - I'm not sure - - -

MR ZABAR: There are -well, you may not, and that's okay. That's okay. I guess there are a couple of issues. One is that - and I will speak from my experience when I was in the UK, right? What we saw when we visited the UK three or four years ago as a delegation of not-for-profits that went there, and there was a couple of things that appeared in this report that has triggered this example.

So we went to see the equivalent of a premier and cabinet role there, and they said to me, "Oh, look, we are agnostic as to who provides the service." Right? That's sort of in here as well, right? And then they said, "Oh, and by the way, we have to slash our public service." You know, they were cutting by 30, 40, 50 per cent depending on which agency you were

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in. And lo and behold third party providers started coming into the mix, and then they had these what they call black box designs, which was they would come in and they would say, "Ah, it is all about outcomes."

And then what happened was that these big providers won the contracts, and then they outsourced or subcontracted to the smalls, but then it went on to say, well, the smalls won't get paid, because it is now outcomes, black box, and so all of the risk was shifted from the government to the main provider, and then all the way down - and we had an example where somebody there was saying, "Look, I actually had to invest almost two years' worth of costs before I actually turned a profit." After two or three years, basically.

And so that's the issue. And so they had a very large organisation, they outsourced, did all the right things, and that was the consequence of that example. And that is why I am a little bit nervous about it just being unsaid.

Now, this doesn't mean it can't be done, but I am just saying, that is the example that I was confronted with.

MR INNIS: Sorry. So it is a good example, and we have been quite conscious of those dynamics. In fact, it is the reason why we have gone down the path that we have gone down, which is to say the form of organisation is not what you are after, it is the delivery attributes of the organisation that you are after.

So I am not seeing, I hope, much difference in intent. It may be that your broader concerns about not-for-profits mean they should be precluded.

MS DE CHASTEL: Yes.

MR INNIS: We would respectfully not agree with that.

MS DE CHASTEL: Yes.

MR INNIS: But intent, it strikes me that what you are saying and what we intend is similar. The question for me is if there is concern that government will misinterpret what we say - - -

MR ZABAR: Yes.

MR INNIS: - - - what can we do to make that less likely?

MR ZABAR: Well, I think one of the responses I would have is to make sure that the unintended consequences are explained, so that it is clear that

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that is not the intent of such a reform. And so again, one of the drivers has to be - you have used the word, you know, consumer - well, it is not consumer-centric, but it has to be person-centric rather than government-centric.

MR INNIS: Yes.

MR ZABAR: And I have got to say, with all due respect, shifting from government-centric to person-centric in this system is really tough. So the problem will be, even as explicit as you might be in the expression, I think the drag will be the other way, and so how it then gets implemented might still be problematic. We still might end up in the result that we don't want, which is these big for-profits coming in and basically shelling out - because that could still be the consequence, and the question for me is, is that a good outcome, both for individuals but also the sector as a whole?

Because at the end of the day we know that for-profits don't really enter into certain spaces, because have a look at rural/regional, you know, who is there and who is not when it comes to services. And so what we are also worried about is that, as you go for big, you will actually then squeeze out the diversity that is also important in that community service environment.

That is the other dimension to all that. But I - but you know, we shouldn't exclude the conversations, in my view.

DR KING: Can I come back to another point that you mentioned, which again, I would like just to get your views on? You mentioned - I think it was around 2015 the publishing of service delivery gaps, and that got knocked back. You mentioned that in your submission and you raised it five minutes or so ago. And I understand that that was on the basis of privacy concerns.

MR ZABAR: That is what the recommendation - that is what the - I think the government response used the word "privacy" as being one of the issues that limited the capacity to do that.

MR INNIS: Do you - would you agree that there are issues with privacy - because we've obviously recommended it in our draft, a similar mapping exercise, providing the service gaps. Do you see privacy concerns being relevant there? And if so, how do you think we should manage them? How do you think we should recast that recommendation to make it more equitable?

MR ZABAR: Do you have a view?

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MS DE CHASTEL: Well, I don't think they're private, no, but I don't know how to re-do that.

MR ZABAR: I guess the real - - -

MR INNIS: So we should test the validity of that argument?

MR ZABAR: Well, that is what we would proceed to do, in the response. There may well be, in the nature of the data collection and analysis, because of the nature of the service and the cohort it may be easier to identify units or family composition.

So there may well be some legitimate concerns. Now, whether - it all depends how far you drill down.

MS DE CHASTEL: That's right.

MR ZABAR: But if you're doing a place-based, you know, I mean - - -

MS DE CHASTEL: There's ways around that too.

MR ZABAR: Around that, yes.

MS DE CHASTEL: Like the ABS data gets around that with small, you know, groupings.

MR ZABAR: Yes.

DR KING: Okay.

MS DE CHASTEL: I'm sure there's ways around that. You can do that, so - - -

MR ZABAR: Yes.

DR KING: ...(indistinct)...

MS DE CHASTEL: They do it all the time because of that issue.

MR ZABAR: Exactly, exactly, yes. So in principle we're very happy for that to happen. And again, we've been very supportive of those sorts of things, it's just that when this was raised once before that was the feedback we got, and it was actually - that was an interesting response to what we thought were genuine gaps that we sort of suspected, but that was the - that was that time.

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MS DE CHASTEL: It's probably for, like, DSS to look across other government agencies to see how they protect small-scale data, because there's precedents for that across government.

DR KING: I want to spend just a little bit at the end here on social housing, and one of the takeaways from your feedback and feedback from others is that we probably need some explanation around the driver of our recommended reforms. In a sense we are starting at the same point of realising that more than 50 per cent of households who are eligible for social housing are in the private rental market.

MS DE CHASTEL: Yes.

DR KING: It has been put to us, well, that means there should be a large investment in social housing. I'm not sure that that would be politically practical. I would hate to think what the numbers would look like there in terms of budget.

So I guess what we have tried to design is a system where we say, well, we may not be starting where we would like to be, but given where we are, how do we make the system work as best as possible for the eligible households?

And so that is why we have said, well, you know, you may or may not like the private rental market involved, but it is involved. You know, you may or may not like the fact that, you know, it's sort of a lottery, ten year waiting periods in there specifically to get into social housing, but that's where we're starting from.

We may think private rental costs are unaffordable, but over half of the households eligible are paying these high rental costs. So I guess that is our starting point, and clearly there is concerns about the level of payment, the increase in the CRA, but one of the real things I would like to get your feedback on, and the things that you mentioned in your opening comments and in your submission, is how do we - if we are going to have the private rental market as part of social housing, preferred or not as a reality if we have that, how do we make that private rental market work for those households and those individuals?

And I guess that is a knot we are faced to try and untie, and we would love your feedback there. You mentioned tenure. You mentioned just straight costs. You mentioned other barriers. You mentioned social barriers. So do you have a bit more - - -

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MS DE CHASTEL: Look, I think that's a really good question, and I think we acknowledge the fact that what you are saying is that there is just not enough social housing, and I think it would be good if the report actually probably went a bit further in that area, and just to say, look, we still think government should - or have a role to actually fund more social housing. And we know the federal government has got a lot of budget initiatives at the moment to try and increase that social housing. So that is great. So I think it is just having that in the mix is great.

With the private rental markets - and we have said it in our submission - people aren't on the same footing as they are in social housing, eligible tenants, and there is a lot of barriers there to get into rental housing, the short-term nature of it. They are open to price increases without really any debate about it. There is often these tenants need special housing, which they cannot get access to.

So there is a whole lot of barriers that currently exist in that area, so actually looking at how can we alleviate some of those barriers I think is one of the things that we would be recommending, and we know that some states are actually looking at their tenancy legislation to look at much more longer-term leases, you know, five year leases as opposed to six to twelve month leases, looking at, you know, giving more favourable consideration to low-income people because in tight markets they are often left on the bottom of the list, as you probably know.

So doing a whole lot of things around the tenancy arrangements I think is a really important step to actually look at protecting those people that are already in that market and have to stay in that market, as you rightly say.

The CRA increase, whilst I think - you know, I think you are on the right - we think you are on the right track by saying that it is inadequate. We would like to see a lot more understanding of how you have got to 15 per cent and if that is actually enough. We contend that it is not. We haven't done the modelling, but we know Anglicare has done - in their submission has done a lot of modelling on that which we would support and say, look, we would contest that that is actually enough.

MR INNIS: So there is a simple thing we use behind the modelling.

MS DE CHASTEL: Yes?

MR INNIS: That around 2007 rental prices started diverging from the broader CPI index - - -

MS DE CHASTEL: Yes, yes, that's right.

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MR INNIS: - - - which is used to index CRA. So we've basically just taken the difference between those two points and said we've got to catch up to at least 2007.

MS DE CHASTEL: Yes. Yes, yes, look, we agree that - and it's great that you've come up with an increase. We very much support that. But is that enough? And also the danger with that increase is that those rent increases will just be passed on, and that's - it's like a company going into a mining town and giving people subsidised rents. It just - - -

MR INNIS: No, it is not. No, it is not.

MS DE CHASTEL: You know what I mean? So I think - well - - -

MR INNIS: Those two things are not the same.

MS DE CHASTEL: Well, there is a lot of people in the private rental market, so I think that has to be looked at.

DR KING: Do you see a role - we touched briefly on it in the interim report. Do you see a role for government head leasing? You know, you can do tenancy reforms, which are in a sense over the entire private sector.

MS DE CHASTEL: Yes.

DR KING: The vast majority of people in the private rental market are ineligible for social housing. An alternative is to have the government step in and say, well, you know, like, the Defence Housing is another set of housing which we still have private ownership but we have under long-term lease. Do you see that as being - - -

MS DE CHASTEL: Yes, well, that - that would certainly give them a lot more protection, possibly longer-term leases and better maintenance of properties, and possibly better quality of housing as well, so yes, I think that is a good outcome.

DR KING: And the other area we touch on is the payment of - specific payment to households that have particular needs, requirements, for work, schools, for social reasons, family reasons, to be located in a high-rent area.

MS DE CHASTEL: Yes. Yes.

DR KING: Now, again, we are fairly light on detail on that.

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MS DE CHASTEL: Yes, yes.

DR KING: Are you able to fill in any of the detail from that? Do you think that would be useful? Would it work? And if so, how do you think it can work?

MS DE CHASTEL: I think that has to be done because of the - particularly in the cities, particularly where the jobs are for a lot of these people. They need to be close to public transport, to the job opportunities and education opportunities.

So how you set those rents is - that is problematic as well, but obviously there has to be some sort of premium, I think, for those people to be able to live in those communities. We are also concerned, and we said that in our submission, about people that already live in these high rent areas. So - and we know, you know, for example Redfern in Sydney, a lot of those people aren't there because of jobs, they're there because of their community, they've lived there, there is a lot of cultural historical links to that area. So I think we are very concerned about what this has for those existing people, not just new ones coming in.

MR INNIS: But these are people in social housing today?

MS DE CHASTEL: Or even, yes, in social housing today, yes.

MR INNIS: And the 10 year transition period that we recommend, does that help, or is that not enough?

MS DE CHASTEL: I think you have to recognise that existing tenants are there for a whole lot of reasons, and not just about jobs, so - - -

MR INNIS: So the 10 year transition is for all existing tenants.

MS DE CHASTEL: I think they should be able to stay there.

MR INNIS: Forever?

MS DE CHASTEL: Forever. If they're not there, they're on the fringes in Western Sydney, and cut off from family, friends, history.

MR INNIS: And a high needs payment couldn't recognise that?

MS DE CHASTEL: If it can be done properly, if it can be done adequately, fine, yes.

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MR INNIS: Okay.

MS DE CHASTEL: Just that there's not a lot of detail about how that works, so we are a bit concerned about that.

MR INNIS: I understand. I understand.

MS DE CHASTEL: But if the principle is there that it's recognising that people can have a right to live in those places, not just because of jobs, I think that is our concern. They are there for a whole range of reasons, so - and they should be able to stay there. That is a basic human right, we believe, so - - -

DR KING: Thank you very much for attending and being here today.

MS DE CHASTEL: That is all right. That is all right.

MR INNIS: Thank you, guys, much appreciated.

MS DE CHASTEL: Thank you. Good luck with it all. Thank you.

DR KING: Thank you. Now, the next organisation is Australian Healthcare and Hospitals Association. Thank you, Ms Verhoeven.

MS VERHOEVEN: Thank you, and Dr Thurecht.

DR KING: Again, if you could formally just state your name and organisation for the transcript.

MS VERHOEVEN: Sure. I'm Alison Verhoeven, Chief Executive of the Australian Healthcare and Hospitals Association.

DR THURECHT: My name is Dr Linc Thurecht, from the Australian Healthcare and Hospitals Association.

DR KING: And are there opening remarks that you would like to make?

MS VERHOEVEN: Yes, thank you.

DR KING: Thank you.

MS VERHOEVEN: So the Australian Healthcare and Hospitals Association is a national peak body for public hospitals and not for profit hospitals and other healthcare providers including the primary care sector. So primary health networks, community health services, some aged care

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providers, and also a range of academic and clinical individual members as well.

Our submission has focused largely on the health component of your report, so - and I'll talk a little bit to that this morning. We acknowledged in a number of submissions that we've made to you that the healthcare sector is very complex, as you would understand, with a mix of public and private service providers, public and private funding, and increasingly consumer costs associated with that. So that is part of the context in which we are speaking today.

We want to highlight right from the outset, too, our concerns around the information asymmetry between consumers and healthcare providers, not only in terms of the clinical attributes related to their care, but also in terms of cost.

So we think that places a significant emphasis on the principal agent relationship between the patient and the care provider. The complexity and the interwoven nature of the healthcare sector we think necessitates very careful policy design around reforms, and we think there is a considerable history where reforms have taken place with good intent but which have had unintended consequences that have been to the detriment of patients in particular, but also more generally the sector and the way it is organised.

We support the concept of well-designed reform. We support the concept of competition and choice, but we think that has to come armed with or backed up with strong government stewardship around that which is focused not only on ensuring competition and choice but on ensuring improvement in service quality, accessibility and health outcomes. So that has to come as part of that.

The more detailed examination of the nature of government stewardship in this draft report is welcomed. We think that has been a real development over the process of this inquiry. We remain, though, cautious about government and all governments' capacity to provide effective stewardship of the health system within the private sector in particular, because their policy levers and their capacity to actually steward the system in the private sector are limited.

And as an example of that, I would cite the limited control that government has been able to exert over private sector providers in terms of collection of data. So we know, for example, that private hospitals, private clinicians, have very little inclination to provide data to government in order for it to be able to design a health system which is actually focused on

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outcomes. That is a real limitation, and it must be addressed, fundamental, I think, to this work.

In our submissions to the inquiry we propose five objectives which we think absolutely must underpin the provision of health-related services in the public sector, whether that is by government-owned agencies, or whether it is contracted out or commissioned out to the private sector, not for profit or for profit, and so those five values I would just like to reiterate again and talk a little bit about them.

Firstly we think the absolute goal must be to improve health outcomes for Australians, and we know that there is a particularly increasing burden of chronic disease. The ageing population ensures that this must be really a focus.

We think a move towards a value-based healthcare model is something that will assist in achieving better outcomes at a lower cost, and we think that should be part of the next COAG funding arrangements, moving the system forward a bit.

The second value is to improve quality. So all services providing publicly funded care must be accredited and must be required to report clinical quality indicators, both public and private sector. That should be a condition of a contract with a private sector provider, that they are required to report data on quality.

We think the third condition is that any changes should improve equity. So funding must be based on universal healthcare principles, and an increase in competition shouldn't include an increase in health inequalities. It must guard against that.

Fourthly, we think changes should be aimed at improving efficiency, so a funding model that is measurable by health outcome indicators, and that applies risk-adjusted funding that is determined transparently and independently using independent pricing authorities, for example, to support affordable and accessible service delivery.

I would also suggest that that requires also ensuring that changes support better integration of health services, and not further fragmentation, and requires a focus on ensuring, as the previous speaker talked about, ensuring that cross-subsidisation can continue in the public sector and in the not for profit sector. Because the reality is, that is how services are provided in many communities across Australia and in many bush areas.

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And lastly, we would say the value around improving accountability and responsiveness, and that should apply both in the public domain as well as in the private domain, particularly around reporting of health outcome indicators that are both clinically meaningful but are also patient-centred.

To achieve those objectives, we think there are a couple of things that need to happen. So increased competition can only really be realised with appropriate transparency, and that is transparency from both sides of the sector, public and private. You know, frankly the private sector is not particularly transparent with health data at the moment, and that is a major limitation if we are trying to increase competition choice.

Secondly, we think that competition can only be realised with appropriate consumer health literacy. We know that health literacy in Australia, as in most western countries, is not as good as it could be. How do we support patients to have improved health literacy? It is around ensuring that they have access to relevant and authoritative health information. It is around ensuring that clinicians and service providers have an obligation to provide and explain that information to consumers. And it is also around ensuring that the principal agent relationship is actually focused on improving informed consumer choice rather than undermining that, and that is frankly what happens at the moment.

Health data has to be portable, and there has to be a greater focus on inter-operability. Some of the characteristics that we think you ought to be seeking are that data structures are compatible across vendor applications and use common clinical coding systems. Individual health data has to be maintained in real time, and that there have got to be appropriate safeguards in place for patient confidentiality and healthcare data to be secure, and for patients to have trust in that security.

Fourthly, we think the varying context in which healthcare is delivered means there must be a recognition that competition settings won't always work. For example, what is feasible in urban settings may not be feasible in non-urban settings. There has to be some place-based tailoring of approaches.

And lastly, the health sector is dominated, as you would appreciate, by fairly entrenched professional cultures and interests. Privatisation of services and greater competition should be focused on advancing consumer interests and better health outcomes, not on further enriching private health providers or on further advancing really very entrenched professional interests. I will leave it at that. Happy to have questions.

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DR KING: Thank you for that. A few areas that I would like to just clarify from your opening statement. First, slightly peripherally to this inquiry, is that issue of data, My Health Records, the move to making that an opt out rather than an opt in type of system, and the issues we have seen with that.

Do you think that is all moving in the right direction? Is My Health Records the right vehicle? Are we getting to the right place in that space, or do you think that we are still a long way from where we should be?

MS VERHOEVEN: Look, a couple of aspects in that. I think I do - we support opt out - a move to the opt out system. We think that is useful. If you look at the experience in the UK and the US, to actually ensure that there is a sufficient cohort of patients in the system for there to be then a sufficient clinical interest in the system requires an opt out mechanism, and there is data, you know, from the UK and the US, which demonstrates that.

It also requires, though, I think, moves - and this is happening at the moment, the work around interoperability, for example. Very long overdue. I don't know why this is happening in 2017. I sat in meetings, you know, 10 years ago where we should have been talking about this. And we were talking about it, but nothing was done.

So those - that has to happen. I think one of the issues, though, with My Health Record is it's a bit of a beast that's been constructed for maybe the early 2000s, frankly, and we are still trying to retrofit it to make it work in our environment. Meanwhile, consumers have moved on, and we have our mobile phones. Many people have their data on their phones, and actually want their phones to be interoperable with, you know, the clinicians, and this is actually about patients owning their data rather than clinicians or service providers owning data. I think until we shift to that mindset it is going to be really hard to actually have a valuable My Health Record.

But good indications around opt out, good indications, and we certainly see some real changes in the system. So only last week, for example, Queensland Health has made available a read-only access to general practice to see hospital data.

So that is a really good step forward, so positive steps like that, I am cautiously optimistic.

DR KING: Data is - sort of underpins any type of outcome measures, and so let me pick one of the areas that we looked at, which is the public dental. Now, we made recommendations, draft recommendations, focusing on

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outcomes and a movement towards outcomes, which need data to underpin them.

Do you think the sort of recommendations we have got, for example, in public dental, do you think they are practical? Do you think that they can work? What barriers do you see that causing? One that was raised, obviously, in earlier sessions are issues of privacy. You have raised the issue of, well, ownership or rights over data. How do you see them being played out if we move to a proper outcomes basis?

MS VERHOEVEN: Okay, so moving to a proper outcomes based data approach requires actually significant investment and work, and that is a space where government should be placing some effort, in our view. I mean, the dental collection - dental data collections are a classic example of failure in my view.

Firstly, there is very minimal private data available. It is selectively made available to the collections at the whim or wish of private providers. There is a series of public data collected, but that is largely focused on inputs and outputs, not actually on outcomes. It is particularly not focused on patient-reported outcomes.

There is some work happening in some public dental services around Australia, and Victoria is one of them, where there is a significant investment in redesigning not only the data collection but actually redesigning service delivery so it is focused on outcomes, it is patient-centred and it is outcome-focused.

And that work is really important. That is at the cutting edge of health data redesign work, and that is happening outside of government data agencies and government collection, so happening in services, and we should be encouraging and supporting that, and investing in it, in my view.

Do you want to say anything else about the dental data? You know the collection a little bit better than me.

DR THURECHT: Yes. I think there is a general recognition within the health sector more broadly of the importance of moving towards an outcomes-based framework. When you talk to people about that, they often raise the problems of trying to implement it, but I think if we look to the experience with what's been done in activity-based funding there is a very real opportunity to deliberately move towards an outcomes-based framework to try and get better value for the dollars which are spent in dental health more broadly.

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MS VERHOEVEN: Yes. I think you could also say if you looked at some of the work being done internationally - so in a couple of countries, for example in Switzerland, the Netherlands, France, there has actually been some moves to incorporate service-based outcomes data into the national health data collections. We would really like to see that happen, and for governments to actually shift their focus from collecting, you know, input and output data actually to focus on outcomes data.

DR KING: One of the - just to follow up on that, one of the issues that we have raised in the report is using that data, the outcomes framework, to come up with a risk adjusted type of payments model, for example, in dental. It has been put to us by others that that would not necessarily be practical, but it would lead to cherry-picking.

Do you think it is practical? What do you see are the risks of that sort of approach to get a risk-adjusted payments model? Or are we simply shooting at something that's nice in theory but impractical? I'd really like to get your feedback on that.

MS VERHOEVEN: Linc, I'm going to hand that one to you.

DR THURECHT: Well, I guess the key thing there is patient selection, and whether it can be selective, or whether it is based on some sort of catchment area or some sort of natural process there.

I think it is informative to look at what is happening with Healthcare Homes, where they are specifically picking a risky cohort of patients. Certainly they have needs. But to think about the kind of - in the payment model that has been flagged in the draft report, if patients can be selectively treated under that payment model then there are risks to sustainability in actually achieving a broader public objective.

But if patients go into the model from a broader group, then you get the naturally sort of insurance effect of having a cross-section of risks, people enrolled under that model.

MS VERHOEVEN: I'm glad you highlighted the Healthcare Homes issue, actually, because I think there is actually lessons to be learned from what is happening in the US on medical homes. So the model that has been put forward here is really - it is confined to a group of six - at least in the first phase, 65,000 patients who have two or more morbidities that are really high-risk patients.

And you know, there is a set fee associated with those in three tiers. Whereas if you look at the medical home model in the US, that is actually

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for a practice's entire cohort of patients, including the less unwell, and there is a cross-subsidisation there which happens, and that makes that model sustainable. It actually makes the model more innovative, because it allows providers to look at alternative ways to provide services to different cohorts of patients.

It moves beyond - I think the model we have got here is very much thinking about a patient seeing a clinician, a specialist clinician often, for a particular purpose, a face to face encounter. In the US, in the medical homes, they are looking at emailing encounters, there are group patient encounters, there is different levels of professional interaction, so you may not always see, for example, your GP. You might see your pharmacist, you might see a physician's assistant or a nurse practitioner. There is a much more devolved model of service delivery there.

So I think we have tried to replicate something from the US, but trying to wrap around, you know, frankly a 20th Century - 19th Century, even, model of service delivery. We haven't actually modelled all the attributes of that system in the design of the Healthcare Home, and I think that is going to be actually at risk. That is going to cause a risk around that model, and whether or not it is successful.

DR KING: So we have got to be careful about making sure that we get that team-based sort of approach. I guess we have partly flagged it through, for example, dentist hygienists and their role, and changing their role.

MS VERHOEVEN: Absolutely, and look, if you look at some of the work being done, for example, in some of the public dental services where they are looking at tele-delivery of services. So a dental hygienist or a dental therapist in a rural community being guided through an examination by a dental practitioner who may be, you know, based in a capital city somewhere, who may give some guidance around the type of service that needs to be provided, or a referral that's needed to be provided, but doesn't actually provide the service themselves.

Some of those models are innovative, and public service structures are using those already, but I really think we need to actually move - it's not as simple as saying, "Okay, we'll just, you know, put this out to a competitive market environment." It is actually about changing who delivers what services, and what we focus on is important too.

DR KING: So again, one of the points I wanted to clarify from your opening remarks follows up on that. You said, you know, competition will work in some areas and not other areas, and you mentioned outside urban areas. That is obviously one of the things we pursued in our dental draft

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recommendations, so a different system in the urban communities than outside.

Do you think - are we on the right track there? Is that something that we should look at further? Is it something that should be in other areas of health?

MS VERHOEVEN: I think we are on the right track. And look, if you look at what has happened, for example, in hospital pricing through the independent hospital pricing authority, while we have - while there has generally been a move towards activity-based funding, in order to maintain diversity of service and availability of service in rural areas we have had to maintain a system of block funding to complement that.

So I think right across, you know, dental and other areas of health service provision, while an activity-based funding approach is useful, looking at the particular requirements for delivery of service in rural areas is going to be really critical, because frankly people will simply miss out.

But that has to be - the flipside of that, I guess, too, though, is - and I did mention the value of quality. It's not just about availability of service. Part of the decision-making has to be around how we ensure quality of service delivery as well, and sometimes that relates to volume. Not always, but sometimes that relates to volume.

DR KING: Just last point of clarification. And again, this comes up from something you mentioned in your submission and something that you reiterated in your opening remarks, which is about the need for patient literacy, for user literacy.

One of the areas that you cover off in your submission is on end of life and the importance of awareness campaigns in end of life. How do you see those working? And are you aware of any overseas examples or other examples we can look at to sort of learn some lessons from about - particularly with regards to end of life, but more generally health literacy as well?

DR THURECHT: I'm not aware of overseas examples that I can refer you to, but I guess we see it as a general health literacy issue, that dying is going to happen, and it's better that it's planned for. And more broadly, we would hope that the agenda can be moved to normalise this process.

Specific overseas examples - sorry, I can't give you any referrals.

DR KING: No, that's fine.

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MS VERHOEVEN: Some of it, though, is about ensuring that we have structures in place so that conversations can actually occur meaningfully. So advance care planning is obviously part of that. One of the complexities in the system at the moment, and it is a complexity not only for patients but also for service providers and clinicians, is we have eight different pieces of legislation around the country around advanced care plans, so an advance care plan in Queensland looks quite different from one in Western Australia.

If Victoria moves to assisted dying legislation, it will look very, very different down there. So what do we do around that? And how do we support clinicians who might move from one state to another to actually work with patients and understand the legislation? How do we support families, not only - the carer might live in New South Wales, but the person for whom they are advocating for might be living in Tasmania. How do we support the legislation in that place?

So simple steps could be, you know, a focus on harmonisation of that legislation as a starting point, and that is the sort of role that governments ought to be playing. They ought to be stewarding the system so it works well for clinicians, for providers, and for patients.

DR KING: Yes. When you mention partnership in your submission between the state and federal and the territory government, that is the sort of thing you think of harmonising the legislation?

MS VERHOEVEN: Yes, absolutely. And look, I think the other area in end-of-life care is that, you know, we do have to actually empower clinicians and service providers to have conversations and encourage that as part of routine business with patients. So it is not just about the provision of clinical care, it is about the provision of care that is important to patients, so it is a shift of mindset. It is a cultural thing, maybe not solved by a Productivity Commission report. Yes.

MR INNIS: Thank you very much, guys. It is funny. We are in Canberra, and we all seem to be talking about stewardship a lot. Who would guess? Coming back to the stewardship question, though, we have talked a bit about, you know, some of these ideas are not new. They are not new. And they are generally accepted.

So what is missing? What is missing in the stewardship world that is not getting us from A to B?

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MS VERHOEVEN: I think one of the areas is around risk and appetite for risk. So the previous speaker spoke a little bit about transfer of risk from the public sector to the private sector, and I think that is actually an area of - you know, that I would say there is some real caution around.

We see that in the Healthcare Homes discussion, where there are general practices that are concerned about their, for example, taxation liabilities because of a changed funding mechanism for patients. Not immediately apparent, but it is a transfer of risk to a provider that they haven't had to, you know, have at the forefront of their mind in the previous way of working.

If I look at the way that primary health networks are operating and the commissioning of services that they undertake compared to when those services might have been purchased directly via - from the Department of Health via a contract arrangement, there is a transfer of risk, not only financial risk, but it is clinical governance risk.

There is a whole range of risks there that are pushed out into the private sector, and which frankly don't necessarily protect the interests of patients and consumers as best they might. So government stewardship around - particularly around competition and contracting actually has to take account of risk and where that locus of risk is, and how that is going to be managed in a way that actually protects the interests of patients.

It is not only about protecting the interests of government dollar and spend. It is about protecting the interests of the community. And that is where I would like to see, you know, their focus.

MR INNIS: And is there anything around structures of government? And if I can ask that across the broader health/hospital regime, the dental regime, given the significance of our recommendations? And then end of life, palliative. Is there anything around the structures of government which could help?

DR THURECHT: To me, one of the main problems I see - we are talking about stewardship, so leadership. And we are talking about Commonwealth/state/territory relations. To the extent that progress can be made, it is all short-term progress, whereas leadership and stewardship should really be much more about longer-term objectives.

And we have seen examples in recent years where unliateral action by one level of government really destroys a lot of trust, and certainly doesn't speak to a long-term sustainable vision. I mean, you talked before a lot

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about the importance we attach on moving towards an outcomes-based framework. That needs longer-term vision.

So where success has been achieved, it's been on a short-term basis, but really we need a longer-term vision and more cooperation, both sides of government and between states, territories and Commonwealth.

MS VERHOEVEN: I think one of the things in terms of structures is we do think having some independent organisations to oversight some of those complex areas of relationship between Commonwealth, states and governments and private sector would actually be beneficial. I think there has been sort of strong gains made in terms of pricing, for example, in the public sector because of the role of the Independent Hospital Pricing Authority. You know, an independent hospital funding authority or health funding authority might be a next step from that, where you can actually get people together around the table without necessarily the interests of their niche as being the driving decision-maker, but interest around making decisions to the benefit of all Australians.

So I think, you know, there has to be some consideration around that. I also applaud, you know, the work that has been done by the national agencies like the Commission on Safety and Quality, for example, on the atlas of variation in care. I mean, that actually gives comfort to providers that it is not driven by the interests of a particular government. It is actually a collective piece of work towards improving service delivery and better outcomes for patients.

MR INNIS: Terrific, and one final question, and again swirling around all of these issues. Looking at our recommendations across the areas that you are interested in, is there anything that you think we should be adding to them? Is there any area where - - -

DR THURECHT: Well, that's a big question. I guess what's happening in the private health insurance space can potentially have quite an impact on the kind of areas you've been looking at, so we wait with bated breath to see what's happening with those processes.

MS VERHOEVEN: I guess I'd probably suggest that big areas of concern for me is the growing out of pocket costs for consumers in Australia. So your report really comes from a lens of how can we improve competition and choice, but we also ought to be focusing on user costs, and that is the fastest growing area of health expenditure in Australia at the moment. It is not actually government expenditure that is growing at sort of unsustainable rates, it is user costs are growing at unsustainable rates.

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There is one area that I think we have not focused on very much at all in the health debate, and that is on the provision of specialist medical services and the costs associated with that. That, I think, is driving a significant portion of health costs, and it may be something that's worth looking at.

Dental sits outside, frankly, the Commonwealth government's interest for most of it, and we also ought to make sure that dental - I mean, dental is really critical to our overall health and wellbeing, and we ought to make sure that that is actually part of a national focus, not just left to the states and private sector to have responsibility for. So yes.

MR INNIS: Thank you.

MS VERHOEVEN: Thank you.

DR KING: Thank you both very much.

MS VERHOEVEN: Thank you very much. Thank you.

DR KING: I think we will just take a 10 minute or so break, and grab a cuppa, and we will re-start at - I'm just trying to look at what time. Do you have an accurate time? I know my watch is fast.

MR INNIS: 10 past 11.

DR KING: Start at 10 past. Thank you.

ADJOURNED AT 11.00 AM

RESUMED AT 11.13 AM

DR KING: So the next organisation is Baptist Care Australia, so I think four chairs, four reps.

MS BALZER: That's right. It's a team approach. One of our team members still has a biscuit.

DR KING: My benefit is I will …(indistinct)… one biscuit before starting.

MR LINDER: You didn't skimp on bickies.

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DR KING: They're good bickies. They are good bickies. If you could please just state your name, organisation first, and then names just for the transcript so that you can be identified by voice, and then just give a brief five minute presentation.

Just as a reminder for everyone, the microphones are just for the transcript, so we were asked during coffee break if we can speak a little bit louder. Apparently we are not as soft as yesterday, but apparently we were very soft yesterday, so - thanks.

MS BALZER: I am from Baptist Care Australia. I am Marcia Balzer, the executive director.

MR LINDER: And I am from Churches Housing Incorporated, and my name is Magnus Linder. I am the executive officer.

MS LENNON: My name is Donna Lennon. I'm from Baptist Care New South Wales/ACT, and I'm a care improvement consultant for residential services.

MS ROBINETTE: I'm Hayley Robinette from Baptist Care Victoria, and I'm an operations manager for family community services.

DR KING: Good.

MS BALZER: So I'll just do a brief overview, if that's okay? So thank you very much for the opportunity to speak with you today. As you will have seen from our submission, Baptist Care Australia and Churches Housing have put forward some comments on some of those - the three reform areas where we have policy and operational expertise. So that is end-of-life care, particularly as it relates to aged care; social housing; and family and community services.

In general, we strongly agree with your analysis of the current approaches to human services in those three sectors. We really strongly applaud the priority you have placed on meeting the needs of service users, and turning our attention away from governments and providers and on to the people who use our human services to improve their lives.

There has been chronic under-funding and decades of neglect in the social housing sector. Governments have been unwilling to address and fund end of life services, particularly for our growing number of very old and very frail people.

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Family and community services have been hampered by short-term approaches and poor contracting practices by government, so we really agree with your analysis there. There has also been inconsistent approaches across jurisdictions in all three of these sectors, and that has been quite marked.

A number of the solutions that are mentioned in the draft report could significantly improve the experience and outcomes of human services users, and we have talked about those in our submission. However, we are strongly of the view that increased competition and contestability have considerable risks, and our main concern is that those who would ultimately pay the price of poorly implemented reform, poor government stewardship and inadequate funding, will in fact be the service users, who are amongst the most vulnerable people in our society, and not the governments themselves who may have been responsible for poor implementation.

The status quo that we currently have is already extracting a price from service users, and we acknowledge that, and we understand - you know, and as I said, we agree with your analysis of what some of those shortcomings are. So we really applaud and support moves for reform in these three sectors.

However, we think that a less risky approach would be to implement smaller-scale more manageable reforms that would deliver results gradually over time without running the risk of kind of wholesale dysfunction and the impact that that might have on some of our really vulnerable people in our communities.

Finally, the issue of ongoing inadequate government funding for human services can't be ignored. Governments have a track record of viewing competition and contestability as a way of further reducing the funds allocated for human services, and funding could certainly be provided better value with a stronger and more consistent focus on outcomes. But if we are serious about making life better for service users, adequate funding is an essential part of the picture.

We would definitely want to see better - we definitely want to see better results for service users. The lower risk reforms that we are particularly keen on, and that we think could provide real value to service users, include better government funding, stronger government stewardship, stronger focus on the consumers' needs, better contracting practices along the lines you have outlined, and increasing reliance on outcome measurement for planning, delivery and evaluation of human services.

That's it.

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DR KING: Okay, thank you. Just one point that I wanted to clarify, and then I'd like to just ask you about some areas that you cover off in your submission, and really so that I make sure that I understand them. Just the first one. On stewardship - and you raised this in your submission as well, and you raised it here, you have concerns that, in a sense - well, I would like to understand your concerns about the way that the reforms are implemented.

It appears that you feel that it would be more beneficial to do a more - perhaps smaller, shorter reforms, and I just want to understand that. I guess in some ways I see our role as being to say, well, here is where you want to end up, and in some areas obviously we are quite light on implementation.

I just want to understand. Are we actually looking at the same thing from just different perspectives? Or do we have fundamentally different views on how reform should work in this space? How do we get those benefits, witnesses? So - - -

MS BALZER: So I think - I think really what - the focus that we have taken is when you are looking at those - those really enormous reforms that you are really looking at, I think you have pointed out in many of those cases how far away that is from where we currently are.

And I think, you know, government services are not easy to change, and things go wrong a lot. So from our perspective, from a kind of on the ground provider perspective, we really see that - we are really worried about what the result of those, you know, things going wrong might be, and you know, while what we've got isn't great, we acknowledge that, and where we would like to go, you know, is better, but I think that it's the size of the change that is a concern for us, and how that might be implemented.

So for example, you know, our - Baptist Care Australia - and these guys might have some other perspectives on this question as well, but our Baptist Care Australia members who are currently involved in implementing consumer-directed care in home care for aged care, that hasn't been smooth, and it hasn't been easy, and not everybody is better off.

So in a sense, just in that - compared to the kind of reforms that you have then - the picture that you have painted in your draft report, that is a miniscule kind of reform, but has an enormous impact on real people's lives. So I think it is the scale that we are really - that we are most concerned about, and the other - does anyone else want to comment on that? No?

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MR INNIS: So Marcia, one of the things we were quite conscious of in doing particularly the family and communities reforms and the end of life reforms was that we are on a long-term change process, and in fact for families and communities in particular we didn't think, for a whole bunch of reasons, that sort of, you know, revolutionary reform was the right path.

Instead we wanted to work largely within the existing system. Is that still worrying you as being too big a set of reforms to handle from a sector perspective?

MS BALZER: Hayley might have a view on this, but I'll just - I'll just make a comment if that's okay. I actually think it is about the cultural changes in governments that's the challenge, with - I noted that that did make our decision, and which of course, as you can probably gather, we agree with, in relation to family and community services, and certainly obviously there's a lot going on in reform in aged care, and you know, I think it's already been flagged that we need to do better with end-of-life care as far as funding structures and all of those things.

So I think that process is kind of underway. Hopefully that will actually end up where it needs to be. But I think it is about those kind of - the changes, and also in family and community services we have a mixed model. So we have different funding sources for different jurisdictions as well.

So most organisations that work in family and community services have some level of federal funding and some level of state funding, and if you're a national organisation, that's multiple states, so that's multiple cultural changes, that may not be consistent, given past history.

So I think - I understand that you've kind of accepted, you know, a smaller degree of reform than perhaps you would otherwise have done, but I still think that's still a pretty - it's still a pretty big change, given where we are, that's all.

So Hayley, do you have something to add there?

MS ROBINETTE: I suppose just thinking from the Victorian perspective in regards to family and children, particularly the family violence space, that when they initially - there was the move towards reform as part of Roadmap to Reform but also the Royal Commission Into Family Violence, wanting to develop the safety hubs.

And having so many different departments not necessarily communicating that well with each other, but the sector was communicating

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well, that there actually became a number of iterations of proposed safety hubs, and it was actually the community sector saying, "We need to slow this down, because are forgetting the child in that space." Because we were looking at amalgamating Child First, Family Services, Family Violence, which are fantastic. We're going to support mum, we're going to support the family. But what specifically about the child?

So I do take on, I think, that measured approach, and I suppose what we are probably seeing across the other areas, we want to make sure that it's a measured approach as we do move forward. We see that the end goal is that greater reform, but we want to make sure that we're not missing anyone or leaving anyone behind in that space.

DR KING: Is it mainly in family and community services, or is it across all of the areas? So to pick up - let me just pick another one. You mentioned residential aged care facilities in your opening comments. So - and we've got a range of reforms for end-of-life care and residential aged care facilities.

Do you see those sort of reforms as raising the same type of risks and, you know, in a sense, there being a big bang risk in terms of reforms? Or is it really in the family and communities where you are dealing with just those multiple different government stakeholders?

So just understanding, coming purely to the part of - - -

MS BALZER: Yes, so I think in aged care there is already a reform process underway. So I think that kind of we have got some - we have kind of got a consensus. We have got the Titanic moving in a direction, and hopefully the Titanic will end up where it needs to be in the long run.

I think where we are particularly concerned about vulnerable people would be family and community services and social housing in particular as well, so I think that there are a lot of those - a lot of the recommendations relating to social housing that we were quite concerned about in - and because we also - I mean, in social housing obviously you also still have that state/federal difficulty as well.

So I think - so I think that's right. I think that we have kind of a different level of concern in the different sectors. And Magnus might be able to just talk a little bit more around the social housing if you would like - - -

DR KING: Please, yes.

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MS BALZER: Yes, to talk about the concerns in the social housing sector.

MR LINDER: Yes. So I think I was encouraged to see some of your recommendations regarding public housing, particularly in regard to seeing state governments becoming more accountable and transparent, and in fact being judged by the same criteria as community housing providers, and in fact just as I was coming in I was reading a joint statement by some of my fellow peaks, some of whom you are going to be speaking to later today, where we have actually come out with a joint statement regarding Commonwealth funding for housing and homelessness, and we are just in the process of sending this off to our state government leaders, including the Treasurer and the Minister for Family and Community Services, and basically we are saying the same thing, is that, you know, greater transparency and equal accountability for the providers of public housing should be also, you know, the same as community housing providers.

I did also express a concern that the current Housing Registrar's office is under, you know, family and community services umbrella, and so I think that that's definitely a conflict of interest, and that would need to be perhaps a more independent, you know, government body, without any, you know, undue influence from family and community services which, you know, now control - Housing New South Wales doesn't exist as a department anymore, and so these sorts of things, you know, across governments there needs to be that separation, and more than likely a re-engagement from federal government to be part of that national registry system so that it is one system, you know, and that any problems on the - you know, on that bigger macro level are ironed out, and there is accountability that is built in.

I think for many of us, we feel public housing has been a very slow-moving train wreck, with, you know, ongoing lack of investment in that, and I suppose, you know, the changing nature of the clientele, you know, increasingly have become the housing hospital, like the bottom of the cliff, and so, you know - and the lack of revenue that is then generated.

I think there would be a lot of arguments to say that perhaps, you know, if you are looking at productivity and increased effectiveness that perhaps, you know, government should get out of that provision altogether and simply hand over community housing - you know, public housing to community housing providers.

MR INNIS: Thank you, Magnus. Can I ask a question about that, because - - -

MR LINDER: Yes.

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MR INNIS: - - - a number of community housing providers or peaks in that area have made a similar comment. Two questions. Question number one is, those transfers that are talked about, are they transfers of the assets? Are we taking an asset that's on the public book and putting it on a not for profit, but a private book? Question number one.

Question number two is, who becomes responsible for ensuring that there's enough either places or subsidies available to meet the future needs of new clients? So I can understand what people talk about, the existing client base, but tell me how that changes - would change the responsibilities for meeting new client need?

MR LINDER: So the answers are "no" and "nobody". The assets - New South Wales Treasury, particularly in this current round of 18,000 transfers to the community housing sector. The assets will remain on the New South Wales Treasury books, and they are very protective of those housing assets, and I think that, yes, it is - that is an issue in and of itself, in the sense that in the past we have seen, you know, shorter-term contracts of - for managing those assets, which have not been particularly well-received by the banking or finance sector, and therefore, you know, it has had very little value in terms of being able to leverage some of that income stream and to be able to renew or, you know, rebuild or simply to build new stock.

And I think that's - you know, that's the big question. How do we, you know, get more stock? How do we get more investment into the sector in a sector where, you know, we have seen a complete under-investment for so many years? And we make the comment that, you know, it's - if we want productivity, you know, one of the key factors of course is that we have got to - we have to invest first to actually get those productivity gains.

DR KING: Sorry, can I just - - -

MR LINDER: Yes?

DR KING: I just want to clarify. So the current policy isn't to change ownership.

MR LINDER: It's to change management.

DR KING: If you were running the system, would it be a preferable system to have ownership changed as well to have the management?

MR LINDER: Yes, yes. And I think there are some ground rules that can be laid in terms of how those assets are treated, and you know, to protect those assets in perpetuity as, you know, social and/or affordable housing for

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those particular uses, and that even if land or buildings are bought and sold that there is, you know, a caveat that basically says that those funds are to be used for capital - new capital acquisitions, et cetera.

So I think there - you know, there are lots of rules that could actually be implemented to protect, you know, those assets to ensure that, you know, they remain in perpetuity, at least in dollar value, as social-slash-affordable housing.

DR KING: Can I explore that a bit more? Because - - -

MR LINDER: Yes.

DR KING: - - - social housing isn't my background, but - and the model you have put has been put to us by a number of community housing providers, and it tends to be the exact opposite of the world I come from, which is the utilities type area, which is - the big risk is when you actually pass the asset over to a non-government provider.

MR LINDER: Yes.

DR KING: Because then if you have got a lack of performance it is much harder to say, well, we no longer want you to manage this asset, gosh, you own it. It's much easier if the government retains that ownership and say, "Look, you're just not doing a good job of management, sorry, we need to replace you."

So I want to understand why that sort of logic - - -

MR LINDER: Yes. Well, I think there are two things there. One, we do have the Registrar overseeing, which is actually, you know, in terms of Community Housing Registrar, it's actually quite more onerous than even the aged care sector, in terms of, you know, the oversight and accountability within that sector.

And so I think that - and I think we also need to recognise that at the moment things are broken to the point where it's - you know, it's not worth maintaining. So you know, governments themselves have failed to re-invest and develop and to grow, and there are many, you know, old, ageing assets that are crumbling around their ears, and they have very little program to do anything about it apart from selling off stock to actually pay for the maintenance of those assets.

And so what we have got to say is, well, we have already seen the failure that we are somehow worried about may happen, you know, if not

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for profit - the not for profit community sector comes on board. Well, I'm just kind of saying that we're already seeing that failure anyway so, you know, the risk of doing nothing is actually a significant risk all of its own.

MR INNIS: Can I ask a question - so still swirling around social housing for a little while. So some of those dynamics are apparent to us, and in my dim dark past I was responsible for Commonwealth housing programs, including $6 billion to spend on social housing, which in a fairly short period later we're all saying didn't do anything.

So the question for me, and I guess the issue that - one of the issues that caused us to say, actually a better system would be place the financial support in the hands of the tenant, was that we seem to be stuck in this housing game between the public housing and the community housing providers where we are not seeing stock generation.

And we thought it would be potentially a fairer system if people - and there are many more people eligible for social housing technically sitting outside the system in private rentals than inside the system - it would be fairer and quicker to give the money to them and unlock the choice they have.

I agree, there is a reasonable question about how much financial support is needed. I understand that, and the high needs payment was intended to allow state governments to have some flexibility in providing appropriate levels of support, but I am just - I guess my big question is, given the history, why do we think a supply-driven solution is going to start effectively addressing the inequities that exist between people who happen to be in social housing today and people who are eligible who are not in social housing today?

MR LINDER: I think it is - we need to take into account the relationship between the private market of housing, which of course particularly in Sydney and Melbourne has seen, you know, tremendous growth, over 70 per cent in Sydney, 70 per cent price increase in five years with 13 per cent wages growth in that five years, and so that is a significant dilemma.

And I think looking at purely supply of housing as an answer to, you know, the cost of housing, I think is a gamble for government if you were to invest in it, because a lot of that money that you could be putting into that private market could be gobbled up and see prices rise commensurately with whatever money it is that you're putting in.

And so - and this has been our message to the New South Wales state government that actually, you know, the supply which they laud, you know,

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they have had record supply, and I agree, it is part of the answer, but in that year of record supply that we have just seen, we have also seen 13.5 per cent increase in price of housing and land.

And so, you know, we are part of a global economy. We also have billions of dollars of federal taxation incentives which actually makes this market not purely one of supply and demand. There are a lot of other influencing factors, and not all of them even within this nation. There are many, you know, global factors that are influencing it, and so it becomes a very, very complicated market.

And I think that there is a danger of trying to meld the two together. What we need more than anything in places like Sydney and Melbourne is actually supply of long-term affordable rental housing, you know, housing that is set aside for longer-term rental.

And so simply having more and more supply, supply, supply, you know, has not dampened the enthusiasm of investors and others to pour their money and to see both prices and rents actually skyrocket.

DR KING: Can I follow up on that? Because I think we are not far apart in terms of our starting points on my reading your submission and what you just said there, in that our starting point was more than 50 per cent of the eligible households for social housing were in private rental accommodation, and when you come to that starting point you say, well, the problem is not necessarily build more social housing, but that - which is unlikely to occur. The problem is to try and make the private rental market that the individuals and households are already in work for them, and I think that is what I just heard you pretty much say in slightly different terms.

We mentioned things like head leasing and the potential for longer lease, the potential for government to stand between the private owner, renter, landlord, I should say, and the renter. Would you be in favour of those sort of reforms or innovations? If not, why not? And what other reforms would you see to be able to get over this problem?

MR LINDER: Yes. Yes. I think a genuine reform that I would love to see is a reform that basically takes long-term rental housing to try and view it as a separate market, in a sense, from the short-term capital gain driven investor market with, you know, a lot of very small individual investors with multiple properties all, you know, different cities across Australia, to, you know, is it possible to actually create a long-term rental market here built on longer term investors, larger investors, institutional investors, that will be happy to see, okay, if we can get a more guaranteed regular return

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for the next 20 years we are going to be happy, rather than a short-term capital gain with lots of, you know, ups and downs that it may or may not happen, and places, you know, at the moment, you know, a lot of people are getting worried because of the state of - you know, the parlous state of what may happen in the future, and so people are realising that, wow, even a few percentage points in interest rate may see a lot of people in trouble.

And so, you know, what would happen if we actually said, "Okay, what if we try and create a market that kind of locks in this as a long-term investment vehicle that is there for rental housing?" And you put that, you know, investment that you are talking about for the consumers, and you direct that investment towards these longer-term much more stable, you know, investment vehicles, stable for both those long-term institutional investors that can actually say, "Yes, we can - you know, with some government backing and support to create" - you know, especially if it's new, obviously need some government guarantee or support around that investment vehicle to say, yes, we can see that, you know, you are going to get the desired percentage return, you know, and it's going to be based a lot more on cash flow, rather than on a capital gain projection on those properties.

Because by the time that investment is done, perhaps it's time to rebuild those properties anyway.

DR KING: Just to clarify, so you see that as a solution for social housing, and/or for more general rental affordability?

MR LINDER: And affordable, yes, yes. I think general rental affordability for - you know, because I think, you know, the pressure that we are seeing at the bottom, you know, and as the church sector we are very concerned about the most vulnerable people that are getting crunched at the bottom, but it would be very remiss of us not to realise that the reason that they are getting crunched is because everyone above them are also kind of getting crunched, and so we need answers actually across the level, and so I would say that, you know, workers on low incomes, and even up to - you know, in Sydney and Melbourne, even workers on moderate incomes, you know, you can be earning six figures in your household income and still can't even contemplate purchasing a house now because you're already paying rent, and there's just no discretionary income left.

And so, you know, I think we do need to think seriously about the impacts of those sorts of things on the broader economy.

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DR KING: You mentioned Melbourne and Sydney before, and I do get worried that - Melbourne and Sydney is a big part of the country, but it is less than 50 per cent of the population still.

MR LINDER: Yes.

DR KING: I do get a little bit worried that we let Melbourne and Sydney drive policy for the rest of the nation. So if you said - ignore Melbourne and Sydney. Let's look at, you know, Brisbane where property prices simply haven't increased by nearly the same extent that they have in Melbourne and Sydney; Perth, where they have dropped; Adelaide, where they have been flat for years; Hobart, where they have been flat until very recently.

Is it really in some ways we need a different solution for Melbourne and Sydney? So would the sort of approach that we're looking at, where we're saying, well, recognise the private market, try and treat equitably between social housing and those people who can't get into social housing but are eligible and are in the private market, would that work in a sense outside those two high rental systems? Are we letting the tail wag the dog here on social housing?

MR LINDER: I'm not an expert on the other capital cities, but I can certainly say that regional New South Wales and regional Victoria both really suffer the same problems as Sydney and Melbourne, largely because, you know, of reduced income levels, and so there is actually a huge under-supply of affordable rental housing right up and down the coast of New South Wales, and many of the regional hubs in Victoria as well, it becomes very difficult for people on low and moderate, you know, incomes to have an affordable and secure place to live.

DR KING: I'll have to move off housing, so - - -

MR INNIS: So one more on housing, I guess. At the heart of our recommendations is a view that where you can empower choice, you should. And I guess it applies in housing, but applies across all of the areas we've looked at in this inquiry, and I just wanted to get your views about how important that is for the people that you do focus on, accepting that choice is not right for everyone? We all know that we have people who are not in a position to make good choices for themselves, but when we are talking about the broad sweep of social housing, we are talking about a lot of people. Would more choice make them better off?

MS BALZER: I might just answer in general, and you can go for the specific on the housing stuff, if you want to? Okay. So the answer is yes,

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we do think user choice is a great thing, and you know, it is really important for people who use human services across the board to have as much choice and control over what they do and how people address their problems as they can.

I think unfortunately with the systems that we set up to do that, often that means that the more - what we have - this is just anecdotal, so I don't have any data to back this up, but anecdotally what we are seeing in disability and aged care home services is that those who have more advantage and support already get more choice, those who have less support and advantage get less choice, because - often because providers are saying, "I choose not to service you."

So unfortunately - and that would then be - you could see it could be easily translated into complex disadvantage as well. So complex needs, where you have got multiple needs, kind of need to be cross-subsidised, and if the, you know, individual user-based system doesn't allow for that or doesn't provide an incentive for that then it's those people with the most needs who kind of can drop off.

So I realise that's not the intention of the system, but that seems to be somehow how it happens at the moment with the systems that we're currently - the new systems that we're currently, you know, rolling out. So I guess that's our concern, because obviously, you know, we want us to be focusing on the needs of the service users. That's - you know, that's kind of a core thing that you do when you're involved in human services, or it should be. It's about them, it's not about us.

But the systems that we try to set up to do that on a macro level, somehow there seem to be some cracks in it. So I guess that's a complicated answer to your question, but particularly in relation to social housing, Magnus might have a few more comments.

MR LINDER: Yes, I'd just comment that two third of public housing tenants are either pensioners or disabled in some way, and so you know, I think choice can be empowering to lots of people, but for them, for many of them, they cry out for stability and certainty, and you know, a sense of security and safety, and being able to belong within a community with their existing relationships without have that threatened, that is perhaps more important to those people.

I think that level of choice can be really, really helpful for people that are, you know, a single mum that, you know, perhaps has escaped domestic violence getting back on her feet with a child, you know, and being given an opportunity to make choices and to actually move to an area where she

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feels safe, to a place where it provides opportunities for the needs of her child or children for, you know, an area where she might be able to get that study.

And she then becomes, you know, the driver of her own destiny, rather than being stuck in whatever unit of housing that she's been allocated. I think that would be tremendous for her, but I think too that, you know, for some people that they just want to be left alone and have certainty and security.

So I think there's not one answer that I see to that question.

DR KING: Just wary of time. There were a couple of things that we wanted to follow up from your submission, but it might be best - I'll flag them and then perhaps we can come back to you. Just you mention that Bapt Care has developed organisation-wide approaches to outcomes measurement in your submission, and we'd like to understand a little bit more about that. I'm not that far ahead, I'm sure Sean's watch is slow.

You also mentioned examples of effective regional planning in Victoria, and I'd like to understand that a little bit more. One that I would like to follow up now, though, is for talking about aged care facilities, and you made a comment in the submission, I think it's along the lines of that these facilities more resemble a hospice than a home, and I wanted just to understand that a little bit more, and what the implications are of that, and how does that then fit in with our approach to end of life, which is in a sense saying, well, your residential aged care facility is your home at the end of your life, and so you should be accessing the same sorts of services.

So just would like to understand that a bit more, and make sure we haven't gone off on a tangent which isn't in line with reality.

MS BALZER: So I might just make something general, and then I'll pass over to Donna. So that comment there came from the reference that is there, which is an editorial, so it's not a peer review, but it's putting it out there and talking about this change in the make-up of people entering residential care and, of course, how close they are to their end of life, much closer than they used to be, and with many more complex healthcare needs.

And so I just lifted the title of that paper and said, you know, is it - do we need to think of it more like a hospice than a home? So the traditional view is if you're in a residential aged care that is your home, and you're dying at home.

DR KING: Yes.

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MS BALZER: That's how it's been looked at in the past, but we've got this change underway, and so that editorial asks that question, do we now need to revisit what residential aged care is? And of course, you know, the implications of that change in the people going into residential care we have talked about a little bit in our submission, but of course that changes the whole - - -

DR KING: Dynamic.

MS BALZER: - - - dynamic of what residential aged care is all about. So that's where that sort of general comment came from, and that sort of seems to be how people are trying to get their head around this issue.

MR INNIS: But that's your practical experience on the ground? That you're seeing a distinct change in the clients coming through? Partly because the policy is, as I think it should be, that people who want to live at home should be supported to do so. And I guess we are interested in, you know, do our recommendations around end of life start to support that way of thinking, which seems to us to be what's happening?

MS LENNON: We certainly have people coming in much closer to their end of life than we have previously, and I guess in terms of delivering quality care to those people and choice about how they want to die, we need to get up to speed fairly quickly with what their needs are in a very short space of time, whereas previously we might have had somebody for two and a half years, so we could actually have those advance care discussions, you know, and we knew the residents well.

Particularly for people with dementia, we could know what their cues were for pain and those sort of things. So where we are moving to is a more rapid service, I suppose, in terms of palliative and end-of-life care delivery, and we haven't seen any changes from a funding perspective that actually acknowledges that.

So we have got palliative care as a factor in ACFI, which is a dependency-based system, but that is really a points-based system where if the resident is already at the maximum level of dependency there is no additional funding on top of that, so you know, that kind of reduces our capacity to be really flexible and, you know, deliver a breadth of care that those people deserve.

DR KING: I guess, just to back up Sean's question though, then our draft recommendations, are they in the right direction? Or in a sense - because the way we've done it is we've sort of said, well, community palliative,

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residential aged care should be on the same - members' hospitals, need for coordination. I just want to check that we're on the right track there and we shouldn't be saying, well, at home, residential aged care, different model again, hospitals if model but need coordination. I just want to make sure we're - grouping those two together is working?

MS LENNON: Yes, I think in terms of discussion around funding, perhaps, you know - I mean, we know that ACFI, there is a proposal reviewing ACFI at the moment, so there is a little bit of fluid space there where that acknowledgement could be made that in fact everybody who comes into aged care is palliative end of life at some stage. So that could be built into that structure there.

And I think in terms of monitoring the outcomes, again, we have got the draft quality framework in a fluid state at the moment, and again there is opportunities in there to say, well, look, if palliative care and end-of-life care is actually our core business, then there is capacity to have some good structure and some good monitoring.

DR KING: Sean, did you have anything else on that?

MR INNIS: No, nothing else, thank you very much for the whole - the evidence you've given, and thank you for that last bit.

DR KING: Yes, thank you very much.

MR LINDER: Thank you.

MS BALZER: Thank you.

DR KING: The next participant is the New South Wales Federation of Housing Associations and Community Housing Industry Association.

MR INNIS: I can't see them. Nobody's seen them. Which - - -

DR KING: So we could give Peta a call? I have their numbers.

MR INNIS: Yes, do you want to just - do you have numbers? Yes, just give them a call in case there's been a - - -

DR KING: Because they'll becoming from away, so there might be a flights issue.

MR INNIS: Yes.

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DR KING: All right, thank you for joining us. Just for your information, the microphones are just for the transcript, rather than for amplification, so if you can project your voice. We keep getting told off because we're far too soft to engage in a conversation.

If you could please just introduce yourselves and your organisation for the transcript, and then if you would like to give some opening comments?

MS WINZAR: Thank you. Good morning. I am Peta Winzar, the CEO of the Community Housing Industry Association.

MS HAYHURST: And I'm Wendy Hayhurst, CEO of New South Wales Federation of Housing Associations.

DR KING: And would you like to make a - just a five minute presentation to get started, or - - -

MS HAYHURST: I'll just give a very short synopsis of our submission. So we have made the submission on behalf of eight organisations that represent community housing providers across Australia, and the first thing I would say, we support the principle of putting users at the heart of the services, at the heart of housing.

And - but what we would say, and what the strong point that we want to make and have made throughout the submission is that one of the key reasons for absence of choice at the moment is the chronic under-investment in social and affordable housing, which the Productivity Commission recognised, but which I think, or which we think, unless that is addressed then it will be very difficult to increase choice significantly.

I just really want to highlight one example in New South Wales, where social housing at the moment is 4.5 per cent of housing. At current rates, looking at what is projected in terms of new supply to meet increasing number of households, but also looking at what's actually planned in terms of social and affordable housing, in 20 years that will go down to 1.4 per cent of all housing in New South Wales unless something is done.

We also want to emphasise that choice can be improved by increasing tenants' voice as well, and we argue strongly in our submission that at the moment tenants are really unable to exercise much influence over services, over whether their properties are transferred, and there is certainly considerable scope to increase that level of engagement that tenants can have.

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The extension of choice simply to mean that people can change their landlord is often not perhaps the most effective or cost-effective way for many low-income people. It's a bit of, like, a final bullet, I think. We want to see increasing their voice. Many tenants also may be unable to access the rental market, the private rental market, very easily. We highlight the needs of Aboriginal people in particular and the prejudice that exists and the lack of culturally appropriate properties there.

We feel that many of the recommendations have merit. We support the level playing field for tenants in different sectors. We do think that there is considerable work to be done to model the impacts of the proposed changes on rental affordability on the allocation of resources between states, to ensure that people do not lose out and there are not perverse consequences as a result.

We also think there needs to be more attention paid to the difference between enhanced tenancy management and tenancy supports. We feel that some of the choice elements where perhaps it is perceived that tenants get a worse deal in the private rent sector may be more to do with the rent - the landlord model than the actual availability of services.

So we think community housing providers, as a matter of routine, provide a lot of that enhanced tenancy management. We also feel that the recommendations and the proposals need to be tested in a wider context. We are advocating for an affordable housing strategy for Australia, and these recommendations should be looked at to make sure that they fit very well into what we hope is an increasing supply of social and affordable housing. Thanks.

DR KING: Thank you very much for that. I would like to start just by touching on a few things that comes out of your submission and out of the comments that you just made. And from your submission, I think we are not too far off in terms of starting point, which is the recognition of the chronic under-investment in social housing, the fact that the number of eligible households simply is significantly above the number that can access social housing, and yes, in the best of all possible worlds it would be lovely to have the government build more social housing, but I'm not sure either of us see that happening any time soon, certainly not in current budget environments.

So we are dealing with a system where the eligible population, more than half of it, is in private rental accommodation. So starting at that point, and you also, like us, say, well, there needs to be equity across the system, which is perhaps lacking at the moment.

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So I want to actually - so I guess our approach to that is to then say, well, how can we then make the private rental market work better for those eligible households who are in that market anyway? And you mentioned a couple of things. You mentioned the issues of access and prejudice, just - social issues, not just monetary issues but social issues. You know, you are on government support and you are looked on by the private rental market as not the most desirable tenant, whether - you know, I don't want to make a judgement on that, but these things happen.

Do you have any suggestions or ways that that can be improved? How should we be thinking about reforming that interface between the household eligible for social housing and that private rental market to make it work better for - primarily for the users, but if we could make it work better for everyone, fantastic. Any thoughts on that?

MS WINZAR: Can I pick up, to start? Your paper actually begins that discussion when it notes the tenancy law reform which the Commonwealth budget indicated it would do some work on with the state and territory governments. I think that is a very important direction to take, particularly in terms of security of tenure for people who might currently seek social housing for that reason.

The issue about the other dimensions of market failure which most often arise are disability access is problematic, and there are few incentives for private landlords to invest in premises which are accessible for people with disabilities. Even though a wide doorway is just as useful for a pram as it is for a wheelchair, for some reason, you know, it hasn't taken off.

So it's on that side. Likewise, there are some very large families in Australia. Most Australian families are quite small, but some families have a lot of difficulty finding houses large enough in the private rental market.

Some of those are Indigenous families, but by no means all, and I think again providing some better signals to the private rental market about what the demand for particular forms of housing is might be helpful there.

The other useful thing which can be done, and I think some states do this to varying degrees, are bridging programs which can take people from, for example, a refugee family which doesn't have references, finds it difficult to access the private rental market, head leasing arrangements by a state government can, for a short-term period, can suffice to give them a record of achievement, which they can then use to move into more mainstream housing. So it's those sort of strategies. But Wendy, you might have some other suggestions too?

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MS HAYHURST: I mean, it can be difficult. If we think in high-cost markets where a private landlord has a choice of people, then we make the point, and I think it is quite difficult to overcome, that if they have the choice between someone they perceive as a problem and a difficulty and someone who they don't think will be that case, they will take the latter.

So I think it is almost you have to think potentially of incentivising those private landlords or providing maybe in terms of, you know, some direction of other government policies that would encourage people to consider those tenants.

But I think it is extremely difficult. I don't want to undermine it. I mean, I think what Peta said about various programs is true, but I still think those operate in certain markets, not the most accessible for people who are wanting jobs, and I think it is - there's a point - I'm losing that point now, so I'll come back to it.

DR KING: Peta did mention head-leasing.

MS HAYHURST: Yes, head-leasing arrangements I think are very useful where - we have got a number of those programs operating in New South Wales, which is where landlords head-lease their properties to community housing providers, to registered community housing providers, and the services and the management reside up there. And certainly there is scope to extend those.

DR KING: Okay. The access, getting in the door in the private rental market is one issue. The other side that you touched on very briefly was the payment, the high costs of rent, particularly in Melbourne and Sydney, and one of the things I would like to explore is, is this a Melbourne/Sydney problem as opposed to other parts of Australia? Because it is really Melbourne/Sydney that have seen the shoot-up of the rents.

But also, you know, in some ways the benefit of a draft is that we can say, well, we can see that we could fix that through some sort of high-cost payment, by some sort of variation run through state governments who are able to say, okay, you have a need, whether it's work, school, family connections, community connections, to be in this area. This is a higher rent area, therefore you can be eligible for some additional assistance.

So the second part is, would you support that approach? And if so, how - we obviously haven't gone into significant details on implementation. If you support it, how would you see it being implemented? If you wouldn't support it, why wouldn't you support it? So I guess two separate issues I'd like just to touch on.

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MS HAYHURST: The first thing I'd say is that it isn't just a Sydney and Melbourne problem.

DR KING: Okay.

MS HAYHURST: Wollongong is the third most least-affordable place, so it is rippling out. Someone described it yesterday as a tsunami of people moving outside Sydney and Melbourne, so it is a much wider problem than I think is actually acknowledged.

The second thing is I think in principle having an additional payment for high needs tenants, if you like, is not something - is something that we would support. The devil is in the detail of that, and I think I will come back again to being very careful to just - or they - or all social housing tenants. I have said this in a hearing before, as requiring additional support, as being - because a lot of the people in social and affordable housing, the support they require is not because they're in there, it's because they're old or disabled.

DR KING: Yes.

MS HAYHURST: And those supports should be available to anyone now, and it's perhaps just a brokerage that means that they are more likely to get them in public and social housing. So that is the second thing. So defining what this high payment is for and being assured that people don't just lose that at the drop of the hat - you can see people getting into rent arrears if it is very difficult to get the assessment process once you're allocated being withdrawn for various reasons.

So I think the devil is in the detail of that, but in principle I think a higher payment to cover someone who requires specialist support is useful.

MR INNIS: So when you say "specialist support", does that mean service support, or does that mean financial support to live in a particular area?

MS HAYHURST: I think it could be either. It could be either, depending on the market there.

MR INNIS: So one of the things we've done is we've sought to reasonably carefully separate financial support from service support, and in fact probably implicitly we are saying that we are seeing, for some of the reasons that you have already articulated, more effort needs to go into tailoring the service support for people.

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MS WINZAR: I think it is a bit of a tangled sort of set of arguments, Sean. I mean, you know, there will be some tenants who need additional support, and that needs to be funded as a separate bucket of activity. Going to the first question, which is, "How do you respond to particular affordability pressures in high cost markets, be they ongoing or be it temporary pressure," is quite an interesting question.

I don't know that we would have the answer to that. We were having a bit of a debate outside about, you know, well what's the story, the pros and cons around regional rent setting, which is essentially the same set of questions.

And the difficulty is that if you're in a high cost market you're closer to services, employment opportunities. Transport costs are probably less. If you're out west of New South Wales, you've probably got a much lower accommodation cost, unless you're in a mining town, but you've got much higher transport costs. So how do you balance all of these competing things?

And to simply look at just the cost of housing is perhaps not quite the right approach. Which is not to say that there shouldn't be something done about additional payment to improve affordability in high cost markets, but what form that might take, I don't know that we're equipped to give you the answer.

MS HAYHURST: And just to add to that, energy costs as well.

MS WINZAR: Energy is significant, yes.

MS HAYHURST: Yes.

DR KING: Okay. Just on - I want to change topics a bit, so have you got any - would you like to follow up on that? I'm going to move on to consumer voice.

MR INNIS: No, we can swap. We can swap.

DR KING: Okay. In your submission you refer to consumer voice and tenants having more of a say in housing decisions, and you raise that briefly in introductory remarks. I guess our approach to that has been through the choice-based letting within the social housing sector. So I guess is that something that you see as addressing consumer voice? Do you see other roles or other ways that consumer voice can be expressed in social housing delivery?

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I'd just like to get some more details on that and understand it a bit better.

MS HAYHURST: It's very limited. The amount that tenants are engaged by landlords is very limited here. So choice-based lettings is one element, and we support that, subject to feasibility. The other ways that we think are very crucial are firstly transfers. Tenants don't have a voice, a very effective voice, in transfers, and where they do it tends to be to, as an individual, not transfer, which isn't probably the best way.

So we're advocating that tenants should be given a choice in whether or not to have a different landlord in the landlord choice. The second area - there is very little information published at the moment about landlord performance. We'll be upfront: there's nothing published really about public housing in any detail in any accessible fashion, and there's very limited information published about community housing, and there's nothing published about the private sector. So how, at the moment, a tenant could make, you know, a sort of comparison? So that is another area that needs to be looked at.

And then there's a whole question. I'm from the UK. Tenants there - and it varies from landlord to landlord - have a right to be consulted about the services that they receive. Here it's very limited. The expectations are very low. And I think you can express dissatisfaction with a service through different ways and not just by, as I say, having to exercise the ability to move somewhere else and disrupt your child's schooling or move away from the other services.

We are actually piloting, or hopefully we will be piloting the method where tenants can actually inspect the services that community housing providers deliver and have a role in assessing what they are like on the ground, because we are also conscious that performance indicators say very little and they often don't - are not consistent with what tenants say.

So all of those ideas. I mean, even the idea that we have spoken about before with you, which is where tenants or potential tenants are taken through more intensively an application process for housing which looks at the broad range of opportunities, and points out to them the variety of things that there may be on offer.

I still say without more social and affordable housing out there, there are limits. There are real limits. And the ability for people to move on from social housing when you've got that missing middle, where you don't have that affordable housing option, I am actually very optimistic that something

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will have to be done in Australia, because the economic consequences of not providing that accommodation will start to hit.

DR KING: Can I - sorry. Can I follow up on that, because we've taken a slightly different approach on the services side in our report, essentially separating out the tenancy services or tenancy management services from the other services, the other support services, in large part because we have the inequities in the system that if you happen to be in community housing, for example, you're getting a different level of support services than if you were in the private rental markets, we have said.

So our approach has been to say, well, that has to then be separated and provided across all eligible households. I guess one, I would like to check if you were in favour of that or don't think that's the way to go. Secondly, if - under that sort of model, do you see that sort of the choice that you were mentioning just before, that choice of, well, what are the services, would that still be relevant, or - I guess I see it as being separate then.

And just thirdly, you did mention tenancy management services and the different models, the landlord models, and I would like to understand that - sorry, three things at once.

MS HAYHURST: Yes. I will try and split them up, shall I? I will start with the last one. I think you need to recognise - and I would say even in public housing - that public housing, community housing, view tenancy management very differently than a real estate agent.

It is a different model. You know, I have experienced both. So in our DNA - and I say in public housing as well - there is an assumption that there are certain services that are standard for the rent that's paid. So it's not about the amount of rent that we get from people. It is in our DNA to do more.

DR KING: Can you give us some examples, please?

MS HAYHURST: So if, for example, someone is rent arrears, there is a standard which is quite high. It isn't, or shouldn't be, straight to the Tribunal. There is - there are interviews, income maximisation. I am talking about the base standards, which is what we are here to actually promote amongst the sector. I'm talking about community engagement.

So if you're going to do something you talk to people before you do it, whether it's renovation of whatever, and provide community facilities. Those things are part of our tenure. That's what distinguishes. That's why

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we're regulated to make sure we do all of those things. We have a role to broker support services.

Now, I'm not distinguishing ourselves from public housing. I don't think they do it as well as we do, but on the other hand, they have that in their DNA as well. Now, I'm not criticising real estate agents, but that is not the clientele that they normally deliver to, so they don't provide that. They have a different motivation.

So I don't - and I don't think any of us disagree that for more specialist tenant support services, whether it's mental health or something like that, that should be completely separated. But that enhanced tenancy management is there already. It's there in public housing, it's there in community housing, and yes, it's more expensive, but it's built in there, into a model.

So the separation we see is in the more personalised services that a small proportion of people will require, say whether it is mental health, whether it is short-term, a transition from homelessness, specialist homelessness services providers to help someone sustain their tenancy. But not those mainstream - and we have given some examples of where we think that is part of what we deliver already.

DR KING: Yes, okay, thank you.

MR INNIS: Is there any reason, either through a head-leasing model or another way, that government can't on behalf of clients seek that extra service level from the private market?

MS WINZAR: No. There's not. But it does need a lot of clarity about what we are actually seeking to provide.

MR INNIS: What it is, yes.

MS WINZAR: So you know, I mean, my landlord hopefully, if I ring up with a complaint, eventually will fix the broken something or other, but they do little more than that and collect the rent and check up every six months that I'm doing the right thing. That is the vanilla model.

MR INNIS: Yes.

MS WINZAR: Now, Wendy's description of social housing tenancy management has got that extra depth to it, but I think you can probably define it separately from more intensive and personalised support services to sustain tenancies, or to deal with - well, in the same way that NDIS has

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separated out their, you know, accommodation and support services, for example, or aged care is in the process of doing.

So no, there is no reason why you can't do it in private rental too.

DR KING: Is it - yes, so - - -

MS WINZAR: But you have to be prepared to pay for it.

DR KING: Sure.

MS HAYHURST: And the landlord has got to be prepared to take that tenant.

DR KING: Well, following up, just your response there - - -

MS WINZAR: Yes.

DR KING: Some of it sounds like just improving the rental market, per se, getting the private rental market working better for everybody, so yes, so that you have got proper processes, proper procedures in place if someone falls into rent arrears, for example, rather than, you know - that tenants' rights are made clear if there is going to be work done on the premises and so on.

So is it really a social housing issue, or is it a general - is there anything extra for a social housing tenant, recognising they may face additional barriers to getting in?

MR INNIS: Can I just add to Stephen just a fraction, because we are very conscious that the pool of people from which social housing has drawn, they are not sitting in never-never land waiting for a place. They are actually in the private rental market now, so they are in that market. So the question is, you know, should we spend more of our effort focusing on making that more appropriate?

MS WINZAR: Let me try that first, Wendy, and then I'll throw it to you. I think that if you look at that global set, and then you look separately at who's providing services, I mean, social housing is just one part of the rental market. It's also providing one part of the social support market, if I can put it like that.

So a homeless service, you know, probably has a really good prospect of finding a house for someone through a community housing provider, or perhaps public housing, in some markets. But in most, because of the

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shortage, they will be using the private sector, and they will be supporting that tenant to maintain a private rental tenancy, in the same way that they might do that either in partnership with the community housing provider or a community housing provider themselves might be doing that.

So you know, I don't see that there's - - -

MS HAYHURST: I think where you have a head-lease scheme you have got some hope of doing that. I think what we haven't really touched on, and which I was forgetting to say earlier, is the very big difference between the private sector and the social housing sector, which is tenure security. And I think without that being tackled, it makes it very hard.

MR INNIS: And your advice to us is that we should tackle that in our report?

MS HAYHURST: Yes, that's right.

MS WINZAR: Absolutely. Absolutely.

MS HAYHURST: Yes.

DR KING: Sean?

MR INNIS: Another question that is always very difficult in that housing world is the responsibilities across governments. So in designing the recommendations around Commonwealth rent assistance, and then the high needs payment, we deliberately left rent assistance as a Commonwealth responsibility that was set across the country, and the high needs payment was a state responsibility so that it could respond to local circumstance, noting that states vary across their geography, and part of our reasoning for that was actually states - the Commonwealth holds some levers on housing affordability, but the states hold some fairly significant levers, and it was aligning that responsibility and accountability and, in a sense, if you have got high house prices, you have got high stamp duty revenues flowing through, so there was a link there.

Long-winded way of saying, is that a sensible balance, I guess, between the levels of government on that structure?

MS HAYHURST: I would say - I mean, government to come in as well, the design is going to be incredibly important here, isn't it?

MR INNIS: Yes.

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MS HAYHURST: And I suppose I'm listening, the first thing that - my reaction will be when you separate out payment, is how tenants access that, how eligibility is assessed, and the synchronisation of that. I mean, one of the worries of any separation of payment is how coordinated it is, isn't it, getting access to the Commonwealth rent assistance and then having to wait a considerable time to have the eligibility for higher payments sorted.

So I think the design of that - I understand the motivation of the separation, and I don't think any of us have any difficulty with that.

MS WINZAR: Yes, certainly. Balancing the incentives to optimise revenue from stamp duties against supporting affordable rental I think is a very sensible approach to take. How it's delivered is a moot point. Whether or not there's some magic way you can bundle it on top of rent assistance, or whether or not it is delivered separately through state government, but you know, I think those questions of design can be considered. Technology might be the help there, mightn't it?

MR INNIS: And another question which - broadly in the housing world, I get a sense that unless everything is fixed nothing is fixed. So I hear what you have said about housing supply, and I note that it is broader than social housing. I think you were very deliberate in using affordable and social housing in language.

My question is, accepting that there are a wide range of things that need to be done in the housing world, do you wait for the positive reform, to the extent that the Commission is recommending positive reforms, and that people have views, but to the extent that we're recommending positive reforms, explain to me why those reforms should wait?

Because the people are where they are now.

MS HAYHURST: I don't think we're saying wait. What we're saying is, as part of the next stage - because you yourself say in the submission - sorry, in your report that you haven't done the full modelling. That is a year now where there is a new agreement between the Commonwealth and the states been negotiated. Your work should feed into that, so we are not talking about waiting to solve a problem, we are talking about making the process one, and not being separate.

MR INNIS: Okay, so it is connecting into the process was really your advice to us?

MS HAYHURST: Yes, exactly. Yes, exactly, yes.

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MR INNIS: Yes, thank you.

DR KING: Coordinating in amongst policy advisors.

MS HAYHURST: Coordinating, yes.

DR KING: Goodness. But that means we have to take account of our own recommendations. Oh, gosh. Thank you very much for your participation today. Thank you very much.

MS HAYHURST: Thank you.

MS WINZAR: Thank you.

DR KING: And we will break for lunch now. Look, if we can come back in about an hour. Say 1.40, let's aim to restart then. Thank you.

ADJOURNED AT 12.35 PM

RESUMED AT 1.37 PM

DR KING: Let me recommence the hearings after lunch. This was mentioned earlier, but for those of you who were not in the room, at the conclusion of today's scheduled participants, I will ask if anyone else would like to briefly appear at this hearing. Please speak with our one of our team if you would like to do that. Just a reminder before we start again, the microphones are just for the transcript not for sound amplification, so we need to keep our voices up. This as much reminding Sean and myself as someone else.

Finally, I would like to welcome the representatives from St Vincent de Paul Society National Council. If you wouldn't mind just stating names and restating the organisation just for the transcript.

DR FALZON: John Falzon, St Vincent de Paul Society.

MS DOBSON: Corinne Dobson from St Vincent de Paul Society, and I'm the National Policy Officer.

DR KING: Would you like to start by making a five-minute presentation or so?

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DR FALZON: Certainly, thank you. I would like to commence by acknowledging that we are talking on land that always was and always will be Aboriginal land. I would like to pay my respects to Elders past and present.

The St Vincent de Paul Society welcomes this opportunity to provide our insights into this process. We would like to begin by saying that whilst we do not have a position that categorically opposes the operation of the market or competition and contestability in all domains, our starting point is to say that our understanding of human services is that they are primarily a universal entitlement and a social safety net.

We are deeply concerned by the opening premise of this inquiry - the fact that we need to begin by looking at where competition would better fit into the provision of human services, and even providing the assumption that it is up to those who question this presupposition to demonstrate why competition shouldn't be a primary focus point.

It is quite interesting to talk about choice as a fundamental criterion in the delivery of human services, and I would like to just make a couple of comments about that. First of all, we would, in our experience as an organisation - and we certainly don't pretend expertise in the detail of how best to deliver human services or the best models for society to adopt - but what we do have expertise in is seeing people at the other end who bear the daily brunt of inequality in Australian society, in prosperous Australia.

We like to look at things from a social and a structural perspective rather than individual consumers, so we deeply question the very notion that one should begin from that premise of each person is an individual consumer in a marketplace. Inequality is the problem; the market is not the answer. The market might be an excellent allocatory mechanism for providing an array of choices, particularly in the area of discretionary spending, however, it has been disastrous as far as being a guarantor of access to essential goods and services in a society such as ours.

One of the interesting things about choice is that this treatment of choice fails to begin with the question as to why people, a growing number of people, are in a position where they need to access the social and human services that are under review here. So to give an example, I was speaking with a person experiencing homelessness in Melbourne a couple of months ago and she was a young woman, probably in her 30s, and she was getting angrier and angrier as people walked past her on the street. As I had a chat with her, she said something very eloquent that I think is important for this inquiry to here. She said, "You know, I didn't choose this life,"

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So it really struck home to me that we're talking about choices with a group of people, various groups of people, who in most cases do not choose to be in the position where they are needing to access, for instance, social security benefits and, indeed, social housing or family and community services. So we would like to at that very high level - this may or may not seem useful to you, and we acknowledge that the Commission has already acknowledged some shortcomings in areas of service delivery and problems in the way governments manage contracts and relations with service providers and we certainly commend you for the detailed consideration of the consequences of market reforms and acknowledges the instances where increased competition and contestability is not appropriate - we reject that starting point of this inquiry - namely, the premise that more competition and contestability is needed in human services.

We reject that individualistic and transactional approach. Again, it completely misses an approach which can circumvent the need for individuals to access services when, for instance, you take a community development approach, when instead of asking about so-called inequities in the provision of housing support - again, something that we reject quite vigorously - asking why in a prosperous country like ours has housing ceased to be a human right and become a speculative sport? Why are people in the position they are in, particularly at that very tight end of the private rental market.

Part of our concern is also the Commission's sector-blind approach which treats the idea of for-profit and not-for-profit sectors, that their organisational type is irrelevant. Again, this sector-blind approach is something we strongly disagree with. We believe that where there is a profit motive, it is going to completely - and has already - change the complexion of the way in which services are provided. And what is the end solution we want? Is it to maintain competition between providers, a so-called array of choices for people who have not chosen the life that has been thrust upon them due to historical and structural circumstances, or is our primary and fundamental purpose to create a more just, equitable and compassionate society built on a new understanding of the politics of caring?

You think about caring in general; it is very interesting that the caring professions and that vast amount of unpaid caring work is profoundly devalued in a capitalist society. Much of it is carried out by women in both the professional and unpaid areas, and this, in itself, is an indication of a gendered approach. But that overall approach which devalues caring has flowed into the provision of human services. These are the sorts of questions that we would like to begin with.

DR KING: Thank you. I would like to clarify something or get

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clarification on a few of the points that you have got there. So you seem to put markets and choice together, and I'm not sure why. We all make choices every day. We make many choices that have nothing to do with the market. Why do you mix those two together? Why isn't choice just something that is completely separate from the market? It may be exercised through a market, but choice is something much more fundamental, surely?

DR FALZON: Individual choice might be, but, again, this is dependent on a very market-based view of society and of the individual that focuses on individual choice as being something that is a given. The truth is, in our experience, people are unable to make choices when those choices are constrained due to economic circumstances. It's not much of a choice, for instance, for a sole parent that we are assisting to say, "Do I make sure that there's food on the table or do I pay the rent? Do I allow my child to go on a school excursion, or do I buy a birthday cake for them?" So these are choices.

DR KING: I understand.

DR FALZON: But this market, it is one thing to have a market-based economy, but this leads - and you are displaying it quite fascinatingly in your line of questioning, if I may say so - to a market-based way of thinking about society as a whole and about individual behaviour. So we would start from the position of yes, we make certain choices within constrained conditions. We are interested in those conditions. We are interested in creating a society where the choices people make are valid choices that are choices between two different forms of being able to lead fulfilling lives rather than deeply constrained choices where, depending on how much money you have in your bank account, you have an array of choices and for others there are very, very few choices.

DR KING: With respect, it seems to me that you're confusing choice and you seem to be stating that for some reason because we're interested in an individual's ability to choose and the choices made by individuals that somehow means that we're favouring the market, and I just don't understand that. As a matter of fundamental principles of individual behaviour, choice can be exercised through a market, but when you choose a partner for your life, I assume that wasn't a market transaction. When you interact with your children, I assume you make choices, but I would be horrified if that's a market transaction. So if you're suggesting that individual choice is somehow necessarily tied to a market, with all due respect, I think you're just wrong.

DR FALZON: I'd be delighted to know that this inquiry actually interested in ensuring the quality and standard that is appropriate of the provision of

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human services to those people in need, but I urge the inquiry to begin with the starting point not of choice - because I think this is quite a furphy to begin with the notion of choice - rather, we need to begin with the notion of need, social need, as an overarching context for individual need.

What choice, as I understand it - and I may be wrong in my reading of what the inquiry is leaning towards - in this context is very much tied to the notion of competition. In a neo-liberal framework, competition is that crucial and, in one political economist's terms, that most valuable feature of capitalism. Through the process of competition it becomes possible to discern who and what is valuable.

Our position is deeply questioning and critical of beginning from that premise of where and how best do we introduce competition as a corollary of choice. The example you gave of my interactions with my children, yes, I do choose how I interact with my children. If, however, that choice was linked to competition whereby one child needed to compete with another child for my attentions or that I needed to compete with my partner for my children's attentions, I think that becomes a profoundly flawed manifestation of human relationality.

DR KING: Just on that, you've made a number of claims about our inquiry and about our work. Can you point to parts of our draft report where we have tied choice and said that competition somehow necessarily is linked to choice as you claim? Because I can point to parts where we say that they are not linked and, in fact, to recommendations which are explicitly different. I would be very interested to know why you seem to be misunderstanding our report this way.

DR FALZON: The report refers to the onus being on those seeking to remove choice to justify why.

DR KING: I agree with that. Sorry, just on that, would you say that individuals shouldn't have choice and, if they don't have choice - - -

DR FALZON: No, not at all.

DR KING: - - - who should be choosing for them?

DR FALZON: No, not at all. But then in the next paragraph where you've spoken about choice, it has become the preamble to then saying this is why we need to put focus on users through greater competition and contestability.

DR KING: Where appropriate.

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DR FALZON: Well - - -

DR KING: I think if you'll read that you'll see it says "where appropriate".

DR FALZON: Yes, I know it says "where appropriate", but where saying it is an appropriate starting point. We seem to be going around in circles here because rather than addressing the concerns that we have raised - which is where are the questions regarding the structural underpinnings of inequality and poverty in Australia - we are having a philosophical discussion about choice, which I'm more than happy to entertain, however, I am interested in an engagement on whether competition and contestability is the best means of safeguarding access, equitable access, to those essential services to reduce inequality and poverty in Australia.

MR INNIS: I might jump in for a second. So you posed a question, and our answer in the report is clearly - not always.

DR FALZON: I beg your pardon, say again.

MR INNIS: Our answer in the report is clearly - not always. That competition is simply a means to an end, and if it's not the right means, you choose a different means.

DR FALZON: And our question is: why are we beginning with a question of why - - -

MR INNIS: I might finish. Sorry, if I may, I might finish. So our starting point was to assess the effectiveness of services. And the effectiveness of services was all about the impact on the people in need, the people for whom the services are delivered. And competition does not appear in our list of issues to be considered. What I'd like to do, though, is jump beyond this discussion. What I'm keen to understand is which areas of our recommendations would you suggest the Commission change given your concerns about what you see as the premise of the report. I don't think we'd accept that is, in fact, the way we went about the report, but leaving that to one side, where are the changes that you would make to our recommendations?

MS DOBSON: Perhaps if I can sort of say one area I think which illustrates the different approach that we're taking to some of these issues would be around some of the recommendations in relation to social housing. So I think one of the recommendations that is made is around removing the difference between people who are in social housing and have their rents pegged at a level that reflects your ability to pay compared to people, say,

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who are in the private rental market and access Commonwealth rent assistance. There are some other measures within that chapter that refer to things, for example, such as opening up contestability for the provision of social housing as a means of providing more choice.

Now I commend the Productivity Commission for identifying that the housing system is broken and for identifying that there are fundamental issues there and we need to take a different approach to what we have taken. But, again - and I think this relates to some of the issues that we were referring to - the approach that's taken and recommended is about removing that inequity, so-called inequity, between people who are in the social housing system and people in the private rental market, and there's kind of some questions that we need to be asking before we get to that point. Again, it goes perhaps to the approach we're taking in relation to asking about and looking at some of those structural issues that are giving rise to those inequities.

There are some areas in those chapters that relate to social housing that really miss some fundamental things that concern Vinnies and other organisations in this space. Critically, issues around the undersupply of affordable housing and some of the factors that are driving undersupply as well. I think if we just go to addressing the issues that you identify with some of the recommendations that are there in the report, we have real concerns that rather than addressing those inequities, there's a real risk of actually compounding them, particularly for people who are in social housing, the most vulnerable and on the lowest incomes competing effectively in a market. We recognise that you've recommended the increase to Commonwealth rent assistance, and we agree it is - and I think everyone agrees - woefully inadequate. So there is some merit in that sort of recognition of that. Whether that would be enough to address the disparity between what people can currently afford to pay and what they need to pay is another question. I think there'd need to be more modelling and consideration around that.

But those chapters and some of the concerns that we have with that I think go to some of those overarching concerns that we have with the approach that's taken. I do want to give credit, too. Our focus is on the social housing and family and community services. We do recognise and we commend the Commission for the focus on family and community services that you acknowledge there is that scenario where the introduction of more competition is not appropriate, and we agree with that.

We don't agree with all the recommendations that are there; we think there are some perhaps good recommendations, but, again it is sort of a bit of a default position where it is a bit of a case of putting the cart before the

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horse, I think, in how we approach it.

MR INNIS: Very happy to talk about the whole report. But given we were talking about housing, what struck us about housing and the reason that we have formed the assessment that the system was broken was one of equity, that the small number of people in social housing looked to be living in similar financial circumstances to a large number of people outside social housing, and I think we'd probably agree that's not an equitable situation.

MS DOBSON: Well, - - -

MR INNIS: The question - - -

MS DOBSON: - - - partly due to decades of underinvestment in social housing.

DR KING: For whatever reason.

MR INNIS: The question then becomes how do you address that. I think that sounds to be where we're starting to diverge, that you would see the appropriate response to be the provision of additional housing with an income-based rent proposal, and what we have developed is a recommendation that says actually provide the funding to the person to give them more choice. You may or may not agree it's appropriate for people to choose the housing they live in. That's a call for you to make.

DR FALZON: Well - - -

MR INNIS: But the question for me, the thing I'm concerned about is questioning the premise for the reform path because where we started from was very much that we've got a system that is not equitable and - - -

DR FALZON: Could I just ask where it's not equitable in your view?

MR INNIS: We've got people eligible for social housing - - -

DR KING: More than half of the people eligible for social housing are living in the private rental market now. Not using social housing at all and are subject to the various vagaries of the market that you seem to be against.

MS DOBSON: Well, so you're proposing that increasing Commonwealth rent assistance and putting people on to that will deliver more choice.

MR INNIS: And a high needs - - -

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MS DOBSON: - - - in a market where there is gross undersupply. Choice is illusory if you don't have the actual affordable housing to choose from.

DR KING: Can I understand, then, your position, you would prefer that people who are eligible for social housing who are aren't able to access social housing - recognising that is more than 50 per cent who are eligible - they should not receive any change in circumstances until more social housing is built?

MS DOBSON: Absolutely not, and I don't think - - -

DR KING: Then what would you like done?

MS DOBSON: We have been fairly clear on our housing policy.

DR KING: That's fine. Then what would you like done in between times?

MS DOBSON: Well, one thing I would say, too, in our approach to this - and we have always argued for a comprehensive policy response. So we're not going to just pick out particular measures. No one measure - and we would concede that - is going to address this issue. It's a very complex issue and it needs to be addressed on a number of fronts. One area, for example, that we have consistently argued for is around some of the tax concessions that distort the market. We thoroughly agree that we need to be looking at that private rental market and addressing the issues within that. That doesn't preclude us expanding the - - -

MR INNIS: So would security of tenure be one of those things?

MS DOBSON: - - - social housing stock that we have and addressing those other measures in tandem. We recognise that there's no overnight solution to this. We acknowledge that there is no single policy response. But we do also think you need to be very careful, for example, if your focus is increasing - we've seen the government do a number of things in the area of trying to improve housing affordability where they've increased the spending to provide some supplementary payment or something to people. As I said, we certainly agree that income inadequacy is an issue and Commonwealth rent assistance needs to be increased.

But if you are increasing that payment without looking at issues of supply in a very tight market, there is a risk that you're just going to simply inflate prices as well. So we need to be looking at this issue as a system and not just a particular policy measure like that. I think that we don't see in that chapter in the recommendations that comprehensive approach that we advocate.

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DR FALZON: I'm interested in your question on tenure, too. Could I just say for the record that your line of questioning, to first of all pose the question to us in the words, "You don't seem to care about" - - -

MR INNIS: I didn't use those words.

DR FALZON: - - - "people allowing to choose" - - -

MR INNIS: No, I did not use those words.

DR KING: Sorry, as chair, let me just interject. Please do not say somebody has said words that they have not said.

DR FALZON: Okay - - -

MS DOBSON: But you implied that we have said - - -

DR KING: No, can you please state for the transcript if you believe Mr Innis said those words or not. This is a public hearing, there is a public formal transcript. If you state things on that transcript which are not correct, they go on to the public record.

DR FALZON: Well, they'll be listed on the transcript, exactly what was said, and you used words to the effect of, you know, "Do you care about people having the choice where they live?" Let the transcript decide what was there. I'm happy to accept whatever is in the transcript, but I didn't imagine the mischievous intent of those terms, and I'm happy for that to be on the transcript, too, because I find it highly offensive that we would be even entertaining this premise of pitting against each other people who are suffering in the private rental market against those who need to access a social housing system which, as my colleague has said, has been greatly denuded.

By all means, I completely accept that we need to support people who do not have current access to social housing, and we are completely open to the suggestion of increasing assistance. We have also stated that that will not provide a sufficient long-term and sustainable solution to the inadequacy and unaffordability of housing for low income families.

But to suggest that the inequity lies between people who are on low incomes needing Commonwealth rent assistance in the private market versus those in social housing is a deeply offensive suggestion. This is like suggesting that aged pensioners should be pitted against Newstart recipients and that if Newstart recipients get an increase then aged pensioners are

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going to pay for price or vice versa.

If you really want to look at the entirety of our market-based economy - again, I note your little quip there that these people are in the market that we seem to be against. We simply noted the efficiencies in some areas of the market and the gross inadequacy of the market in providing access to essential services, such as housing. I think this is borne out by the evidence. If we're serious about addressing those, we need to look at the entire system. As my colleague has said, we need to look at the tax concession treatment of certain players in the marketplace in the housing market. We need to look at that the quantum of assistance of government subsidisation to people who do not need it precisely in the housing market via some of the tax concessions that have been mentioned and other subsidies. We completely reject this - - -

MS DOBSON: Can I also say - - -

MR INNIS: Can I ask a question?

MS DOBSON: Can I just sort of say because you did sort of say - and it was in a bit of a tone that was a bit sceptical, are we seriously saying that people in the private rental market, that we don't support more support for them? And I just want to really stress that our organisation has consistently - we have a whole raft of policies that look at people precisely in that situation as well. And one important point to remember in relation to these particular recommendations is we are talking across different levels of government, which adds considerable complexity, but we have provided a whole range of policy recommendations and have consistently advocated for things as well at state and territory level, for example, making sure that we are opening up supply of affordable housing, which includes social but also affordable housing for people in the private rental market and mechanisms to achieve that.

So I just want to really be clear that in questioning the approach that you've taken, it's completely wrong to say that we're happy with the inequities - and they are inequities - that people in the private rental market face. They are fundamental inequities are not because they're competing with people who have the advantages of social housing; they are broader inequities about the housing market more broadly and concerns that we have about - and John alluded to this - some of the tax concessions which add to the distortions in that market. So I think that, now, I just want to be clear about that's our approach.

MR INNIS: Thank you for that. And very happy with the word "inequity", and, indeed, as I explained, that was the reason why we felt the market was

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broken. Not happy with the term "pitted against one another", because that is not the way the Commission sees what's happening nor what our recommendation is designed to do.

DR FALZON: Could I just clarify: when you say - - -

DR KING: One second, please. Please let Mr Innis finish his statement.

MR INNIS: You say that part of the game is about the supply, and I think our report does point to that. Fundamental recommendations on supply are outside our terms of reference, but we would agree that our recommendations for social housing need to be set in a broader context of housing, and there's a lot of debate around that at the moment. But I think what would be good is to talk about the recommendations that are within our terms of reference that we have made and where you would see them being improved. That would be very helpful.

DR FALZON: Could I just clarify: when you said you're happy with the word "inequity", what's the inequity between?

MR INNIS: We've got people in very similar circumstances receiving very different levels of government support.

DR FALZON: Right. So your idea of inequity is an inequity between low income households in the private market and low income households in social housing, is that correct?

MR INNIS: That is - am I describing that as "the" inequity in society? No.

DR FALZON: No.

MR INNIS: It is inequitable.

DR FALZON: So this is an inequity in the context of this inquiry, is that what you're saying?

DR KING: It is an inequity in definition - that if two people in similar circumstances are treated differently by government - - -

MS DOBSON: True, but looking at broader inequity - - -

DR KING: - - - that is an inequity - - -

MS DOBSON: - - - in the housing market. Now, if we take that to - - -

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DR KING: Sorry, because the transcript doesn't pick up the shaking of heads. So Dr Falzon - - -

DR FALZON: Shook head, yes.

DR KING: So you disagree with that, so you do not believe that it's an inequity?

DR FALZON: Look, I just find it absolutely unconscionable that an inequity between two low income groups should be the focus of this inquiry. It just blows my mind when we look at the inequities in the housing market and in our market-based society as a whole - which I'm very happy to discuss - that this should be the focus between two groups that are suffering the effects of a housing market that is simply unable to provide housing certainty - the right to housing is a human right - to a large chunk of our population. And to drive a wedge between these two groups, as I say, I just find it a very unusual place.

MS DOBSON: Can I - - -

MR INNIS: We're not seeking to drive a wedge between any members of our society.

MS DOBSON: I understand that may not be your intent, no. We accept that. That's not your intention, but I think that it is, and if we are talking inequities - and I can see that you're saying that this is not the only inequity, but that's a critical issue. What we're looking at is the housing market that is deeply inequitable. I'm talking about the private rental market. We're just looking at the private rental market. It is deeply inequitable.

So even if you provided the 15 per cent increase that you're proposing, now if we go to, for example, looking at the recent Anglicare rental affordability snapshot, okay, we put that 15 per cent increase in. How much more private rental accommodation will people be able to access? Very little, according to Anglicare. And if you look at some other, I think, analysis that's been undertaken by AHURI - which I can't remember what the acronym stands for - but you know who I mean for the purposes of the transcript. By zeroing in on that inequity and ignoring the broader inequities in the housing market, the consequence of this approach would be to throw potentially hundreds of thousands of people who will be moved off social housing into a very severe situation. They wouldn't be able to afford the rents.

MR INNIS: So - - -

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MS DOBSON: So the notion of choice, if we had a market where private rentals weren't so exorbitant, if we had a completely different situation in our housing market, then, you know, we might take a different approach to what you're proposing, but it's not dealing with the realities that we have. So that's, I think, where we're concerned about. Zeroing in on that inequity between people who have social housing and people on very low incomes in the private rental market is really missing the fundamental inequities that we really need to be tackling. It is not going to address it.

We would be very concerned about what would be the outcomes for those people who are currently on social housing should these recommendations be agreed to.

MR INNIS: I might explain our recommendations. As they stand, they are draft recommendations.

MS DOBSON: Yes.

MR INNIS: And the purpose of this process is for us to learn and improve our recommendations. Two things: one is the CRA changes were part of - not all of - what we recommended happen in terms of support.

MS DOBSON: Sure.

MR INNIS: We also recommend that state governments be responsible for assessing and providing high needs payments to people who require additional financial support. We also recommend very significant changes to the assessment process for service support and an ability for those services to be provided across wherever people live.

Like you, we share a concern about those who are in the market now in the social housing system now and we recommend that their conditions be protected for at least 10 years. So I understand and I think we do share many of the same concerns. We probably differ on what some of the solutions might be, but we've sought to ensure that both people in the system today are protected as well as ensured that we have a more adequate and more equally provided level of assistance into the future that is in the context of there being some issues with particular markets in Australia. I don't know think the housing market in some areas of Australia is anywhere near as bad as Sydney and Melbourne, for example. But, clearly, Sydney and Melbourne are of deep concern at present.

So I just wanted to explain, and I don't think that some of the things you said - we're far apart on at least where we see some of the issues, and it's certainly not about one group against the other; it's about ensuring that

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people in similar circumstances do get similar support from government.

DR KING: Similar and appropriate and adequate.

DR FALZON: Well, is that outcome that we're are interested in.

DR KING: Sure.

DR FALZON: And whether it's 10 years or one year, to talk about the effective ripping up of social housing as we know it by tying rents to the market rather than to incomes, we have very grave concerns that this would, indeed, not lead to a more equitable solution by any measure but one that would actually increase homelessness and housing stress. This is what we see at the coal face. We're not coming from an ideological position; we're coming from a position of experience and an enormous sense of sadness that good people are unable to enjoy the choice to live in a place that they can call home - not a choice between two different types of homes but just to choose to be able to live in a place that they can call home.

I'm glad you do care about adequacy, but our concern is that by beginning with that assumption that choice needs to be the primary motivator, then we're going to have a very long road before we get to adequacy - in fact, we're more likely to be moving in the opposite direction.

MR INNIS: Thank you. Can I ask, on the income's based rents, would you expand that to a larger group of people and, if so, how would you go about that? Who would get an income-based rent and who would not?

DR FALZON: Well, if you're talking in terms of expanding the stock of social housing, then his is something that we would be profoundly in support of and would welcome that as a recommendation of this inquiry. That would be wonderful. That's the traditional way in which rents have been tide to incomes - through that vehicle of social housing. So we'd be very, very supportive of that.

We feel that this is something that as real incomes decline for people on social security benefits and at the low end of the labour market, noting that there is certainly a rising percentage of people who are in insecure, often precarious work conditions - and, of course, you can't look at housing without looking at income and employment - noting that, it would be enormously helpful to secure people's right and access to housing to be able to tie rent to income where those circumstances require it. So, thank you, that would be a wonderful suggestion.

MR INNIS: My question is: to whom would you give that? Is there a

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stopping point or should that spread?

DR KING: Would you see an income-based rent approach being preferable to the current CRA approach, for example, for those who are eligible but are unable to access social housing?

DR FALZON: You'd like to …(indistinct)… to this.

MS DOBSON: I think I'd need to give more consideration to that. It's complex to think how that applies in the private rental market. I mean, look, I do think whilst we do disagree with the approach taken to removing the so-called inequities as you see it between social housing and those in low incomes in the private rental market, we certainly do support increasing Commonwealth rent assistance and increasing the support for those on low incomes in the private rental market.

I think one thing that I would say in relation to - and I'm not quite sure how you arrived at the 15 per cent figure that you've recommended, but I think there would need to be more careful modelling and consideration given to that. We don't know exactly what the level should be, but certainly based on the evidence - and I know you have Anglicare following this and they can perhaps elaborate on that with their rental affordability snapshot, certainly if you look at that, and, as I said earlier, look at a 15 per cent increase, that's not going to be enough to bridge that gap between what private rents are and what people have the capacity to pay.

MR INNIS: Recalling that we do recommend another payment for people who have particular need.

MS DOBSON: Yes. Look, I think there may be some merit in that, but, again, we'd probably need to give more consideration as to how state and territory governments would administer that.

MR INNIS: Sure, I understand.

MS DOBSON: We know in this area of policy that there are always complexities. I can anticipate that would be a very complex path to go down. That said, many things I think in this particular area are. But just exactly how that would work and how we get consistency as well, they would be some key concerns we have.

DR FALZON: But we'd certainly welcome the notion that people who are currently eligible for social housing being able to access the benefits of social housing through an income-based rent formula. I think that would take enormous pressure off those households. And at the moment the people

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that we're assisting, housing costs are what eats away at their meagre incomes, whether they're in that precarious end of the labour market or on social security benefits.

DR KING: I'm going to break my own rule because unfortunately we are out of time, but I did want to follow that up with one more question: are you being supportive of our recommendations that those who are eligible for social housing but are in the private rental market because they're not able to access social housing also receive the same support services that currently are only available for social housing recipients?

MS DOBSON: Yes.

DR KING: So you'd be - - -

DR FALZON: As long as it is not at the expense now or in the future of the current level of support that people in social housing are getting.

DR KING: Thank you very much.

MR INNIS: Thank you both.

Our next participant is Professor Dickinson. Would you be able to state your name - I understand you're appearing in your own right, as it were - just formally for the transcript.

DR DICKINSON: Helen Dickinson, I'm an Associate Professor at the Public Service Research Group at the University of New South Wales in Canberra.

DR KING: Thank you. Do you have an opening statement you would like to make?

DR DICKINSON: Yes, I guess, as you've seen in the submission, we're reflecting on these reforms in relation to the research that we do both nationally and internationally, particularly in the field of commissioning and stewardship and looking at that across family and community services. I guess looking at that, we're broadly supportive of a number of the recommendations, although cautious in the sense that, as with all things devil is in the detail around some of this stuff and is really in the implementation of this to make it a reality.

So we welcome things like the focus being on users and thinking about public services in a far more strategic and kind of planned way across different service areas and talk about that as a way of driving change. But

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the report also notes a number of the challenges with how stewardship is currently operated in Australia, and that's reflected internationally in literature as well. There isn't a vast amount of evidence of where people have got this really, really right. There are pockets of it around the place, and this suggests that it's a really difficult thing to do and that there's a huge amount of capacity and capability that needs to be developed within not just public agencies but also the stakeholders who are working with this within these services to make sure that it operates as effectively as possible. So this isn't just about how you design a system; it's about how you skill people up to operate that system and operate within it.

DR KING: Thank you. I'd like to follow up on a couple of areas that you touched on in your submissions. Hopefully we've reflected some back in our discussion on stewardship in the report. One is that you notice the natural risk aversion of government and the effect that that has on the way the governments commission services, the way that governments manage services. In our stewardship discussion we've noted that risk aversion and problems that can create. I'm just wondering, what ways do you see to reduce that risk aversion? Is it a case of improved data, improved accountability systems within government? Are there other ways that we can help government micro manage less, for want of a better word?

DR DICKINSON: It's a challenge, isn't it? There's nothing just inherent within individuals that make them risk averse, but there's a culture of practice. I guess taking a wider perspective around that, we'd say that's not just because of the ways that individuals act within those organisations; it's also because of the pressures that people come under from politics and from communities who want to have particular notions of accountability.

The challenge is when something happens, the first thing that the public and the media often ask for is who was accountable, who is to blame in terms of this, where is the vertical chain of accountability around that. So there's an expectation that that is there but also that we are managing these kind of outcomes where we give providers freedom and flexibility to operate within some of that. That's a really nuanced kind of challenging area to operate within and not one that we often give people the kind of freedom and flexibility to do some of that sort of stuff.

I've been doing quite a lot of work with some of the recent experience with primary health networks. I did some work with a bunch around the country recently. Their experience sometimes as they attempt to kind of contract for outcomes is going through a very expansive processes and really doing a lot of work to get to this and then they get to the legal department who say, "Hang on a minute, no, you can't get this through." So there are some practical things around contracting mechanisms and

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commercialisation skills in that sort of sense that needs some work. But it's also a cultural issue and it's what we want government to be like and how we incentivise that to be. What we often want in communities is a very strong vertical sense of accountability that actually sometimes is at odds with what we're suggesting about outcomes and those sorts of things.

A lot of that doesn't mean you can't do it and I think the report talks about this. It's on notions of relationality and trust. Those things take inordinate amounts of time to build up, particularly if you have a recent history that has not always been positive. For some providers that will be the case. And that trust is really quick to break often and it's difficult to get back. So it takes a long time to shift towards those sorts of systems.

MR INNIS: Can I ask a question: what I guess I'm hearing is that hard to recommend and hard to do but some patience and some tolerance is required to make these things work well because the trust and relationships have to be built over time between provider and client but also between provider and funder and ultimate steward as well as the person who's accountable.

Do our recommendations make that easier? Do they make that harder? Is there something we should add to our recommendations to better enable particularly governments to have that patience and tolerance that I think you're saying is needed?

DR DICKINSON: That's a difficult thing to do, isn't it, in any sort of space and to have that. The thing that we would know is the real issue is how this capability and capacity is going to be built while we operate systems as usual as well. So essentially we're saying we need to deliver what we have at the moment and yet fundamentally at the same time reform culture and practice around a lot of this sort of thing. One of the challenges, I guess - I am particularly talking about the family community services chapter, which is one that we mostly focus on in the submission - is a lot of recommendations are over the space of a couple of years and really to drive those is going to take a lot longer than that to do.

I guess our big question is what are the recommendations about how governments can build some of that capacity to do both their own stewardship role and help partners build capacity to be able to engage in that as well.

DR KING: Can I put that back to you: what suggestions or recommendations or examples should we be looking at to be able to bulk out put more detail into those recommendations to make them more implementable to enable that change? You can't stop the world and change culture and start again, so we're changing culture, we're changing

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approaches at the same time as keeping the system moving. Any examples from overseas from the academic literature or from practice literature overseas that we should be looking at? Where should we be looking?

DR DICKINSON: So a key question we get asked quite a lot, particularly from organisations who are looking to embed a stewardship or commissioning-type approach is if we're going to do that, what are the competencies and capacity that need to reside within the organisation, what skills do we actually need in the first place to start to get to grips with this.

That's a really tricky question, particularly in a context where, if you've entirely moved away from service provision how you are able to design and inform and to oversee a system where you don't have skin in the game is a huge kind of challenge and needs thinking about engagement in different sorts of ways. So I think the engagement skills are a really critical part of that sort of process.

This is something we did quite a lot of work with health organisations in England a few years ago with primary care trusts as they were first established and became commissioning-only organisations in the health space. The same question was asked: well, what skills and capacities do we need, and there was an approach, a framework, developed out of some of that work, the world class commissioning competence framework, that actually starts to get to grips with what are some of the sorts of things you might want to think about in terms of roles of your organisation.

This stuff is inherently difficult and takes time to build and so that makes it a really difficult thing to write recommendations about. I appreciate that. And you go too far in being too specific and it doesn't fit every situation and every sort of circumstance; you pull back and you're less specific and then the charge could be there's not sufficient guidance there to help us with some of that. The report is there and there is an acknowledgment in a wholesale way the big change that is needed and the time it will take to do that. But there are examples around the place where people are doing parts of this already that we can learn from.

MR INNIS: One of the things we've noticed is that governments are, as you say, starting to put a lot more effort into their commissioning capability, if you like. So, for example, New South Wales now has a commissioning unit in their Treasury department. Is that something or that sort of model something that you think is (a), useful and (b), maybe/should be suggested to other jurisdictions?

DR DICKINSON: I think there's a definite need for some resource and some capacity building around that. I've worked with the CCU in New

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South Wales a bit and they've got some really great kind of policy framework guidance and practice guidance in a broad sort of way. Again, the question in the line agencies there now is, "Okay, well, what else can be done?" This is broad background stuff, what else can be done to build capacity? I think with a program like this there is a need for some focus of effort and supports for people as they get to grips with this.

There are huge tensions with where that lies and I know as the discussions were happening where CCU should reside there were debates about whether Treasury was the best place for that to be and what the implications of that would be in terms of power relations between different agencies. I think that's a difficult decision to make.

But I think resources like that are helpful, but that's not the only kind of model of doing that. There are a couple of examples internationally of where other models have been taken.

MR INNIS: Can I take the opportunity to ask some specific questions about our recommendations?

DR DICKINSON: Sure.

MR INNIS: In the broader families and community space, we recommend longer default contracts, much more certainty about when tenders would take place, longer time periods upfront so that people can organise more comprehensive and collaborative bids, a longer period at the end of a contract to allow better handovers. Are they positives? Are they things that you would say we should take forward, noting that you've said that, actually, this is a harder gig to implement than a naïve reader would have at first blush?

DR DICKINSON: If you're look in the research literature, all of those things are pointed as being issues particularly for community sector partners in partnering. If you do look overseas, there's 20 years of commissioning experience in England and there was a select committee investigation into the relationships between community organisations and government bodies. All of those things were raised as being issues there as well here. So kind of more certainty and more ability to engage with those is a good thing.

That will not necessarily mean that organisations will definitely be able to engage with that, and you acknowledge some of that as well. Occasionally there will be a need for some capacity building both in the ability to bid for some of those but in educating around different potential provider models as well. So there's a bunch of different pulls at the same time whereby as a government agency, if you're contracting with a high

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number of different providers, it can be very difficult to actively manage those contracts. I know in a lot of your recommendations they are about how can governments be more engaged in managing these contracts in a productive way so that we can assure accountability and levels of performance.

The reality is, if you have loads of those contracts, it is very difficult within the staff size that you have to be able to actively manage those. So the pressure comes - and you talk about that in the report - for organisations to be asked to merge or work together. And a merger is one version of how you can do that. There's a bunch of other kind of arrangements that you can enter into as well, but, again, sometimes there isn't a huge amount of knowledge about the different opportunities there and the different trade-offs involved in those sorts of models and how they run together. So, again, engaging in capacities building around those exercises could be a really helpful opportunity for the sector as well.

DR KING: Can I just follow up on that?

DR DICKINSON: Yes.

DR KING: Because I guess we see our recommendations as pushing the boundaries either further with the engagement going on during the contracting process. We've used the term "relational contract".

DR DICKINSON: Yes.

DR KING: Partly reflecting that both in family and community services and remote Indigenous, we're looking at significantly longer contracts, and we can see some benefits there. But that does make the ongoing management of those contracts much more difficult, as you've noted. I guess what I would be interested in is are we pushing too far then too fast? Are there steps or interim steps that we really should be focusing on in our next stage, if we're going to have longer contracts, more relational contracting approaches, interest steps that we really need to include to make sure that they're picked up as part of our recommendations? Are we going the right direction or would you say, "Look, it's just not going to work, guys"?

DR DICKINSON: The challenge is, of course, you're making recommendations about a bunch of services in different policy areas, different physically geographic areas and with really different kinds of histories. As you say, it is impossible to jump directly from a context where you may have had historically problematic kind of relationships, maybe there have been issues in recent recontracting processes - which there have

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been in a number of areas around the country, particularly around family and community services - that have often been processed to deliberately destabilise the sector and that's led to some challenges in terms of relationships. It is very difficult. It's impossible to jump from that bit directly into now we're going to go into relational contracting and we're all going to play together nicely.

As you say, it's an evolution of that, and different parts are going to be more ready to go to that sooner than others. There is a tendency - academics probably are worse in terms of doing this than other people - of saying, "Well, you moved from this, we had this rather adversarial notion of contracting into now we've decided we're going to do relational contracting and everybody's going to do it." The reality is, it doesn't happen that way and there are steps between that of being ready to different points of that. That is the challenge in building the capacity and capability. Even if you think of one agency, different parts of that are going to be in really different places and some will be more ready to go that that sort of system than others. So how you recognise that nuance and manage for it is a real challenge. As I say, there are bits of this, bits of effective commissioning, effective stewardship, that go on in bits of pockets around the place already, but there are other bits that are really far away from that. So how you shift at the same time.

MR INNIS: You said something then that was very interesting. You used the words "intentionally destabilising" - forgive me if I've got that wrong.

DR DICKINSON: No, that is correct.

MR INNIS: One of the things that we wrestle with is our recommendations are designed to create stronger partnerships between funders, stewards and deliverers for the benefit of the user. But at the end of the day, there's also recognition that the money is taxpayers' money and periodically we think to ensure that taxpayers are getting appropriate value, there should be some level of contest for the best proposals to spend that money.

I'm just interested in understanding whether you think the providers in the commissioning world hold that same view - that ultimately there is that decision, that's a difficult decision, about value for money?

DR DICKINSON: I guess the challenge is around when we talk about contestability is what we're talking about being contested. When I go around the country, there are very different versions of it where some people see contestability is if you've got two or more providers who are going to bid on a contract, so what you need to do is make sure you've got at least that because then you've got contestability, or whether you think it's about

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contestability in terms of quality of service so, therefore, it might not be problematic if you have one provider in an area provided you think there's a agree of contestability in terms of the services that you're delivering.

There's a detailed explanation of the meaning of "contestability" in the report there, but I think more broadly we need to have a sense of what we mean by contestability and how you do think about value for money. We did some work when I was previously at the University of Melbourne at the Melbourne School of Government for the Community Sector Reform Council in Victoria trying to kind of work with them to think about how you value different sorts of outcomes that are delivered by community organisations. This came about because there'd been a couple of recontracting processes where some providers thought that they hadn't been handled well and that the full value of organisations hadn't been taken into consideration.

I guess this is the challenge, particularly when you talk about the recommendations around efficiency and making sure that there's the most efficient use of resources. Can you talk about that in terms of full value that organisations produce? Often we talk about how can we make community sector organisations more efficient and behave more like private sector providers, for example, who are often seen to have kind of better management processes and being more efficient around that. I guess the argument from the other side, though, is if you've got not-for-profit organisations who are investing their profits back into the delivery of public value, how do you capture some of that benefit and make sure you take account of it in those commissioning processes, particularly in the context where I think it's probably true that, you know, a lot of historical contracts are delivered in family and community services by community organisations and we've kind of deliberately underfunded for a number of years on the basis that we know that they'll make it work somehow.

DR KING: They'll get the money from elsewhere from donations.

DR DICKINSON: Yes, and we don't know what the kind of true cost is around those. So I guess the challenge is I'm all for thinking about contestability and making sure that we use resources in the best, most appropriate way, but to do that we've got to make sure we've got a way of being clear what the outcomes are that are being delivered and what outcomes we want to be delivered. I think some of the tensions often exist in that kind of lack of clarity around what better outcomes for a particular group are and you have a bunch of stakeholders who are working who all think they're delivering better outcomes but maybe have a slightly different version of what that actually is.

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MR INNIS: Indeed. And one of the things that you've mentioned that we have sought to address in our recommendations is you can see that governments sometimes do not fund the full cost of delivering a service appropriately to a client group. We certainly sought to address that through our recommendations, accepting that there's a challenge in translating that easily to fruition.

I also wonder whether we always take into account the other support that's provided through the system for community not-for-profit organisations through the tax system et cetera and how that plays into the game, whether service delivery, service contracting, is the best way to necessarily support and fund that broader purpose.

DR DICKINSON: This is the challenge. As you well know, all of the intention and the talk about thinking about users, thinking about full costing or thinking in the more strategic way, absolutely intuitively makes sense, but they are actually really, really complicated things once you start to kind of get to grips with that. So how we develop that capacity is a big challenge.

DR KING: Just one final question from me: as you've noted, it can be comparing apples with oranges when you, say, have not-for-profit versus a for-profit with different ways of providing a service. How do you compare the value of volunteers or cross-subsidy versus perhaps an organisation that has very strong incentives to keep costs low but may have different quality outcomes, how do you compare those. I guess the approach we've taken, which seems to have been a little bit controversial in our report is to say in a sense the government needs to upfront think about different organisational types, different incentives and objectives of those different organisations and not simply say at the start, "Well, we favour one group versus another group all the time," but to think on a much more nuanced basis, so it may actual be that they say for-profits would be appropriate to provide GP services and in this other area cooperatives and not-for-profits might be better. Have you got any thoughts on that sort of approach, because is it a different approach and it has clearly upset some people in the industry who think, no, we should never allow certain organisational types to be considered. What are your thoughts?

DR DICKINSON: We went through a decade or so ago reform in the health service in England around this more agnostic approach to who are providers of those services. It's a slightly strange debate anyway staying agnostic about who's providing those, because the majority of them are GPs who are small businesses but don't get understood as such.

I guess my position on this is there is no ability to say all private sector organisations one way or public sector organisations are another or

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community organisations are another way. That is not something that exists, and the literature bears that out. In fact, the literature suggests that actually what's really important here is the size of your organisation. A larger community organisation, the more it is incentivised to behave more like a big corporation and the things that go with it. I don't think you can say in a wholesale way all organisations behave in particular ways.

I guess my worry about having a really expanded role for private sector organisations before the capacity and capability of the public sector is there to contract for those is that that stewardship function doesn't operate as effectively as it might. You talk in the report - there's a phrase - to the extent of the benefits of choice and competition and contestability, and these benefits can be fully realised when we've got an effective system of stewardship in operation and then make the point that actually that doesn't exist in many places as it currently is. So I guess the concern is that if you move to that without being able to do this other stuff.

As an example of this, I was talking to some people recently who were - as it's public here I won't talk about the specific policy context - contracting particular sorts of services looking at the coverage in a national sort of way. "So what we've realised is they'll be a lot of people wanting to bid for these services in metro areas where there are a lot of people and a lot of competition for them but we're going to really struggle to get these delivered in more rural, remote areas and we think our only option is to step in as government and to provide them there." When we were talking to them, "Well, if that's your entire market, across that area, then will you be happy with the system where you allow people to come in and make a large amount of profit in the areas that are profitable but then you're going to invest money into the others where you can't do that?"

The market management skill is not that you're there yet to do that. So I think until there's a better handle on some of that then one of the potential - if we know that one of the potential dangers of private providers is that they may do some of that, then, know, government sets the rules of the game around this. No kind of one way is the ideal way to do that. So thinking about what the potential risks of this at the outset and how you mitigate for that is a really important thing.

Hospital funding and funding through DRGs is other example of activity-based funding. Should we be surprised if we have things that we read about in the media episodes of where surgeons are doing more procedures than are clinically necessary in operating rooms because they can put that on to the DRG and that provides them more money. The surgeons when you talk to them will say, "Well, we need to do that to operate our service in an effective way. That's how we have to pull our

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funding in." Not often a great outcome for the person who's on the table, but, then again, we know that activity-based funding systems incentivise that sort of behaviour. And we also know that a surgeon in an operating room is the one who's the charge and who's leading that sort of team where there are a few challenges again. So we need to think in a more sophisticated way. If that's what we're being incentivised to do, how do we guard against the worst effects of that.

So this is back to the capacity/capability thing. If we're going to go down that route and have more competition and have more contestability in the ways that you've talked about, have more consumer choice, can we ensure that we have the stewardship skills to make sure that happens.

MR INNIS: So as a summary, I think what you're saying to us is we need think very carefully about recommending to government the capability side and emphasising that as part of the reforms we're doing across all of the areas that we're doing? Is that a fair summary?

DR DICKINSON: Yes.

MR INNIS: Thank you.

DR DICKINSON: And some of the building around that and recognising the time and the costs involved in that. There is a sentence at one point in the report that does say there may be some additional costs associated with that. I think especially in the first couple of years there are going to be significant investments that will need to be made.

MR INNIS: Thank you.

DR KING: Thank you very much.

The next organisation is Anglicare Australia. If you wouldn't mind stating your full names and organisations for the transcript.

MS EBSWORTH: Imogen Ebsworth, Director of Policy and Research for Anglicare Australia.

MR MANDERSON: Roland Manderson, Deputy Director for Anglicare Australia.

DR KING: Would you like to make an initial statement?

MS EBSWORTH: We would.

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MR MANDERSON: A little team effort.

MS EBSWORTH: Yes. I guess first we want to acknowledge that we're meeting on the land of the Ngunnawal people and pay our respects to Elders past and present. Thank you very much for the opportunity to engage with you on this.

I guess from our point of view the way we would put it - we like literary references - is the draft paper for us is a bit of a tale of two outcomes. We are really heartened and really happy with the direction of the recommendations in family and community services and Indigenous remote services as areas that obviously Anglicare is engaged with, not so much with social housing, and I'm going to let Rol speak to that.

I guess the two comments I'd like to make in regard to your recommendations around family and community services and Indigenous services is to take what's not a Zen Buddhist saying that everyone thinks it is, which is leap and the net will appear. I guess what we feel is that your recommendations are enormously valuable in moving the conversation in Australia really forward on the delivery of these services. Just listening to the dialogue you were having with the associate professor, there's a lot I would agree with. What I think we're looking for is two things: one, to take it a little bit further and explicitly acknowledge, as you have, but actually conceptualise it in our recommendations that human services deliver more than just individual outcomes and that commissioning processes should actually explicitly look to measure that and to commission for it.

Then as a result, we are a little bit hung up, you probably noticed, on the concept of intelligent commissioning. But that's not because we think it's the only way, but it's more that we can look directly to the UK at a Westminster government system that's got 20 years of experience of trying to bring in institutional frameworks to deliver the kind of things you're recommending. So I guess we're looking for that intelligence to be built into your recommendations because it does two things we think are really valuable: one, it helps us to have a framework for which all participants in the human service delivery can actually look to the institutional and regulatory forms that we need and the information we need and the training and capacity; and, secondly, it takes what I guess we've always been talking to you quite a bit about and saying don't think of user choice, think of user empowerment and agency, and particularly that concept of co-design and co-production and look at the example of intelligent commissioning in the UK and how they're trying to do that.

It's got an awful lot of correlation, I have to say, as the lucky bunny in

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the office who works on the NDIS with what we're trying to do with the NDIS. We're trying to actually go quite a lot beyond user choice and control with the NDIS; we're trying to empower people and give them aspiration in their lives. There's no reason why we can't think that way about what we're doing in human services. But we honestly think the language of user choice is too impoverished to encapsulate that.

There's an interesting bit in your report where you kind of say, "Well, if we can't have user choice, you could have co-design and at least give people's preferences some airing." We're saying, one, why not both, and, two, we think that actually co-production and co-design go much beyond just giving you, if you like, the brochure effect of consumer choice of where you go for your services and actually say, "Well, what outcomes do you want," the person who is receiving these services, and "How can we support you to get them and what role can you play in delivering them, which is fundamentally empowering." I'll hand to Rol now for the bad bit.

MR MANDERSON: So you won't be surprised with our position on this because we've extensively about it. So I guess you know in our view, part of the reason I really wanted to come and talk is because I think that the Productivity Commission is in a really important position in that it's analysis is considered fairly carefully by all sides of the political fence. As you know, we see the recommendation to move to market rent across the board with an increase in CRA as actually genuinely dangerous. We think it's a recipe that will increase poverty and rental stress for at least 850,000 Australians, and we also think there is no shortage of people or interest groups who would view the notion of cutting back on security of tenure and allowing the market to find a solution to be a good thing. So our fear is that in coming out with these propositions people will grab hold of the part of it that supports their view to their ends or to their enthusiasm or to their ideology and the human consequences will be for the people who we work with substantial and immediately visible.

We have yet to see any evidence that suggests these changes would make any appreciable difference to the number of properties available and affordable to people receiving Commonwealth rent assistance. So when we ran through, as you know, the figures against the information that we have, we found that maybe two more properties might be affordable to a couple on Newstart if we increased CRA by 15 per cent.

We point again, as so many others have done, with the actual failure of the housing market to meet the needs on low incomes in Australia. We understand the brief of this inquiry, but we remind you that you still could and should acknowledge the market failure that you're seeking to address with these possible reforms to the social housing system. Given it's the very

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same people who the market has failed who are likely to find themselves back in the market if part or a whole of those recommendations are just picked up and run with by government.

So we understand there's been no modelling done on the impact of these changes. I could be wrong, and I would be interested to hear that, but, as far as I understand it, you haven't actually done an analysis and a modelling of what impact it will have on all of those people and the markets of the 15 per cent increase to the CRA and the shift towards market rent.

We'd also like to fly the flag here for stronger tenant rights. The private rental market does not have real security of tenure, quality of housing guaranteed, energy efficiency, scope for modifications et cetera. So to have as a kind of a semi throwaway, "Yes, we should improve a bit security of tenure," doesn't go anywhere near close enough to talking about what tenant rights would need to be to even imagine that the private housing market in Australia, even if it was restructured completely, would come close to providing any degree of secure, appropriate, affordable housing for people living on inadequate incomes, which is essentially what we've got, with the hundreds of thousands of people who live on inadequate incomes in this country who are deliberately put on inadequate incomes in this country.

Similarly, we can have no confidence that people living a disability and people who are ageing and growing more frail can hope for the private rental market to meet their needs. It will not do that. We can maybe put some requirements in place to make it respond a bit more to their needs, but I don't know how we get to a market which wants to meet those needs if we're just talking about a private market.

I had a brief conversation at the Melbourne Economic and Social Output Conference last week, as you might know, I was there. I spoke to Commissioner Richard Spencer who was on the panel with me, and he said that while the Commission maybe couldn't prescribe all the solutions to the housing problems of Australia, which I'm referring to here, maybe what you were doing was suggesting at least some improvements. I'd say we dispute that. I'd say, in fact, that you are suggesting damage and a further unpicking of any kind of broad social commitment to ensuring that everybody has a right to a home. To recommend greater housing insecurity and market rental for everyone living on grossly inadequate incomes is to generate increasing disadvantage and housing inequity across Australia.

DR KING: Thank you for that. Perhaps if I could start by clarifying a few things. I suspect we'll spend a fair bit of time on social housing, so I won't start there.

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MS EBSWORTH: I suspect you're right.

DR KING: You mentioned the intelligent commissioning and user empowerment. I think that's actually a fantastic term. I really like that term - not the one used in the terms of reference, unfortunately.

MS EBSWORTH: Yes.

MR INNIS: While Steven's collecting his thoughts, when we use "choice", I think words, words, words. When we use "choice" we certainly are intending to mean the agency and the empowerment that comes with choice.

MS EBSWORTH: Yes.

MR INNIS: So I think in our minds as a Commission we're trying to capture through that word probably something that's closer to your mind. And I appreciate different people read words differently. I'm interested in your take on the UK experience. So when I look at the UK, I see they've done a lot of things and in a few areas we are certainly following them. I'm not necessarily seeing this 20 years of experience resulting in markedly better social outcomes than we're achieving in Australia. Context really matters. I understand the UK is living in a somewhat difficult context. But I'm not seeing something that would say just buy that because they're definitely better.

MS EBSWORTH: Look, I would agree. I think the devil is in the detail. I think what I see as different in the UK - and I had the privilege of a one-month study tour in 2014 looking at a few things - was, first of all, the context of austerity is incredibly loud and confusing in the UK. I think one of the reasons we don't see the outcomes that we would like that will be commensurate is, bluntly, because they've defunded an incredible amount of their human services.

I went and met with councils. Councils in England, as you probably know, rely up to 90 per cent for their funding on the central government, and they lost over 80 per cent of it in some cases. So they were in the process of doing things like selling off all their community housing assets at the same time trying to use a process that would allow the social value of that asset to be retained.

I agree; we're not trying to say here's an off-the-shelf model that you can just pick up and whack into Australia and it will work, because nothing works like that. I think what we could learn from them is perhaps what your former witness was talking about, which is about building the training and capacity and the institutional frameworks to support intelligent

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commissioning. That's where I think they're a long way ahead of us. How they've implemented it is a whole other question, I guess, but you can see the UK government until not that long ago, used to have an entire office of the third sector that was entirely devoted to working out how to leverage the best social value from what we refer to as not-for-profit or the third sector, a community sector. Scotland's retained it in what could be seen as an ongoing argument about Brexit.

They have invested in a social return on investment methodology and actually tried to apply it across the place and actually see what that tells their commissioners about leveraging value from their services. If I can perhaps flip it the other way around and talk to you about what I can see value in, I had the misfortune to be involved both at the political level and the personal level in the green loans debacle, if you remember that program. What probably most people remember is the department getting slapped pretty hard by the audit office and ending up with I think it was nearly 20 breaches of the Financial Management Act, which is some kind of awful record.

What I remember about it was it was designed to introduce energy efficiency into people's homes, particularly people on low income, but actually just kind of anyone who needed or wanted it. And what happened was that despite the fact that absolutely no thought was put into this element of that program, the people who started training to deliver those services were frequently people on low incomes themselves, people with disability who could see a job they could do that was small scale but would actually deliver a sufficient return and could make a meaningful difference to their lives, single mums.

So when that program collapsed there was this enormous unintended consequence of about 5,000 people - and I know this because I was part of the process of documenting it for parliament - of which a significant percentage had not been in the workforce for some time and had taken what little savings they had or had taken a loan and had gone to a training agency specifically to get into this program. So you had this entire other social value from green loans that was lost and was never even measured and was never even intended.

The difference I can see with the UK is because they have invested time into thinking about intelligent commissioning - and this point we keep talking to you about - and the actual value of return of an investment in human services that's beyond just that particular user or that particular group, is they would have recognised potentially the value of that program and gone looking to commission it in such a way to capture some of that value. We're not doing that in Australia that I can see, or, where it's happening, it's because of largely mission-based organisations seeing

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opportunities and taking them.

Within our own network I can see that at the moment playing out with the NDIS there's this nasty nexus of trying to talk to the NDIA about the pricing structure and how to get that right and show that they're reforming and they're actually trying to deliver in a market and also looking at the staff who are being paid too little unless they actually choose to pay more, and then further looking at the possibility of actually employing people with a disability and that conundrum that's going on.

You can see the opportunities here, but I think in the UK what's different is there is an explicit intentionality from government to try and capture all the value of the services they're commissioning and to build institutional frameworks that allow them. We do not do that.

MR INNIS: Can I ask a question about our recommendations? One of them is to better match what government pays for a service and what that service is intending to do so actually pay for the full value rather than relying on implicit intra-organisational essentially cross-subsidisation. Does that help with those sorts of issues, because it starts a discussion about what is the value?

MS EBSWORTH: I think so, and I think also your recommendation around longer contracts helps with that as well. As an ex-bureaucrat I can't think of the number of times I've seen government programs really finally starting to deliver but, "Oh, no, it's year 3," and there's a change in government or, "We need to save something that's an election promise, and we'll just quietly gut that thing."

I think just alone that part of your recommendation helps remove some of the political tension in delivering good services and actually allows for policy iteration, including within contracts. That's missing at the moment. It's very difficult to get.

I think your other part about trying to actually properly value what's being funded and then understand what you're getting, yes, is equally valuable. But I would agree, again, with your previous speaker about the need for cultural change. It is a really big one, and it's very hard for bureaucrats to get that space otherwise. The culture of risk aversion is just massively increased by political time cycles.

DR KING: Can I take you back to something you mentioned in your opening comments, which was the importance of community outcomes and measuring those outcomes. I note that you discussed that previously. I guess my wonder or my issue is how do we actually make that practical?

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How do we measure the community outcomes? How do we feed that in to the process? It's hard enough to measure individual outcomes.

MS EBSWORTH: Yes.

DR KING: How do we measure community outcomes in a way that is practical, can be used in a contract or can be used in a relationship?

MS EBSWORTH: Look, it's a very fair question, because the danger is strange activity-based outcome measures that lead to really perverse outcomes. I honestly don't have any of the answers - like no-one - by a long shot, and I want to be cheeky and say, you're an economist, right.

MR INNIS: And he is.

DR KING: In theory, of course.

MS EBSWORTH: I think perhaps this is where the social return on investment has partly come out in the UK from third sector scrambling to show their real value bluntly with an austerity environment and show that they actually go beyond what they're numerically paid for.

There is one example I found in Australia just recently, and I only just had a chance to start reading about it but it really interested me. The Prime Minister and Cabinet actually commissioned a social investment return analysis of Indigenous protected areas to try and capture community value there. So I guess what it says to me is that there's a body of literature and methodology developing around this. How far it's got I think is up for robust criticism and discussion. But I think a lot of Australian innovation often comes best from taking what people start with and then riffing off it, and maybe this is an area where need to look at.

I think also, finally, what I would add to that is the Commission's recommendations particularly around training and capacity for government are vital, not least because there's been a hollowing out in government of those skills because they've been outsourcing a lot of the services, there's not been seen a need to keep people within who actually understand how to measure or to deliver or to monitor. That's a real problem. If we don't build up that training and capacity, the government then can't be confident enough in admitting that it's learning. It's very hard to admit that you're learning when you don't actually have any of the expertise in house to know what you're measuring.

I think, yes, things like the social return on investment are worth looking at. Whether they've got all the examples, I'm not sure, but I do note

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that in the UK one of the reasons they are continuing with it is it can also be scaled up through economic modelling, which then gives us something to pull apart.

MR MANDERSON: There's a couple of Australian examples. Out-of-home care in New South Wales developed an integrated outcomes framework. I was talking at the conference and there was integrated outcomes framework for out-of-home care in New South Wales. So they're looking there about impacts on family, impacts on community and a whole lot of things, not just looking at what's happening to the young person and are they staying safe where they are and are they going to school. It actually tries to zone in on all those other things.

I think it's probably also worth - I know it's not the answer to everything - but the Communities for Children program which began back in the 90s or the early 2000s under John Howard, which builds in some governance of community organisations as well as lead agencies who are funded to deliver outcomes for children and their communities do some interesting work on that front. I know that Professor Ross Homel is doing some work on collective impact and trying to work with those organisations to develop some projects over time to start to build that kind of measurement process which actually reaches beyond the programs but works toward the next iteration programs for community.

So I think there are things that are happening in Australia. It is not like we are just talking in imagination; we just do not have enough things in place really to be able to kind of know and institutionalise them.

MR INNIS: I can see a tension ultimately between primary objective and secondary benefit.

MS EBSWORTH: Yes.

MR INNIS: And absolutely you want to consider it all together. But when you start the practical process of governments making priorities and allocating funding, there's got to be a primary objective. I just want to test - and I am testing - you would agree that you've got to start with a primary objective?

MS EBSWORTH: Yes.

MR INNIS: Communities for Children is a good example where there's a primary objective.

MR MANDERSON: Even the primary objective is quite broad there.

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That's the interesting thing.

MR INNIS: I understand that. Out-of-home care probably has tighter objectives. I guess I'm confirming that you've got to start somewhere.

MR MANDERSON: I think it's a bit about language, too. So we talk about independence and I got Anglicare Sydney pulled me up a few years ago and said, "We don't pin all our flags on independence so much, Roland, we use interdependence, because we actually think that the value for the human being" - if we get back down to the individual - "is their connectedness with other people, and the value for those other people is their connectedness with that person." Your capacity to do things isn't dependant on what you can do yourself necessarily. It might be dependent on how you work with others. So even when we get right down to the primary purpose, the language we use will make a difference in terms of how we see it.

MR INNIS: Again, a words thing - independence sitting in government probably means a slightly different thing to independence in - - -

MR MANDERSON: Well, it may and it may not, depending on who's making the call at the time I think.

MS EBSWORTH: Yes, to come back to your question, I agree. You've got to have a primary outcome you are trying to commission. I think as your recommendations have shown, one of the issues we're facing is that governments are an awful long way from understanding precisely what their primary outcomes are they're trying achieve. If you're worried about confusing them now, I am too.

But I think more specifically - I hate common sense tests, but there is a slight element of that. One of the examples, I used to live in Tassie. There used to be a service for people with intellectual disability that gave them jobs that delivered the local resource and recycling tip shop where you go and stuff that shouldn't have been chucked on the tip has been rescued and cleaned and you can purchase it, and it was great. It gave people local employment. They got to interact with everybody. It was really positive. They delivered it effectively and cost effectively, and the local government put it out to tender and a large for-profit came in and said, "Well, we can deliver across all three tips for cheaper," and so they got it. And community uproar ensued, and, quite rightly, because it was like, "But you had a perfectly good thing going. It was cost-efficient, and it was delivering employment outcomes, and out of that it was making all these other families happy because they had somewhere for their kid with intellectual disability to go."

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I'm not really even trying to have a subtle whack at a for-profit; I'm just saying that there is a certain common sense element. The primary objective of that was to run the tip shops effectively. They just were getting a beautiful value-add. Why would you throw that out or not measure it?

DR KING: In some ways, our remote Indigenous recommendations, smarter contracts, think about more than just the money.

MS EBSWORTH: Yes.

DR KING: We're trying to capture some of that.

MS EBSWORTH: And I think the other thing that's really interesting, you talk quite rightly a lot about the need for better collaboration in government and between government. And it seems to me that one of the ways to make that happen is to actually try and capture the values beyond primary objective because then departments are kind of forced to talk to each other a bit more.

Just to finish on an anecdote, one of our key people in Anglicare NT was talking to me about how he'd just been to a seminar on the NDIS and he kept asking them if they had recognised the fact and were doing anything about the fact that he was going to one provider for aged care, and it's the same providers in the community but there's been no formal effort by government to try and link up those providers and think about more cohesive services, even though there's a lot of similarity. The answer of the chief bureaucrat to him was, "No, still not doing it. Can you keep asking that question because then I can force someone to do something about it."

MR INNIS: In our own way, our focus on outcomes, whilst starting at the individual, is partly designed to do that.

MS EBSWORTH: Yes.

MR INNIS: Because services do - - -

MS EBSWORTH: That's right, exactly.

MR INNIS: It's probably time for us to move on to the less friendly discussion.

DR KING: Yes, social housing. What I'd like to do, let me give you the 2-minute why we got to where we did so that you understand. Then I'd really like to work through what we see as the three key areas, one which is

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income-based versus market-based CRA-style rent. One is the interaction with the private market and the third one is the high-need payment or the high-cost payment and how that's done.

MR INNIS: Could I just clarify something?

DR KING: Please.

MR INNIS: Roland, you've mentioned the rental stress of 850,000 Australians. I just want to understand that. We've got roughly 400,000 people in social housing.

MR MANDERSON: We've got 850,000 people in social housing. The AIHW figures.

MR INNIS: Okay.

MR MANDERSON: So that's 309,000 households.

MR INNIS: Okay, so it's households versus - - -

MR MANDERSON: Children.

MR INNIS: And dependants and others, okay. Our recommendations say that those people should be protected for at least 10 years, that their circumstances would not change.

MR MANDERSON: Yeah, that's your - - -

MR INNIS: For at least that 10-year period our recommendations involve an increase in support for those who are currently outside - - -

MR MANDERSON: Yes, I appreciate the outside, yes.

MR INNIS: And our recommendations certainly start with CRA but include a state-based high needs housing payment, which is designed to allow and provide responsibility for state governments to respond to their local circumstances by providing additional support to the people who need it within their jurisdiction. I just want to make sure that - - -

DR KING: It's all the bits fitting together.

MR INNIS: It's the 850,000 people will be in rental stress. I now understand that it's every person living in those properties. But I just wanted to reinforce nothing in our recommendations results in someone

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being less well off than they are today.

MR MANDERSON: So I guess I'd say to that - and I understand that exactly - one, you make recommendations that give or take actions and they're not necessarily exactly linked to the prescription of how you think they should happen. So what you're doing is you are saying it's okay to go to the market, it's okay to get rid of the link between income and housing. So, yes, if the government didn't make the rule, just go straight out on to the market tomorrow, it wouldn't happen tomorrow, but, eventually, you know, my view is you add up the numbers, that's the quantum eventually of greater rental stress that's being created by stepping away from the link between an income proportion of rent. And that's because, I believe, that the housing market has failed and there is not a housing market there. There's not a supply of housing that's affordable for people on low incomes, even with 15 per cent increase.

I appreciate the thing about the state notion and, again, you know, I have enormous doubts that, one, the states would do it in the way that you would want and, two, that they would do in the places that those people necessarily live because the value of the properties are so much et cetera, et cetera. So I think that it is kind of like, yes, I was talking with what I see as the implications rather than the recommendations, but I'm absolutely convinced that those are the implications.

DR KING: So if I can come in, because that's really good. I guess, begin, our starting point, even ignoring the 10-year part, the state governments, of course, get the higher rent, the market-based rent. The CRA is increased and it would go to social housing. So the state government is getting an extra pool of money from this which, if they so chose, they could just say, "Well, we're just putting that back to social housing." That's our definition of high cost. If they did that, then in perpetuity no-one would be worse off because all you're doing is transferring money from left and right to the right hand. Of course, they can be more subtle than that and hopefully we would want them to be more subtle. Your fear, if I have got it right, on that high needs payment is the next time an austerity push, to take your words, comes in - - -

MR MANDERSON: I think state governments are dealing with austerity pushes non-stop at the moment anyway, so I think there's a whole revenue problem going on across Australia's political world. So I don't think - I would argue that there's not enough money in the system to pay for all of the services that we need. I can't see - - -

DR KING: Definitely not.

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MR MANDERSON: I would say that state investment in social housing has been inadequate over the past many years. Their ownership of public housing has diminished. The cost of public housing per unit of human being has gone up because of that. So if it was framed in a different way, I would have much more sympathy for the argument, if I understood that you were saying that those factors - the problem of the market, the lack of the revenue, the disinvestment of the past years - are all things that need to be addressed in a strategy to deal with it. Then I would be much more interested in looking at careful at what are the mechanisms we can make to make all these things work together. But it seems to me very clearly that that's not the environment we're living in. Like I say, my fear is you are talking into an environment which is not sympathetic to that kind of prioritising that needs to happen if we want everyone to have the right to a home.

DR KING: That really is right, then. I guess we're saying we take on board all of that and say we are where we are and how can we make things better for the people trapped in the system?

MR MANDERSON: I think the very first thing we should do is acknowledge that the market has failed and there has been insufficient investment. That would give those of us who could be your advocates for a change in policy a reason to believe that there was a point in advocating on track with you. I'm not convinced, but without that there, you know, all you're saying is that - I won't say what I imagine you're saying. I just don't think that that's helpful without setting it up in that way.

DR KING: That's very useful, because an initial push back has been by people saying, "We need more social housing." And, I guess our response has been, well, that hasn't been built in the past. We can say that, but it's not going to do - - -

MR MANDERSON: Well, you should say that, and you must say that. Like I say, people listen to what the Productivity Commission says. If you don't say that, you're saying it's okay.

MR INNIS: We're conscious a little bit, and I'm particularly conscious, that not so long ago the federal government invested $6 billion in the creation of new social housing, and yet six years later, seven years later, that investment is not showing up as making any difference from the evidence that's been presented.

MR MANDERSON: Well, you know, I think one of the things that is clear in the NAHA announcement's budget is the argument which we absolutely support to say all governments have to be accountable. It's not one government. It's not cost shifting; all governments have to be accountable

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for increasing the supply of social housing.

And the other thing I just come back to in terms of - and I absolutely agree with the argument to say that the way it works at the moment, people who are in social housing and have some security of tenure are advantaged over those who are equally or almost as equally disenfranchised and disadvantaged but who don't have access to that housing. I would say just because some people are missing one leg, it is not a reason to chop the leg off everybody else so they're equal.

DR KING: We understand that.

MR MANDERSON: To me, the argument that to make the system more equitable everyone needs to be on that, we must get rid of the link between a proportion of income - I do believe we must get rid of it, I just made my point. To get rid of the link between proportion of income and rent because then we'll all be equal is ridiculous.

DR KING: Can I stick on that point, because that's one of the key things. You'll see in the report that we discuss - the trouble is we see so many different versions and background papers and so on, I'm pretty sure it's in the report. We had an internal debate on do we move down the income base or proportion of rent base and which is the better system. Our starting point was, well let's just look at each of them and let's see which one works the best.

Our problem with going down the proportion of income approach is where that's been used particularly in areas like the US in some of the states, what happens is when you have the private market involved - so we wanted to make sure that, again, we didn't have one system on social housing and then a worse system for those who can't get into social housing. So if the private rental market went out on to a proportion of income, we've seen in the US that that creates very nice incentives from the perspective of landlords because, of course, you're paying a percentage of your income which is fixed up to a rent cap, you don't pay any of the extra rent, so, surprise, surprise, all the properties that were available for social housing, or low income families, essentially, who were receiving this payment or have this right end up being just below the cap. So all the government does is transfer great big wads of money to private landlords. That was a key argument by saying, well, that's not going to work in the private sector if you then in the public sector - it's just transferring the money to the government and the state government can then transfer the money back.

MR MANDERSON: I wonder what would happen if there was so much social and public housing that it really was a buffer to the market and so that

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there wasn't quite the advantage or the capacity of the private market to essentially charge - there's not a lot of competition. So that might change the whole mix if you actually - - -

DR KING: And I actually would like to come to that next, but, again but given the world we've got, there is inadequate public housing, so that was one of the arguments.

MR MANDERSON: We are trying to grow the supply of community housing. There are some things in the budget that you guys talk about. But it's going to take a long time.

DR KING: Yes.

MR MANDERSON: And there are a whole lot of drivers of government policy that, if changed over time would - there are a lot of things. I don't want to wish for the property market collapse completely because I think we have an economy based on people having wealth. But, you know, we should at least acknowledge that that wealth has created a system which has created this division.

MS EBSWORTH: Sorry, it's just when you pick up and read your draft report and you start with palliative care and there's a massive unmet need, we need to invest in it with public money, and then you turn to social housing and it's like, the market has failed, we should give the market more money to solve this problem. I mean, I'm being a bit simplistic, but that's the dichotomy that really first strikes you reading the report.

On that, as you said, we wouldn't disagree that there's been a fundament failure for public housing to be built. That is a really large problem. But is it so ridiculous to addressing the social housing system that you might say to government, "Gosh, perhaps you could stop incentivising people to have massive investment portfolios and you could take that money and you could quite rapidly, if you can't build it, purchase housing for social housing." That is just not happening, and yet most of the analysis says it's not a lack of housing stock in Australia; it's who has got it and who can access it.

DR KING: Empty housing and tax incentives for negative gearing.

MS EBSWORTH: Huge things going on, exactly.

DR KING: I agree.

MS EBSWORTH: I appreciate your brief wasn't to tackle the whole lot,

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and perhaps you sort of sat and cursed a lot that you couldn't, because you could make a more substantive - but even within your terms of reference, even with palliative care where your terms of reference was about competition and contestability, you certainly had the space to say, "Well, actually, what's missing is enough service." In social housing, what's missing is enough access to affordable housing. That's what's missing. So we're kind of looking going, therefore, why the dichotomy in approach? I guess it's particularly inexplicable when you look at the conditions of renting in Australia. I'm a well-paid middle-class woman, and I'll probably still not move - having moved to Canberra - because my landlord's ace, right. Even though the house is not entirely - do you know what I mean?

DR KING: Yes.

MS EBSWORTH: If you are - - -

DR KING: It's hard to rent.

MS EBSWORTH: The recent report showing that 83 per cent of people have no fixed lease, that 50 per cent felt discriminated against, particularly if they're on low income and on disability, how can you possibly think that that framework is going to help people on low income. If you look at accepted poverty lines without the housing cost, basically our housing market we've got two things going on: people don't have enough money and the housing market's bloody out of control. So even a little bit of CRA is not going to address this and in this place you have no security of tenure and you'll be discriminated against.

DR KING: One more point and then I'll pass over to you.

MS EBSWORTH: I'm just genuinely lost.

DR KING: We're sort of largely in agreement. It's the solutions that we're going to - - -

MS EBSWORTH: Yes.

DR KING: I mean, we mention - again, this is a draft report, because we want feedback.

MS EBSWORTH: Yes.

DR KING: So we mention head leasing, but we don't push it too hard. One of the ways to get over both the problems is inadequate social housing, well, there's not inadequate number of dwellings out there.

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MS EBSWORTH: No.

DR KING: We've just got to get them in.

MS EBSWORTH: Yes.

DR KING: The private rental market isn't working for private renters, so, you know, it will work far less for people who are on government benefits. They're at the bottom of the list. So, again, one of the ways is government coming in head leasing and actually saying, "Well, we will act as the intermediary." Rather than having to build more dwellings, which is going to take a long time and a lot of money and, quite frankly, I think has very little likelihood of occurring - it's certainly not going to solve it in the next 20 years - let's take the dwellings that are out there in the private market, let the government act as an intermediary and say, "Let's take head leases on private properties. We deal with the landlords out there. We then use those as social housing." Is that a way - there's a rental relationship still - you're renting but formally through the government - is that head leasing a way of sort of breaking this? It's sort of trying to cut that Gordian knot.

MS EBSWORTH: Yes, maybe they should rent to buy. Sorry, but - - -

DR KING: That could be right, yes.

MS EBSWORTH: Because it's put to a lot of people on low incomes is that they rent to buy in social housing. I wonder if government should try it with head leasing. I don't know. I'm looking at Roland to see if he's going to kill me.

DR KING: Even without rent to buy, is that a way of - - -

MR MANDERSON: It seems to be wrestling with the problem. And that's fantastic. It's really about flying the flag to say this is the dimension of the problem, we need to wrestle with it. Just to come back to the rhetorical point we made before, before you move on to your next bit, Sean - I won't keep you waiting too long - the issue to do with capital gains tax and negative gearing, you know, the Labor Party - just to be completely political about it - the Labor Party is flying that and that's been great for the public debate, but they're not saying they're going to put the money into housing.

The coalition is saying, "No, we can't do that because we're not in the market, we're trying to solve the housing problem in a different way." Pretty well everyone I know other than people who have got a direct investment in property - and that includes superannuation, it includes banks, it includes

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accountants, it includes economists, it includes people in our sector - would say that's a problem which should go. If the Productivity Commission said that should go but, for goodness sake, put that money into housing, you would move the whole debate another giant step in the direction towards providing over time greater supply of affordable housing for people on low incomes in Australia. You can do it. You have that power in your hands by simply saying something which is a little bit contentious in that way but doing it in a way to say it's actually about solving the housing problem; it's not about just putting more revenue in the back pocket of the government.

MR INNIS: So hearing your recommendation to the Commission, we will, as always, think carefully about our terms of reference and think carefully about the powers the Commission does have.

MR MANDERSON: Of course.

MR INNIS: I want to reflect back before I go on. Reflecting back, as a number of participants have said, we probably have not explained the context of our recommendations deeply enough because there are things happening outside our recommendations that are very important determinants of the ultimate outcome. And I think what you're talking about in terms of the broader housing market and the supply of affordable housing - and I distinguish affordable housing from pure public and social housing, they are different things.

MR MANDERSON: Good, yes.

MS EBSWORTH: They are.

MR INNIS: We are talking about housing that is available and affordable to low income people.

MR MANDERSON: That's right.

MR INNIS: I do want to come back to partly the other things that are involved about supporting the people we are really talking about. Again, our starting point was we looked at the system as a whole. We said about a strong a thing as you can say about social housing - which is it's broken.

MS EBSWORTH: Yes.

MR INNIS: Part of the reason we said it was broken is that we've got all of those people, as you acknowledge, outside the system on exactly the same incomes. They are not on different incomes; they're on the same incomes as people inside the system. At an absolute practical level, I cannot see the

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number of dwellings being built. If we're relying on the government to build dwellings, even with a bit of extra support, we just can't see that happening in any practical sense. So $6 billion bought 20,000 dwellings about as cheaply as you could get. We had an estimate yesterday that 200,000 are needed in New South Wales alone. So other people can do the math.

What we did think we could do was make sure that there was a system that did two things: one, evened up for the new people - not the existing people because we're grandfathering them - evened up the level of support so we're delivering a little bit more equity in the system, put a bit of heat on state governments for those who benefit from high housing prices through their revenue to support the people who are affected by those house prices through high needs payments, but clearly also focus beyond the price issue to the other support that people need to be able to hold a tenancy, be it in the private market or be it in social housing.

MR MANDERSON: That's right.

MR INNIS: We were focused on a few things. One was security of tenure. So we've got an awful lot of people who others have argued that, actually, it's not necessarily price that's their biggest concern; it's the security of tenure. That's their biggest concern. I just want to reflect that to get a reaction. Should we focus a bit more about security of tenure issues in the private sector and what the private offering is?

Secondly, in the world we're trying to head towards - that real focus on a proper assessment of not just the dollar needs upfront but actually the support needs - is that heading the system in the right direction so that support is available no matter where they end up?

MS EBSWORTH: So I think to take your first part, yes, I think you need to focus much more on tenancy rights. Even if we put aside disagreeing with you on where we find the housing for people and how we do it, tenancy rights in Australia massively lag behind most of the OECD in terms of what you get. They're not even rights based particularly well. The fact that you can be summarily evicted with 60 days' notice in most states in Australia for no reason - you don't have to give a reason, you can just be evicted in 60 days. We could give you examples from services on the north coast of New South Wales where children have had to go into foster care because their parents cannot find accommodation sufficiently quickly after being summarily evicted with no reason given. It's that bad.

That's the extreme of it, but it's bad for everybody. So, yes, it needs huge reform in that area. If you wanted to look at a niche area - just coming

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back to your question of head leasing that comes to mind - it would be perhaps the 45,000 estimated people with a disability who are not going to get any assistance through the NDIS for their housing needs. If you look at the NDIS, as you may know, it says that if they're going to pay for modifications for your house if you're a person with a disability, you have to be able to show value for money and that you've got the willingness of your landlord if you're renting. You don't have to be much of an expert to put those two things together and see it's rarely going to happen.

So if you wanted to explore whether head leasing could be particularly useful as a way of expanding social housing, perhaps that's one group that is significant and significantly disadvantaged that you could look at.

MR MANDERSON: Aged care also.

MS EBSWORTH: Yes, Roland knows way more about aged care than me. You can find cohorts of population with very particular needs that you can see it's in everybody's interest if they had security of tenure through government assistance that then they could get the modifications they need and the housing they need for their lives and a significant proportion of unmet need.

I guess the other thing I want to put back to you in terms of if you're going to look at - I totally take your point about the fact that there is this huge swathe of people outside the social housing and that we're not going to see houses built necessarily in time, so what is the public intervention. I guess I'm curious that you went for CRA and not, like, the base rates because CRA is pretty small and it's meant to be a supplement and it's broken. The reason that it's kind of broken - and youth allowance gives you a really good example - is that what we got from DSS is that CRA was kind of meant to kick in at about 20 per cent, ironically, proportionately of your income. So you can't get away from proportional income. But what's happened is that youth allowance particularly has fallen so far behind you now don't get it until you're at 27 per cent, which is just below rental stress. And then what you get is the same as everybody else, but you're still lower than everybody else so you're still stuffed. Which is why our rental affordability snapshot finds that even if you're in Whyalla where everything has collapsed, including the housing market, you still can't afford to rent as a young person. It's that bad.

So why CRA and not talk to government about the fact that they haven't raised income payments for people for over 20 years and they're so massively out of step even the business community wants it fixed? Why CRA? Maybe CRA should go and we should actually pay people what it costs to live, including housing in Australia. That's just, I guess, a thought

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I would put back to you. If you really want to look at making people, if you like, portable within the system with sufficient funds to get what they need in terms of human shelter, perhaps that's the place to look.

MR MANDERSON: And the other question that you raised was the one about tenancy support services or human support services for people so they can sustain their tenancy. Absolutely we agree. Other than the big picture ones which I've kind of flown the flag for as extremely as I could, I think those other things we were really heartened to see that stuff. Exactly, the tenancy support, choice-based letting, if there could be enough housing that was available, then choice-based letting makes lots of sense. And in cases where there is more, because supply around the world there are systems set up where you can actually put yourself on a list and make choices, but you do need the supply there, but absolutely choice-based letting is another example. There's a whole lot of things there when you pull that apart.

And we did raise some questions about a kind of philosophical division between if you own a property or you're a tenancy manager or the service provider they should all be separate. And I guess we would say that like a lot of these things, many circumstances are different to many other circumstances and depending on where you are and who the communities are and what the place is and what the supports are, then maybe it does make sense and maybe it doesn't, but certainly you need to be cautious about how you bundle up the support and how you are funding different services. We agree with that, but we wouldn't have a hard and fast rule.

DR KING: Thank you very much.

MS EBSWORTH: Thanks for that.

MR MANDERSON: Really appreciate the opportunity.

DR KING: Thank you.

Ladies and gentlemen, that concludes today's scheduled proceedings. For the record, is there anyone else who wants to appear today before the Commission? If you can come down here and state your name and if you represent an organisation, state your organisation for the record, otherwise in a personal capacity.

DR HEATON: Dr Adam Heaton. I can represent the views of FRSA - Family and Relationship Services Australia. We put up two submissions, one to the preliminary findings report and secondly to the most recent draft report.

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I've got a couple of thoughts. As you've seen, I've been here all day - I've probably eaten half the biscuits out the back there. FRSA represents organisations that do deliver family and relationship services, so anything from family violence responses through to child protection through to family mediation when there's a conflict et cetera, et cetera. There's quite a few different services. We are just one part of family and community services.

So just the fact that we deliver all these different services and we are only one aspect of the family and community services sector, which is chapter 7 of the report, kind of indicate the degree of range of kind of services that you guys have had to tackle, and I appreciate the complexity of where your heads at, even right now at the end of a very long day, trying to consider all these kinds of things. I do note, though, that about 80 per cent of the discussion today has been around the social housing area.

My focus is, again, on chapter 7 - the family and community services recommendations. I've noticed that during the day you've wanted specific feedback on the recommendations, so I've jumped to the chase. I've got four responses here that I would like to go through based on four of the recommendations that you have put forward.

First of all is the remuneration of efficient service delivery. I think that the term "efficient" needs to be unpacked and defined a little bit more clearly because family relationship services are very complex, but we are dealing with very complex family needs. What you mean exactly by "efficient remuneration", it needs to be fair and reasonable based on trying to deliver a holistic wrap-around service for the clients that we do try to meet the needs of.

So maybe a bit of a definition around calculation or what maybe the intention is. It's too much information. I realise that it's already a 420-page or something draft report. It can't be an 800-page report, so in response to a few of these recommendations, I really do believe that part of your bigger or overarching recommendation to the minister probably needs to be that in going forward with any of the recommendations, let alone more than a few of them - because they are pretty big recommendations, as we've heard a few times today - that there does have to be clear consultation and negotiation with the sectors involved, realising that there are numerous sectors that do overlap, even in just the delivery of one particular service program. That takes time to do, so I really think that there does need to be a very clear overarching recommendation to the minister moving forward. So the first one's about the efficient service delivery and exactly what that does mean and trying to work out the definition and the calculation of how that would play out does need to have that consultation and negotiation.

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Number two is the relational approaches to contract management. That is a new term that wasn't in the preliminary findings report, and I realise it's not new to service delivery, but it is new to our sector. Again, I think it does need to be defined and that does need to come through consultation and careful listening and negotiation with the sectors involved.

The third one is to not discriminate between for-profits and not-for-profits. We have heard that a couple of times today as well. I do believe that you do need to discriminate against for-profit and not-for-profits because there are very different outcomes and purposes of both. One is trying to make a profit and the other one is trying to get a social value. I heard your questioning before - I think in the last session - about what is social value, like, how can it be defined. I'm happy to share a couple of documents out of session regarding how it can be measured, how it can be maybe understood as part of the mix, because I think it does need to be part of the government's decision-making processes in deciding who gets funding.

I do think that there is a risk - which takes me through to the next point - about seven-year contracts, great, it's fantastic. I don't think anybody would dispute that. But there does need to be checks and balances along the way to make sure that someone is delivering. Again, that has to be spelt out. It does need consultation, negotiation. So it's always going back to that. And I do really think that that has to be flagged. Whatever you come up with in your final recommendations and your final report, you are not going to have all the answers, and you know that. But that does need to be communicated clearly to the ministers upstairs, in particular, to Scott Morrison.

So then the other part of that is that if a for-profit is funded and they're not really delivering needs to vulnerable people because their bigger concern is making a profit and it's easier to make a profit in not meeting the complex needs of a vulnerable person, which is a very real risk and is already the case quite prevalently, then there does need to be those regular checks and balances. But, at the moment, there's no recognition of what that could look like. I don't blame you - again, it's a big thing. It does need that consultation and negotiation again with the sector. And I do really encourage you to put that forward clearly.

The last thing I wanted to recognise, I think, is also an overarching recommendation to the minister - the need to give fair and reasonable reimbursement to organisations involved in the delivery of these recommendations and the further scoping of them through the consultation. We know that the government tries not to spend much money, but,

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unfortunately, I think there does need to be money attached in this process, but also in the reimbursement or the remuneration of the delivery of new approaches. Again, what is meant by "efficient" and what really should be fair and reasonable toward meeting the holistic needs of complex families in reaching out for a number of different services across different sectors is really quite important.

So, again, really, really tricky, but I really do believe that that, I think, is your biggest challenge in moving forward and wrapping up your report - in putting forward to the minister that you do kind of make these complexities, the nuances, of the sectors involved, in recommending that there is that consultation and negotiation with our providers, because you're not going to get all the answers before you do make these final recommendations going forward. So thank you.

DR KING: Thank you.

DR HEATON: Any questions?

DR KING: In a sense, you've touched on a number of things there that we have been thinking about. So I don't think I've got any questions. I guess, just to reflect back, we are thinking of these things. Internally on the seven-year contract and the checks and balances, we have been using the term "big red button". There needs to be a big red button that can be pressed if a contract isn't working. So, yes, I think we probably can't put "big red button" in there - we know what it means but nobody else would.

I take on board your point about "efficient" and one of the bits of learning, I guess, I've had as part of this process is that whilst I think within the PC we understand that "efficient" means think about the services, think about the outcomes that you want, make sure you're capturing the relevant outcomes, make sure that you're getting an appropriate remuneration to the party, that you're identifying it, that you're not saying, "Well, look we'll underpay you because we want you to cross-subsidise," that needs to be made clearer. I think a lot of people see "efficient" as, for some reason being cost minimising or least cost or something like that. I can understand that some people have that view, but that's certainly not what we mean.

DR HEATON: Sure.

MR INNIS: But it does mean that an organisation with very high costs to deliver the same quality would not necessarily get all of those costs met. And I think that's the balance we're seeking to achieve. We would like organisations to deliver effectively and well with appropriate quality, but inefficiency shouldn't be rewarded.

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DR KING: Yes.

MR INNIS: So working around that in terms of how we explain the concept.

DR HEATON: Yes, I think it is in the wording. And from that there could be the potential to fund a for-profit because they don't require as much funds and they've got their own capital. So the value for money kind of aspects are maybe part of the discussion as well. But, then again, is that for-profit organisation really there to meet the needs of each and every vulnerable person in the community? So there's those kind of nuances and aspects of criterion in your selections in moving forward in who does get funded and how much toward providing sufficient funds for delivering a service.

DR KING: In another context, we've actually used the term "best practice" rather than "efficient".

DR HEATON: Yes.

DR KING: Just to try and get across the idea that it's broader than just cost, but it also includes a cost element. We don't want to be wasting funds that could be used to help other people.

DR HEATON: Yes.

DR KING: Just on the organisational type, whilst taking on board your concerns about for-profits, two feedbacks on that. What we've been trying to get across - clearly we need to recheck our wording because it hasn't been as clear as it should be - that it's government taking into account different incentives of different organisations, not that it simply is blind to those different incentives, but that is part of the decision-making process.

DR HEATON: Actually, the first time I read the recommendation, it didn't really jump out at me as being a big issue. You're just not wanting to discriminate, you're wanting to consider all the aspects of each application that you do receive, or each potential service provider. But then a few others in the sector identified that, you know, if there's no discrimination, then it could mean et cetera, et cetera, just as much funding or favour is given to for-profit organisations and hence it can have a dire effect on the number and the quality of service delivery from not-for-profit organisations. Again, it's in the detail, I think.

DR KING: In other parts of the human services sector, such as health, provision is actually dominated by small for-profit sole traders who seem to

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do very good jobs. So, again, I think it's making sure we've got horses for courses.

MR INNIS: Thank you for your patience and your useful contribution. We are certainly going to look at making sure that we're clear in what we mean, if not always pleasing in what we mean.

DR HEATON: Really quickly, the other thing was that somebody made the comment before - and there was a bit of discussion around this - that these are very big recommendations if you're implementing all of them. So maybe part of what you put forward as well as is the fact that it is very selective in what is being put forward and again, with that consultation and negotiation in moving forward and choosing a few, like progressing them and then seeing - because obviously all the recommendations kind of impact the next.

MR INNIS: So we will go away and think about implementation. But we're also a little caught that there are very few opportunities for a truly independent look at delivery systems, particularly delivery systems as important as these.

DR HEATON: Yes.

MR INNIS: I would certainly be reluctant not to make full recommendations to government on the basis that they might be a bit awkward to implement if people rush. Instead, I think what I'd certainly do is articulate the full recommendations, but then talk about the nuances over time.

DR HEATON: Yes.

MR INNIS: For what that's worth.

DR HEATON: Yes, so clear communication to the sectors involved that this will be the process in moving forward or at least some parameters regarding the approaches.

MR INNIS: As others have noted, we're either going to assume that governments act in good faith or we assume that governments act in bad faith. We will be assuming that governments act in good faith.

DR HEATON: Yes.

DR KING: I think the other point on that is, as you will have seen during the day, there were some parties who would like us to be much more

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expansive in terms of what we include. We are guided by our terms of reference as well as just straight practicality. We could make lots of recommendations in lots of areas, but I'm not sure that would be helpful.

DR HEATON: Sure. Thank you.

DR KING: Thank you.

Thank you, ladies and gentlemen. I now adjourn these proceedings, and the Commission will resume on Thursday in Melbourne. Thank you.

ADJOURNED AT 4.04 PM

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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

AT LEVEL 12, 530 COLLINS STREET, MELBOURNE
ON THURSDAY, 27 JULY 2017 AT 9.00 AM

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RESUMED **[9.00 am]**

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 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 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 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 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 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 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 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 which may be up to 24 parliamentary sitting days after completion.

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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.

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 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.

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 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.

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

MR NGYUEN: Yes, that's correct.

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

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 sure that increasing access to services using a – and moving towards a preventative model of care is certainly important for the Australian

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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.

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.

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.

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.

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.

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.

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.

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?

MR NGYUEN: Yes.

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

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 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. 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?

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 kind of services that should be included is obviously appropriate and

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

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 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.

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?

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 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 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 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 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 would be good and we are conscious that some people don't like going to

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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.

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?

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.

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.

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?

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

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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.

DR KING: Yes.

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.

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.

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.

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

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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.

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

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.

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.

MR NGYUEN: Yes.

DR KING: So just more clarification that anything else.

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.

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

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

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.

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

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?

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

MR INNIS: Yes.

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.

MR INNIS: Thank you very much.

DR KING: Thank you, very much.

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.

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MR INNIS: Apologies guys.

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

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?

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.

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.

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.

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.

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

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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 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 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.

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 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, 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 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 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 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 going to be worrying too much about all of the - - -

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

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.

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 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 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 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 - - -

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 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 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.

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

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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.

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MR INNIS: Thank you.

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.

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.

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 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 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.

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.

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 consumer reps. But it was just – it is surprising that people still to this day, don't realise that they can access care.

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 outcome measures and I guess, the fourth part is, do you see that happening

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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.

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.

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.

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.

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.

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 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 I think it's applicable.

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

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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

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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.

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.

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 - - -

MR INNIS: Requires, that, yes.

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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.

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.

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.

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.

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.

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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?

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 - - -

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?

MR INNIS: Yes.

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

MR INNIS: Fair enough. Thank you.

DR KING: Thank you very much.

MS COLE: Thank you.

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

DR FLOOD: Yes.

DR KING: Yes.

DR FLOOD: Thank you, gentlemen.

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

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

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

DR FLOOD: Except for Stephen.

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.

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

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

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

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

DR FLOOD: Overall?

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

DR FLOOD: Conversation is about half an hour?

DR KING: Yes.

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 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.

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 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 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?

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

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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 his 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

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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.

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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

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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, its'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?

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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.

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.

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.

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?

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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 - - -

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 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.

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. 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. 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.

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.

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 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.

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

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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.

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

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.

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.

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.

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.

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.

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

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

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 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.

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 thing'. Is that right?

DR FLOOD: Yes, we could manage on it.

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 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 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.

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.

DR FLOOD: Yes.

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

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 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 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.

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

DR FLOOD: Yes.

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 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.

Do you want me to just speak briefly on the private rental section, and 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 would pay on 10 per cent deposit and current Commonwealth Bank rates of

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

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 - - -

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.

DR KING: It is in the appendix, yes.

DR FLOOD: Appendix B, second last page.

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

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.

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.

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

DR FLOOD: No.

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DR KING: You're in the private sector.

DR FLOOD: In the private sector, yes.

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 - - -

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 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.

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 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 - - -

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?

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 cheapest option all the time.

DR KING: Yes.

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

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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.

DR KING: Thank you very much, Joe.

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

DR KING: Yes.

MR INNIS: Thank you.

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]**

RESUMED **[11.00 am]**

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.

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 in these opening comments.

DR KING: Yes, please.

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 Care, we were all contemplating making applications but decided to do

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

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 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 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 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 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.

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 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 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, however, and in particular we've expressed a strong objection to the draft

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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

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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 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 organisation, even though it may not be the lowest cost.

… [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 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 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 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 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 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 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 get a particular outcome, rather than the reason why you're there in the first place.

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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.

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.

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.

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'.

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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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 - - -

MR TENNANT: Yes, absolutely.

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.

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.

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.

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.

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 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 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 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 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 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. 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 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 of that outcomes-based approach?

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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

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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.

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.

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

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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 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 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 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 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 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 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 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 at a governance level and then regularly come together to deal with operational matters and the actual delivery of programmes and individual

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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.

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MR TENNANT: Goodo.

MR INNIS: David, thank you.

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.

MR PATTERSON: I am not Kate.

DR KING: We had 'Jenny' down.

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.

MR PATTERSON: Thank you so much.

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

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 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 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 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 all clients, and indeed here in Victoria homelessness services turn away 108

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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

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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.

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 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.

MR INNIS: Thank you.

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. 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.

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, 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 - 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. Clearly, that's not your view and I really want to understand where have we gone wrong?

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

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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.

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 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 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 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 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 financial support?

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

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.

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

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

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

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 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.

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

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

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.

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 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 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.

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 the second argument. The real argument is around how people are going to

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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.

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

MR PATTERSON: Yes.

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?

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

MR INNIS: Okay.

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

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.

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?

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?

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

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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.

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?

MR PATTERSON: That's right.

MR INNIS: Okay. Coming back - - -

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.

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?

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.

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.

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 - - -

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MR PATTERSON: Yes.

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 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?

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 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 - - -

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?

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 a property is advertised and all those who are eligible may apply. And so - - -

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.

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

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complex person.

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

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.

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?

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.

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.

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?

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

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MR INNIS: Yes.

MR PATTERSON: That is not the current state.

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.

DR KING: It's certainly been clarified though.

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.

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?

MR PATTERSON: That's absolutely correct.

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

MR PATTERSON: It's great.

MR INNIS: Thank you.

MR PATTERSON: Thank you.

DR KING: Thank you Damien.

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.

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.

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

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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.

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.

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.

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.

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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? 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 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 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 of patients at home for end-of-life 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 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 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 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 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.

DR KING: Thank you very much for that.

MR INNIS: Thank you, Sue.

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.

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.

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.

MS MANTON: Correct, yes.

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?

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

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

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 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.

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 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.

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.

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.

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.

MS MANTON: Yes.

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.

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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.

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?' 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 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.

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 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 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.

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 was never a suggestion that she would have anything other than aggressive treatment from the health care professionals.

DR KING: Yes.

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

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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 – 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.

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.

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 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.

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 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 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.

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 I said, 'Oh, no, well, her GP's concerned about' – because the GP had been

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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.

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

DR KING: A clinical service rather than - - -

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.

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 is it an appropriate way of doing it or not?

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

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 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.

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 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.

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

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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'.

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.

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.

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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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.

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 heard.

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.

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 system, and you know, translating models is very difficult, so I wanted to let you know that we're really wrestling with those issues.

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?

MS MANTON: Yes.

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

MS MANTON: Okay.

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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?

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.

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 part of the journey - - -

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

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 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 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 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 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 provided to Palliative Care Australia, but if you go to an Indigenous

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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.

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 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. 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 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.

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

MS MANTON: Was that correct? Have I given you a broad enough summation of - - -

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 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 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 will roll out, once you put a spotlight on things, people ask the question,

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'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.

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

MR INNIS: It may need to vary.

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

MR INNIS: Philosophy is learned from everyone.

MS MANTON: Yes, for sure.

DR KING: Thank you very much.

MR INNIS: Thank you, Sue.

DR KING: Thank you, Sue.

MS MANTON: All right. Thank you.

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

LUNCHEON ADJOURNMENT [12.31 pm]

RESUMED [1.33 pm]

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.

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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.

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.

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.

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'.

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.

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.

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 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 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 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 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.

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 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 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 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, and that's a Tasmanian number.

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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'.

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 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 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 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 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 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 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 if it wasn't us, and I made that clear in politicians' offices, in government

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

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 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?

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.

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?

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 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 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 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 problem, and the Commonwealth say the state have to contribute.

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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

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

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.

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 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 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.

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.

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.

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 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.

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,

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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.

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.

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 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.

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.

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 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.

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 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.

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.

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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

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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.

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 - 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 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 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.

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 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 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 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 two levels of government very heavily involved. So if we're going to make

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

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.

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.

MR INNIS: So should it be a state responsibility?

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

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 - - -

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

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. I said, 'Fair enough, you just give me back the savings and I'll run the packages', but that's never going to happen.

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.

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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 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 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 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 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 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 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 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

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

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.

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 - - -

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

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'.

MR INNIS: Thank you.

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

MS MACGOWAN: Thank you.

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

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.

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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.

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

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

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.

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.

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 - - -

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

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

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

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.

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 translated directly from western models and concepts.

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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.

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.

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 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.

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 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.

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 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.

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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.

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.

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 take into account the preferences of many Aboriginal people for community controlled organisations and ensure policies and programs support access to this choice.

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.

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 quality and culturally safe services to these populations.

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.

Informed user choice will only contribute to the development of responsive and appropriate markets where users are sufficiently empowered

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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.

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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.

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.

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.

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.

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.

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

MS NEVILLE: Yes.

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.

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

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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?

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 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.

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, 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 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.

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 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 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 some assistance, to be able to say it has been put to us, it's been argued that

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

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

DR KING: Please.

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 less than both CALD populations and mainstream populations. So there's a quick example, off the cuff.

MR INNIS: Thank you.

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 - - -

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, I'm a little bit - - -

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

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.

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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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.

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.

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.

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?

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?

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?

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

MS TUNNY: Like a preferred provider.

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

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

MS TUNNY: Yes.

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.

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.

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.

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.

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 - - -

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

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.

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

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needs.

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?

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.

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.

MS NEVILLE: Yes.

MR INNIS: Thank you from me.

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.

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 parliamentary inquiries and some others.

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

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 actually the effectiveness of services or, as we would say, what's being

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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.

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 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.

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 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 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 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.

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 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.

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

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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

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

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.

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.

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.

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.

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.

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

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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,

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

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.

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.

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.

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.

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.

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

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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

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

MR YATES: Sure.

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.

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.

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.

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?

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.

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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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?

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.

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.

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 - - -

DR KING: The example is where we - - -

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?

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

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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).

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.

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 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 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 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.

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 product right is, I think, really important.

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

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 human consequence. If we can licence tradespeople on model legislation

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

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?

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.'

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.

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.

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.

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

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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.

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.

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.

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.

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

DR KING: Sure.

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?

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 no question it needs to be clear one or other level is responsible for ensuring

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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.

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 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.

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.

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.

DR KING: Thank you very much, Ian.

MR YATES: Thank you.

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

ADJOURNED **[3.16 pm]**

RESUMED **[3.32 pm]**

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. 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

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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.

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.

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 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 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 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 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 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 - - -

MR MARTIN: Public awareness.

MS BARTEL: Yes, public awareness as part of the advanced care 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.

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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. 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 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 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 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 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 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.

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

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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.

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.

MR MARTIN: Sure.

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.

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 tailors off because of the (indistinct).

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.

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,

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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.

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?

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.

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.

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.

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.

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

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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 changing values and goals and preference in the context of the current health situation.

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

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.

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.

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.

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 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 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.

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 specialist will have that conversation.

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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.

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.

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?

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

MR MARTIN: Please.

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.

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

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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.

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, 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.

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.

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.

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 - - -

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.

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 - - -

MS BARTEL: Yes.

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

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

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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

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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.

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.

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.

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 - - -

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.

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.

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.

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. There are some great international examples of transition care projects

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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.

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.

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?

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.

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.

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.

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.

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

MS SMITH: I'm Cindy Smith.

MS SCARFE: I'm Angela Scarfe.

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

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

DR KING: Thank you.

MS SMITH: Should just qualify that, acting CEO.

MS SCARFE: I beg your pardon.

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.

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.

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 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.

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

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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.

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 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 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.

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 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 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 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 perpetuating existing problems.

DR KING: Thank you.

MR INNIS: Thank you.

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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

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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.

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 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.

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. 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 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?

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 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 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 lot of community health do it well, but certainly there's a struggle with those

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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.

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.

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.

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.

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.

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.

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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.

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.

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.

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.

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?

MS SCARFE: Because there's also local government.

MS SMITH: I was going to say, municipal health plans come to mind.

MR INNIS: We're well aware - - -

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MS SMITH: For me, I mean, yes, it starts with that municipal health plan and then it's a State.

MR INNIS: Okay.

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.

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.

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.

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.

MR INNIS: So just to confirm, you're really reinforcing the importance of locational planning and locational connection and design.

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 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 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 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 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 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 care.

MS SMITH: Absolutely.

DR KING: Thank you. That's all from me.

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.

MR INNIS: Thank you.

DR KING: Thank you very much. Apologies for being at the end of the day.

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MS SMITH: No, thank you for a great report.

MR INNIS: Thank you.

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 location to complete our hearings here in Melbourne. So thank you very much.

MR INNIS: Thank you.

MATTER ADJOURNED AT 4.24 pm UNTIL FRIDAY, 28 JULY 2017 AT 1 pm

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Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

INQUIRY INTO REFORMS TO HUMAN SERVICES

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

TRANSCRIPT OF PROCEEDINGS

LEVEL 12, 530 COLLINS STREET, MELBOURNE
ON FRIDAY, 28 JULY 2017 AT 1.00 PM

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MR KING: Good afternoon. Welcome to the public hearings for the Productivity Commission Inquiry into Introducing Informed User Choice and Competition into Human Services. My name is Stephen King, and I am one of the commissioners on this inquiry. Sean Innis is Special Adviser on the inquiry.

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

We are grateful to all organisations and individuals that have taken the time to prepare submissions and appear at these hearings. We held public hearings on Monday in Sydney, Tuesday in Canberra and yesterday here 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 of the evidence presented at the hearings and in the submissions, as well as other informal discussions.

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

The purpose of these hearings is to facilitate public scrutiny of the Commission's work and to get feedback on the draft report. We like to conduct all hearings in a reasonably informal manner, but I remind participants that a 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.

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

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

For any media representatives attending today, some general rules apply: please see one of our staff for a handout which explains these rules.

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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 are 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 wardens.

Participants are invited to make some brief opening remarks of no more than five minutes. Keeping the opening remarks brief will allow us opportunity to discuss matters in participants' submissions in greater detail.

Now I would like to welcome the representatives from the Australian Services Union here today. Would you mind stating your name and your organisation formally for the transcript.

MS GASKE: Emeline Gaske from the Australian Services Union

MS WHITE: Linda White, Australian Services Union.

MS KEEFE: Colleen Keefe, ASU delegate working at Wombat Housing and Support Services.

MR WIEGARD: Leon Wiegard from the Australian Services Union.

MR KING: Thank you very much. Would you like to make some introductory remarks?

MS WHITE: Sure. I'll make some short remarks, as will Colleen. Thank you for the opportunity to appear before you today. The Australian Services Union has appreciated the opportunity to participate in this inquiry through our three submissions and the recent roundtable discussions. I wish to say at the outset that the ASU does not believe that family and community services should have formed part of this inquiry as we do not believe it is a sector that should be subject to increased competition and contestability. However, the purpose of our appearance today is to respond to the draft recommendations put forward by the Productivity Commission.

There are three draft recommendations that I wish to focus on: recommendation 7.2, 7.5 and 7.6. If I go first to 7.2, which states that the provider selection criteria for community services should be such that they do not discriminate between not-for-profit providers and for-profit providers. The ASU in each of our submissions strongly opposes this recommendation. ASU members are strongly of the view that for-profit providers should not be able to obtain public funds to deliver critical

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services to vulnerable, disadvantaged and marginalised people and make profit from this work.

We believe that every cent of public money that is spent on providing social support services should be direct to the supports, not to the pockets of big business or shareholders. If there is an excess of funds available, that should be put back into service provision.

It is for these reasons that our primary position is that for-profit providers should not be able to tender for community services. However, at the very least the broader social impact of the organisations tendering should be able to be a factor considered when determining tenders.

We also believe that an approach of allowing companies to make a profit from community service provision is inconsistent with community attitudes and expectations in relation to services to vulnerable people.

In our written submissions we have also drawn your attention to numerous failures of for-profit providers where they have been given government funds to deliver essential services both in Australia and overseas. These are not isolated incidents; they are examples of systemic failure once a profit motive is introduced into the delivery of community services, which leads to rationalisation of labour costs and incentives providing the bear minimum in service.

If I can turn secondly to draft recommendation 7.5, which recommends increasing default contract lengths in community services to seven years. In our submission we suggested five years, but we strongly support the recommendation of seven years. Presently organisations have little incentive to invest in training and skill development or create career opportunities for their staff because they have little certainty about future funding. This model hampers innovation and the trial of new strategies and approaches.

In addition, short-term funding can mean that essential services that have been made available to a particular community are withdrawn once project funding ceases. This is not ideal given the lengths social and community services go to in establishing trust, building relationships and meeting new community expectations.

Short-term contracts require organisations to have a short-term vision. Seven-year contracts will provide much-needed certainty to community service providers and their workforce. We expect the government would be nervous about long contracts, so we would not want to see providers inundated with unnecessary administrative requirements in response to the

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lengthening of contracts. We acknowledge that there needs to be a balance between oversight and monitoring of non-performers, but there should not be a system that is designed that presumes as a default position that every provider is a non-performer.

One issue that is raised with us in the draft report is that it could be read to mean that after seven years of a contract the existing provider could be out of the process. This may not be the intention of the recommendation. If it is, we do not agree with this. If it is not, then we suggest the Commission clarify this in the final report.

Finally, I would like to address recommendation 7.6, which recommends ensuring that payments to community service providers for family and community services reflect the efficient cost of service provision. Payments should reflect the need for the diversity of providers and, in particular, small and community-based providers and the promotion of collaboration. We support funding being made available to providers on the basis of the actual cost of delivering the relevant service as opposed to an arbitrary carve up of funding. We also welcome the Productivity Commission's reference to this cost, including workforce capacity building and coordination between service providers.

I note that a recent report out of the University of New South Wales into the NDIS price model found that the current NDIS pricing model does not adequately allow for sufficient funds to meet minimum payments and conditions, adequate staff training, supervision or administration. This is having and will continue to have an impact on the quality of service provision under the NDIS. It is also impacting the ability to attract workers to the NDIS workforce. We do not wish to see the same difficulties arise in respect to the community services sector.

Accordingly, we think the Productivity Commission should express in its report that the efficient cost of service provision also includes: sufficient funds to meet the relevant applicable employment terms and conditions; appropriate training and supervision for employees; adequate time to allow the non-client-facing elements of service delivery like travel, administrative reporting and administration; and an appropriate supervisor to support worker ratio. Those are matters I wanted to open with, but Colleen as a worker in the sector on behalf of the ASU will say a couple of words as well.

MS KEEFE: Yes. Simply, I guess to my specific experience of service delivery within our homelessness sector, I want to make the point that certainly in my experience of working with some private providers, while acknowledging that in the homelessness sector private providers are

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limited, generally speaking, when we are working or attempting to work in a collaborative manner with very complex clients, my experience is that it is very difficult to get private providers to the table in care team approaches to exchange information, to discuss recommendations, to work on, for example, secondary consult for improved outcomes for clients. That is just one observation I would like to make in terms of, I guess, recommendation 7.2.

In terms of draft recommendation 7.5 referring to the seven-year contracts, in preparation for this I approached my executive officer and asked what advantage would seven-year contracts have on the organisation. His response immediately was in reference to asset purchasing, for example, we have a fleet of vehicles that were due to be replaced. We are all outreach workers, and in the instance where part of the funding the organisation receives was uncertain beyond a year-by-year approach, even whilst others were three-year recurrent funding, they just were not in a position to replace the vehicles that they needed. Obviously that has safety impacts for workers and also productivity impacts as well for reaching clients that we need to in a given time.

I guess the other point of note that I wanted to add was that uncertainty of funding – and I can think of one particular program that only had that certainty year by year – makes it impossible to attract experienced staff. Therefore, the less experienced staff in the organisations were not able to benefit from that experience, weren't able to benefit from that mentoring approach that the experienced staff were able to offer and it just became untenable for that program to continue.

MR KING: Thank you very much for that. What I'd like to do is spend most of the time on 7.5 and 7.6, but I would like to actually also clarify and make sure we understand exactly where, in a sense, you're drawing the line on 7.2. So, first off, a pedantic clarification, but just so that we make sure the transcript reflects your intention, I think you said every cent of the funds should go to services. By that, do you mean that every cent should go to the legitimate costs of providing those services, including, for example, capital costs such as cars?

MS WHITE: Yes, that's what we mean. We don't mean that it should go to shareholders as a dividend or owners as profits.

MR KING: Sorry, a bit pedantic, but I just wanted to make sure it was correct on the transcript.

I just want to check also, when you say for-profits, you don't believe they should be involved, do you mean, in a sense, corporates as opposed

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to a social worker or a psychologist working as a sole trader. They would formally be a for-profit. I am thinking of exactly your team situation. Do you have problems with those people being involved unless they are employees of a not-for-profit?

MS WHITE: We do not have that. We are talking about people whose business is to make a profit. They're in it to make a profit, either for shareholders or themselves. I don't think we're expanding it to sole traders. That's not what we mean. We mean the corporates really.

MR KING: Okay.

MS WHITE: And that's where the problems have really been. We would say in relation to sole traders, though, that we don't want – and we've seen this in the NDIS – people with ABN numbers. We would not want to see a situation where they are remunerated less than what the award for an employee would be.

MR KING: I understand.

MS WHITE: Unfortunately, they don't understand that in the NDIS, though because there are people that are not being rewarded. So there is an Uber society and on-demand thing, and that is certainly below what the award market would pay.

MR KING: I understand. You wouldn't want ABNs and contract processes undermining award wages. It was more that there obviously are a range of areas in human services, most obviously in health, where there are sole practitioners and we rely on their professionalism. So I assume they're not people who you would say, 'No, they shouldn't be involved.'

MS KEEFE: Could I just add in relation to that, in terms of that professionalism, it is assumed, I guess, in terms of the process of tendering, but also those specific cases, especially the smaller providers, are the very providers that we find in the collaborative approach difficult to bring to the table. Because oftentimes they simply just don't have the time. When every minute is accounted for in terms of their provision in a packaged approach, it is very difficult for them to network, in my experience.

MR KING: Thank you for that, because that is something I did want to clarify. So when you're talking about the private providers, you do mean also the smaller sole traders?

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MS WHITE: In relation to small traders, in terms of what you fund them for, you've got to make sure that they are funded for these things that the community values, like networking and collaboration and things that we suggested. That should be properly funded. We have experience in the NDIS, and admin is funded 3 minutes an hour, which you just can't possibly do the work in the period of time that it is. And those are the sorts of things that we are talking about. You strongly suggest that collaboration is a good idea. Well, it has to be funded, and these small providers, a small, single-person provider, may not get that.

MR KING: A final bit from me, I guess, on 7.2, and then Sean, if you've got any bits you'd like to clarify, of the for-profit corporates, if I can call them that, understanding there is no bright line, in human services, do you consider that it should be a blanket ban or can you envisage there are situations where, for certain services, a for-profit may be an appropriate provider in the human services space? Again, just clarifying your position so that we understand?

MS WHITE: I don't think we can foresee any time.

MR KING: Okay.

MS WHITE: Our underlying philosophical view is that you should not make profit for these situations of human misery, to put it at a high level. We just see that if it is government money it should be going directly into the services.

MS KEEFE: Is it appropriate for me to give another example I can think of?

MR KING: Please, yes.

MS KEEFE: So when a client presents as homeless and is seeking some long-term housing where private rental is not an option because of complex needs and social housing, certainly government housing, is not available because of the long wait list, there are times we use private rooming houses. For those complex clients, the private rooming houses simply have a blanket approach to, for example, challenging behaviours – they will evict. That is where the high turnover comes into play and that's where the same clients present again and again and again for support.

Where the provider doesn't have that same profit motive and has, I guess, a more social justice approach, such as the community housing providers, we just have more capacity to negotiate and more capacity to network and form those relationships whereby we can, I guess, negotiate

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some of those behavioural issues, offer long-term support in order to work through some of those issues. I'm not saying it always works, but certainly it has a better outcome for the client than does simply eviction and looping back into the homelessness sector again and again.

MR KING: Thank you for that.

MS WHITE: So we see that transferring. That is our experience.

MR KING: I understand. Sean.

MR INNIS: Thank you. Like Stephen, I just want to make sure that we test your views so we understand the impact of them. So a couple of examples just to test: your views wouldn't extend to other areas of the inquiry focus. I am very conscious the health system, for example, runs on a very strong mix of for-profit and not-for-profit entities you're not suggesting – or are you suggesting we should have another look at how that part of the world operates?

MS WHITE: We have not put a submission in relation to that, so we're not going to comment further. The ASU are in public health, but we're not - - -

MR WIEGARD: Community health.

MS WHITE: Community health, but we're certainly confining - - -

MR INNIS: So you're not commenting?

MS WHITE: We're not commenting. We're confining ourselves - - -

MR INNIS: You're confining the proposition to the family and community services area of the report?

MS WHITE: Yes.

MR INNIS: Thank you. Within the family and communities area of the report, we received evidence yesterday, I think it was, that services to Indigenous people should be not open to not-for-profits and, in fact, should be limited only to Indigenous-controlled organisations. How does your concept interact with that and how would we resolve that tension, I guess, that might exist?

MS WHITE: That's a good question. I think we did address it in our report. I think we can certainly understand that people with specific needs

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or specific cultural interactions would want that maintained, so we are not unsympathetic to the view that, particularly in remote areas, Indigenous organisations are well placed to deal in those communities. We certainly have had a similar experience with women's organisations where I think in domestic violence services until in New South Wales that was upturned in the last tender process. The way in which those services are now rolled out is completely different – less money I think – so we are not unsympathetic to a view that specialist providers with detailed empathy and knowledge can provide a better service.

MS KEEFE: Can I just add to that. Certainly in my experience of working with some Indigenous families they also benefit and seek choice in seeking assistance. So my advice from clients is that there are times where seeking support from a specific Indigenous service is not appropriate for them for a number of reasons so, therefore, the options will be of benefit to those clients.

MR INNIS: Sometimes people give examples of family violence as an area where there might be sometimes concerns.

MS WHITE: It might be advisable that we also review the evidence based on what I've said and if there's anything additional, we might come back to you, if that's okay?

MR INNIS: Of course. That would be welcomed. The final question in this area is coming back to something you said at the very least – forgive me if I get your words a little bit wrong – the broader impacts should be considered, including community attitudes and some other things. In a sense, the proposal that we have put around this is intended to do that by focusing on the attributes of the organisation and their ability to deliver outcomes, for example, where high levels of collaboration are needed. That would be a very important criteria. So organisations, whatever structure they were under, that are not able to or likely to collaborate presumably would fail that criteria. I'm not suggesting this is your primary position; we've heard that. But as a way of at least trying to get to some of the issues without a blanket ban or a blanket it should be Indigenous organisations always when servicing Indigenous people, is this at least part of a way forward?

MS WHITE: I'm not sure.

MR INNIS: Fair enough. Thank you.

MR KING: Thank you. If we can turn to 7.5, which is the length of contract, I guess just an initial comment, you mentioned that our draft

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report could be read as though at the end of the contract period the existing provider was excluded from further tendering. That is not our intent. So thank you for that and we will recheck the wording of that to make sure it's clear.

MR INNIS: We will make sure that's not put.

MR KING: Thank you also for the examples, Colleen, of the benefits of that stability. I guess the main issue that's been brought to our attention is the practicality and with a risk-averse government or risk-averse management of contracts whether a seven-year period would be practical. How would that ongoing management of a contract be dealt with? Particularly it's been put to us that a competency doesn't exist within government to manage those contracts in an appropriate way over a seven-year period. So I'd be very interested in your views on that and just the practicalities of making that recommendation work.

MS WHITE: Certainly we have got some concerns about whether or not government could administer long contracts, particularly, as I said in my opening, if you adopt the view that the default position is that every person is a non-performer, then you devise a system where you're always looking for non-performance rather than, in contrast, performance. I think that is a mindset and it just needs to be tweaked. But, politicians are often risk averse and so they like to look very closely at things. Ministers like to look very closely to make sure nothing bad is going to happen. But I think that the organisations that we have members in want to do the best for people and so the non-performers are going to be smallish numbers.

I think we've suggested in other areas that you have some sort of qualification to be able to tender. And if you put that sort of system up, then you are going to, for want of a better word, weed out people who are new and present risk. But we think that the risk is far outweighed by the benefit – that is, these programs do need a long time. With complex needs and difficult situations, you need a long time to make big differences. That far outweighs the risk of non-performers in our view. It just is a mindset change.

But we also see – and I think we've said in our submissions – that these organisations get weighed down by paperwork and weighed down by so many boxes to tick and reports to write that they have to devote a significant amount of time. We see that that is just not a productive way of dealing with it. So I think our primary position is that the benefits outweigh the risk and government could do it. Whether they're capable immediately of doing it is another thing, but it's just a mindset change as to what the long-term outcome is going to be. That is not to say that they

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are not monitoring, that you get a seven-year contract and, 'We'll see your in six years and six months.' We're not saying that. And government is absolutely entitled to be looking at it. But I think a long horizon for the reasons that Colleen has suggested, of getting more experienced workers, having some certainty and the outcomes, our assessment is it is going to be way better.

MR KING: You mentioned the monitoring. One of the things that has been put to us is that we haven't quite tied the relational aspects, that we see the good contracting, the seven years, the monitoring type of approach, together as well as we could have, and we'll take that on board in our final report. But do you see the sort of relational approach which we consider working during that seven years, so an ongoing dialogue, if I can put it that way, rather than a tick-the-box monitoring, for want of a better word. Do you see that actually being practical? Some people, again, said it's just not practical.

MS WHITE: I think it is practical. I think it is absolutely practical. What we're talking about is people who are organisations standing in the shoes of the government. That's what we're talking about. If they're standing in the shoes of the government then it is the relationship and building that and understanding the program and understanding the areas. In another life I saw this on the federal social inclusion board where the relationships, the collaboration, the things that you highlight, can be done with great will. But you can't do it with the spectre of short term-ism over you. Continuity is king in all of this. What we have seen and our members have seen is a whole bunch of pilot programs which don't give people a long period of time. So we do think it is possible, and a long-time horizon, given the complex problems that we're talking about, is going to build those relationships.

MR WIEGARD: Can I just add to that? Think you mentioned the word 'relationship' there. I'm working on a couple of state government panels at the moment in Victoria around the NDIS and the road map for reform, so out-of-home care and obviously the NDIS. Both of those forums involve agencies, unions, client groups, peak bodies, a whole range of providers, talking about the structural issues around the service provision in that sector. The only way they work is because you have people of good will who aren't driven by profit and who don't have to hide, in my view, corporate confidentiality or anything and they're openly talking about the structural issues and how to make that work. That is a really great example of some great relationships that are driving some really good outcomes for clients and for workers in those sectors.

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I think it can work because I think it's working right now in terms of driving better outcomes for clients and for workers, and for agencies as well, within the sector.

MS KEEFE: And can I possibly just add as well, it is maybe stating the obvious, but in recent years the process of rigorous accreditation that most human services organisations have had to go through surely is one of the checks and balances that can be used during that seven-year process. As a front-line worker who was initially very sceptical of those processes in terms of benefits that may bump on towards clients, I certainly can say that I've been turned around because the degree of scrutiny and the high level of those standards and the cultural change that that scrutiny allows for the organisations to benefit the clients is very apparent in terms of service delivery.

MR INNIS: Thank you very much. I hear what you say about accreditation as providing a foundation stone for the trust that a long-term relationship needs to be built on, at least between those standing in the shoes of government and government itself. Is there scope to do some of the accreditation more efficiently? I'm conscious that we've got organisations that cross a lot of program boundaries. Is that something that should be looked at?

MS WHITE: I think yes. I think we've seen examples where organisations might have to get seven or eight or nine sets of accreditation. For those organisations to meet that it can be burdensome, particularly if they are agencies that have multiple programs. I think that that would certainly help, if there was some streamlining of it or some recognition.

MR WIEGARD: I think in terms of that recognition, if there is going to be an ongoing expectation of government, there is that sort of level of accreditation required across multiple different areas, then that needs to be built into the price as well because that costs money to meet those standards. You actually need to factor it into the price.

MS WHITE: Yes, that's true. Exactly.

MR INNIS: I understand that point. Final question in this area, if I may: as Stephen said, what we're trying to build is an environment that creates a strong relationship between the government and providers so that both can focus on ultimately the people we are all in this for – the user or the client. Is this set of recommendations going to achieve that, and is there anything else that we need to be advising government or that government

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need to do beyond some of the things you've said to make the most of the opportunity?

MS WHITE: I think these are the things that we wanted to focus on. These are big ticket items, these ones. The length of the contract is a very big ticket item that we think is a significant change that people have been calling for. Proper costing of it is really important. As I said, the example of the NDIS not being properly costed, that is a devastating issue for people at the front line. So we think the three – those two are absolutely core ones for us. I can't think of anything else that we haven't canvassed.

MS GASKE: The flow-on consequences of those things would be significant in that it would facilitate a focus on outcomes rather than outputs and all of those good practices that at the moment are difficult to always attain in the environment in which you are operating under, in some years, 12-month rollover contracts. So I think those things would also facilitate those other structural changes that are needed.

MS KEEFE: Can I just make an overall comment, too, that certainly an inhibitor to building those relationships in the current model between the funding body and the agencies has been the constant change, the constant restructuring and change of staffing in the department which means that those relationships that have been forged over many, many years have not been able to be consistent. So all of that knowledge and all of that level of trust has to be rebuilt and rebuilt and rebuilt.

MR KING: And presumably not just one level of government but at multiple levels of government?

MS WHITE: Yes.

MS KEEFE: Absolutely.

MR WIEGARD: And I think the longer term the funding, the better the relationship is because you don't see it as being something that is so transactional – 'You have to have this.' It can be more transparency and honesty in that relationship the longer term the funding is.

MR KING: There needs to be that.

MR WIEGARD: Yes.

MR INNIS: I have no more questions. I just want to make sure that you've covered all the issues you'd like to raise?

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MS WHITE: We have covered them, yes, absolutely everything. We appreciate the questions to elucidate some of the points that we made.

MR INNIS: We appreciate you being here. Thank you.

MR KING: Thank you very much.

Our next participant is Adult Learning Australia. Welcome, thanks for joining us. If you would be able to just state for the record your names and organisation.

MS MACAFFER Okay. Hi, I'm Jenny Macaffer; I'm the CEO of Adult Learning Australia, which is a national peak not-for-profit organisation representing adult and community education.

MS COTTER And my name is Meg Cotter. I'm the co-president of VALBEC – that is the Victorian Adult Literacy and Basic Education Council. I'm also an education projects coordinator at Wyndham Community and Education Centre out in Melbourne's west.

MR KING: Thank you. Would you like to make some introductory remarks?

MS MACAFFER Yes, thank you. Thanks for having us here. I've brought Meg along because she's more on the ground doing some grass roots work and some expertise particularly in literacy, which is one of the areas that we highlighted in our submission. Adult Learning Australia has also contributed to the Community Council of Australia submission, so you'll see that we've had some input in there.

Why we wanted to come today is that we wanted to focus on a couple of things. We haven't looked at each of the specific recommendations; we wanted to pull out the foundation skills – language, literacy and numeracy skills – and the role that they play in people's ability to make a choice about the services they have. The impact of the role of the adult and community education sector – that is neighbourhood houses, community colleges, community centres, some of those small neighbourhood groups – so the impact that changes might make to those organisations and their roles, particularly around cost shifting to the community sector. We are seeing some of that already. And also looking at what the impacts of some of the previous privatisation has had on our community, like privatising the vocational education and training sector. Again, our community sector is still recovering from that, and certainly government will be financially recovering from that for a long time, and wanting to make sure that doesn't happen again.

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I might just hand it over to Meg just to give a little bit more information around the role that literacy plays and some of the examples she has.

MS COTTER Thank you. As you may be aware, a few years ago the results of the program for international assessment of adult competencies came out. It was published by the ABS in 2013. It showed that 44 per cent of adult Australians have very low literacy skills that make everyday tasks very difficult. Breaking that further down, that stat, approximately 7.3 million aged between 15 and 74 had low literacy skills, and numeracy skills was even higher – 8.9 million, which is around 54 per cent of Australians with very low numeracy skills.

So breaking that 44 per cent down, 14 per cent had very low literacy skills and then 30 per cent had low literacy skills that made them vulnerable to unemployment and social …[inaudible]… in the modern knowledge-based economy. Not surprisingly, of course, people who were employed were likely to have higher levels of literacy skills and numeracy than those who were unemployed and out of the workforce, which was very low skills indeed.

The challenges, of course, that that presents for people in being able to carry out everyday tasks and negotiate systems is very difficult. I am just going to give a few examples that we come across just in our daily education system where we are teaching people language, literacy and numeracy skills.

For example, the other day at my workplace – and this is a common occurrence – a student who is in the SEE program – which is the Skills for Education and Employment program – which gives additional hours for literacy to help gain the skills to get into employment, their job service provider took them out of that program and enrolled them in a certificate II in hairdressing. The student didn't want to do hairdressing. The student's literacy levels were lower than was required for that certificate, and it was an online certificate II in hairdressing. The student did not have a computer at home. So he always wasn't quite sure how he was going to do it.

The teacher said that he was happy to advocate on the student's behalf, 'Let's ring the job active together and sort this out.' And the student said, 'No, no, no. Don't cause any fuss,' too scared that he was going to lose his benefits, too scared to cause a fuss, and didn't want the teacher to advocate on his behalf. This is very common. It's probably something that happens in every community centre every week, that

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literacy students are being told to go elsewhere. It is very common that they do not want to rock the boat and they're scared of the consequences of not doing what they're told.

The implications are in our society, not being able to communicate effectively because of limited literacy skills and limited English language skills can have a profound impact on self-esteem, motivation, attitudes to learning and ability to look after family and fully participate in the community. Often people hide the fact that they're not literate, and that's the reason why they will just continue on pretending and agreeing to things that they would not otherwise do, just to hide the fact that they are not literate.

Another example is work with the reading and writing hotline, which takes calls from around Australia. They have lots of calls from people who have problems often in accessing information online – they cannot either get access online, they don't know how to use online or just the literacy in and of itself being able to type something. Most recently last year with the census there were an influx of calls from people. People in the past have been able to complete their forms in their own homes with the census representatives. Last year they were told there was no assistance. When people called the census information line and complained that they could not read or write, they were given different types of advice and often the advice was inadequate and it could be even rude – people not understanding or disbelief that they could not read and write – then offering things like a video to be sent from Vision Australia because they think they can't see and not being able to explain that it wasn't sight. Another person was told that they could have the Auslan form of the census material.

So there was a big lack of understanding about how literacy impacts on people in the community and how that can impact on them making decisions and accessing information and retaining that information, being able to evaluate information and then make informed decisions. That information or examples was from the reading and writing hotline.

I will just give another example quickly from a local TAFE in Melbourne. Again, the government introduced the unique student identifier, which is like an ID student identifier a couple of years ago. The teacher I was talking to said it has been highly disruptive in the process of enrolling students and they have to employ extra staff just to help with the process of generating a six-digit number. One of the major problems using a computer automated form is the transliteration of different languages into English, so, for example, with Arabic speakers, when they change their name into English script, the way that they might Romanise their

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names with the Roman alphabet can be different. When you make a mistake online and it's not done consistently in all different documents, the system doesn't recognise the name and the person is unable to proceed with the application. The unsuccessful application forms then generate a new layer of complexity that the person has to then deal with in the form of receiving emails, which they may not get because they haven't set it in their notifications. They then have to contact help centre staff. It then has to be case managed and then it sets about having to scan a new set of immigration forms, citizenship documents and upload them to the system. All of this has to be assisted by teachers outside of teaching hours in our sector. It is kind of like the unpaid work, the extra work that is done just to support people because they do have these problems in their daily lives in so many things.

I am highlighting the need, I guess, of navigating systems is difficult for people if you consider that 44 per cent of the population have low literacy. Probably the people who are actually accessing human services, it is higher than that. Obviously they are the people - - -

MS MACAFFER Particularly in Aboriginal, CALD and people with disabilities.

MS COTTER Yes. So informed user choice purports that the service user is best-placed to make the decisions about the service, but as these examples show, these people often do not have the literacy skills to put them in the best position to be able to read and understand material and know their legal rights and responsibilities. Even accessing complaints procedures or withdrawing from courses can be difficult – they don't know how to do it. As we've seen recently with the VET help scandal, there have been people in for-profit organisations that have actually taken advantage of disadvantaged people who have not been able to read contracts properly and they then have a VET help debt for a course that they actually really should be ineligible to apply for because their literacy skills would actually not be high enough to enter the course.

Just going back to the PEAC results, they looked at computer skills, and 25 per cent of Australians who were surveyed chose not to even use the computer; they preferred pen and paper so they were actually unable to even be assessed, I guess. So there is a high number of people still out there not confident using online systems.

Also, health services, there has been extensive research to show the value of higher language and literacy skills in terms of health outcomes. International research of health literacy is considerable and studies have found that the links between lower literacy and higher risk of

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hospitalisation, higher rates of depression and inability to understand and comply with the use of prescription drugs is a problem. There is the functional literacy, but it is also how that relates to financial literacy, how it relates to health literacy and all the impacts that that has.

MS MACAFFER I will just add to that. Many of our community providers are already dialling the phone numbers or actually writing the forms through MyGov or for Centrelink, so they're also being privy to confidential information and they're not necessarily trained to do that, whether they're a library staff member or whether they're at the front of house at a community centre. Because they're there and available and they have a computer, they try to assist people every day. There is increasing demand for this in our sector, and the sector is not resourced, not necessarily trained, to navigate and understand what's in those systems.

So I guess our concern is that if that sort of demand transfers into wider human services, then our sector, one, the issues for the most disadvantaged people making informed choices and decisions and the other thing is around the cost shifting and extra demand that is put on our sector without recognition of what they're doing and increased resources. Then there is the quandary of people potentially being signed up or being committed to things that might not be appropriate to them if they have had to have someone else – a worker – support them through, support them through that, who's not necessarily trained but they're available because they're in their local neighbourhood. They are some of the key issues.

Also, there are 2,500 we've identified as what we'd call community adult education facilities. Some might be also like Men's Sheds or might be Aboriginal cooperatives, learning cooperatives. Half of those are in rural and remote areas, so often it is the only point of contact in some of those small towns. There mightn't be a TAFE. There might not even be a major health service there. So the small community centre or neighbourhood house might be the community hub for everything. So they are generally well located but not always well resourced.

MR KING: Thank you very much for that. In fact, you have put into words something that I've had trouble verbalising, which is in a few of the submissions made to us there is an assumption that you just put the forms online. We had one yesterday where we were saying there were difficulties. It may have been end-of-life care. 'Oh, it would just be done online.' It's more than just simply access to computers; I have enough trouble sometimes understanding forms and filling them in online.

MS MACAFFER And that's assuming people can actually – I don't know if St Vincent de Paul and some of the other peak welfare agencies

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do – but you'll see in relation to access to utilities where people are being cut off because they cannot afford to access those services, whether it's phones or computers. They again are coming to libraries and community centres to access computers because they can't afford to make the payments.

MR INNIS: I know you didn't want to talk about specific recommendations, and that's understood. I thought it might be useful for us to reflect back to you some of the things that we've at least tried to do in this space. The first thing is – hopefully this is clear in the report – we recognise that not everyone is well suited to a pure choice environment and in some areas, particularly an area like end-of-life, we emphasised consumer protection measures. In families and communities we've emphasised looking at the service through the eyes of the person so that in selecting providers you were making sure that those providers were able to appropriately provide services to the client group that they're targeting.

I guess I wonder if those are the sorts of things we need to be doing. Obviously there's a big education thing behind this. Some people have put to us that perhaps more emphasis should be given to funding navigators that assist people through complex systems. Again, using the example of end-of-life where you're making some terribly big decisions about support for - - -

MS COTTER Are they face-to-face people, those navigators?

MR INNIS: Yes, we're not suggesting robots. But a navigation service. We hear what you say about online, and there is an absolute tension between a world that is moving more online and making sure that people are ready to do that and that for those who are not, there is something else. I understand that. But the notion of navigators, I guess, is my question.

MS MACAFFER I guess it depends on your definition of what a navigator is. Adult Learn Australia runs broadband for seniors, and we've done that for eight years. That is a digital literacy program. So we have 1,400 computer kiosks around Australia located in places like it could be a bowling club, it could be an RSL, it could be a nursing home. We have volunteers attached with that and we have a help line. So what we find is people, in relation to navigating the system, the help line tells us that people want to speak to real people, especially older people, obviously, and that people tend to learn more when they've got face-to-face opportunities. I guess it depends what you mean by 'navigators'.

MS COTTER I think time and trust would be an important part of a person who would help make decisions. You would need to have a system

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where that person became a trusted person, obviously, and appropriate culturally for the person and every other way and would be understanding, I guess, if they had literacy issues, being able to do it verbally, not with writing.

MS MACAFFER Certainly, for some people, given we are talking about human services and hospitals and health and social housing, those care areas, people are often also seeking that human connection because they might be in positions of social isolation or social exclusion. Sometimes they just drop out of the system completely, as you would know and they're not even registered on the system if it's too hard or there isn't someone there to help them navigate those choices.

I was going to say some examples in the VET sector once it was opened to the private sector. We had people that, you would have heard probably, were at Centrelink queueing up and then they had these private providers giving them iPads and laptops at the same time. Some were signed up two or three times and they didn't know. So they actually now have these debts two or three times. Some people are distraught by all of this.

MR INNIS: We have in our reports used that specific example as one where there's been, in our view, a very strong failure of government stewardship. Some of those things were eminently foreseeable and should have been designed to prevent from the outset, in our view. So we certainly recognise the example you've given.

MS MACAFFER I think it was Monday we were presenting to Professor Valerie Braithwaite, who has been employed to look at what's happened with that. So there's obviously some investigations underway about how regulation could be done better.

MR KING: In some ways there are lots of bad examples. We've mentioned that, we've mentioned employment services. If we were looking for good examples, if we said look for a good example of a form of service delivery—and it need not just be within the human services space, it could be broader – but government service delivery that is literacy and numeracy appropriate, any that come to mind? Are there any where we could look for an example to be able to say, 'This is a way that this government organisation or this department or this program does it well'?

MS COTTER In the education sector I think it's the pre-accredited programs. But that's very much education based. But it's allowing a flexible framework that actually looks at the learner's needs and then

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developing an A-frame kind of curriculum around it, rather than having set training and trying to fit the students into that. So it's that kind of looking at the actual needs and developing around the needs and developing assessment and evaluation out of the needs rather than the other way around.

MS MACAFFER For a pathway. And that's one on one.

MS COTTER Yes, one on one for the interview. But the actual classes can be a group, but, again, it is all about their needs. So the pathway is one on one.

MS MACAFFER Before they're channelled into what might be some sort of accredited training or work or skill development.

MR KING: Similarly, do you have any good examples of effective partnerships between human service providers and adult education or community education providers?

MS MACAFFER Some are actually co-located, so there are some. Some of the community hubs that are being developed now, particularly in Victoria but also – Victoria has got a stronger base of community education, Victoria and New South Wales. South Australia has a reasonably strong adult community education sector with neighbourhood houses and Western Australia has some and Tasmania. It's less so in Northern Territory and Queensland and the ACT. But there are some examples here in Victoria that I'm aware of and some I've seen in South Australia where there's co-location. So you've got human services and health services, Braybrook Community Hub, for instance, which is just down the road in the west, the council there has developed a hub that includes a library, a neighbourhood house, a Men's Shed and community health services. It has a front desk. That is one example of co-location. Then it's a matter of relationship building between those services.

MS COTTER The Department of Human Services do have their community liaison officers. It can often depend on that individual how good they are at coming out into the community and providing information. So you can have ones that are very good come out regularly to community centres and other places and giving information and running workshops and doing that in the libraries. So it depends on that liaison officer and how good they are.

MS MACAFFER And that is in Victoria only.

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MS COTTER I think it's actually something that should be built and more connects made.

MS MACAFFER There are some community centres or houses that have a strong relationship with mental health services and services around housing and homelessness because they are kind of one stop shops where people will go when they're needing some emergency relief or assistance, and they might get linked into a whole range of other support services. So adult and community education providers aren't just about learning; a lot of them also offer welfare and social support.

The other thing that they tend to do is they can also offer a whole household or a whole family unit, they might have child care as well. There are other aspects. So they tend to be able to integrate into a range of different services. It does depend on individuals and a lot of them have got community management. So they're also dependent on their governance model and their local community to survive.

MS COTTER And the individual strengths at the centre as well.

MS MACAFFER Some have been operating for 40 or 50 years, so they have long-term links into public hospitals. I worked in mental health and housing and homelessness, so linking in where people were coming out of hospital into a support network. It might include a neighbourhood or community learning centre as well as other human service and health providers. So it depends on the outreach and the links and the networks.

MS COTTER And also, too, it can depend on whether it's a program or a project. Projects end and often good things that are piloted, these kinds of things, have an end date and they can't be supported ongoing.

MR INNIS: There's nothing else for me. I just want to make sure we've covered the issues.

MS MACAFFER The only other thing I'd just point out again is the cost shifting which tends to happen for these things that are federal and state level where the cost shifting tends to come down to a local community level.

MR INNIS: I understand. I think that's in your written material.

MS MACAFFER Yes.

MR INNIS: Terrific, thank you very much.

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MS MACAFFER Thank you.

MR KING: Thank you very much.

Our next participant organisation today is the Health Workers Union. Welcome. If you'd just be able to state your name and organisation for the transcript.

MR EDEN: Yes, sure. G'day, I'm David Eden. I'm currently the Assistant Secretary of the Health Workers Union. I've been working in the health sector since 1988 as a registered endorsed enrolled nurse. As a result of my formal qualifications, I have had the pleasure of working in community health settings, aged care, public sector acute settings as well as private sector aged care and private sector youth settings. Thanks to my qualifications I've been able to have a quite expansive career, I suppose, in the health setting. But for the last four and a half years I've been the Assistant Secretary of the Health Workers Union.

MR KING: Welcome.

MR BEKHAZI: Hello, my name's Kamal Bekhazi. I work as the Research and Project Officer for the Health Workers Union. I've been doing that for the last four and a half years. Prior to that I was working as a clinical psychologist, mainly in the public sector. My last roles involved working as a senior psychologist for the primary health team for the CAT team, which is the crisis assessment and treatment team, and the psychiatric triage, which is based in the emergency department. Prior to that I was working as a case manager and psychologist for the Northern Area Mental Health Service, for the Western Area Mental Health Service and I've also had experience working as a research clinician for the Mental Health Research Institute of Victoria. What that basically entailed was basically producing manualised psycho-social interventions and then going out and doing trials, and if the trials were successful – in my case they were – trying to disseminate these manuals to other health services like Heidelberg Clinic in Hawdon Street. I also went interstate and we managed to sell some of these interventions and train before we sold to the Mental Illness Fellowship of South Australia as well as to the South Australia Mental Health Services and as well as to the ACT services.

MR KING: Would you like to make an introductory comment for the inquiry?

MR EDEN: Sure. So the Health Workers Union covers private disability settings, dental health services, both public and private, public sector hospitals, private sector hospitals. We have coverage of pretty much every

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classification from CEO down to cleaner, with the exception of health professionals, like your physiotherapists, OTs et cetera, your doctors and also registered nurses division 1. Besides those individuals or those groups, we have a coverage of anyone who works in the acute settings. We have coverage in aged care, all classifications, once again, except for division 1 nurses. Aboriginal health and what other settings do we have coverage of?

MR BEKHAZI: Disability, aged care, did you mention that?

MR EDEN: Yes, I mentioned those. We've got quite a broad coverage, which has its benefits as well as its complications. We are probably a little bit too broad in what our representations are. We'd like to get a little more specific, but today we shouldn't take up any more than maybe 3 hours; we should be able to cover it all. No – we won't take up 3 hours of your time.

What I'm probably going to focus on initially is public sector health and the reasons why we shouldn't be exploring contracting out in those particular areas. Kamal is going to cover some other areas. We do bounce off each other a little bit. If there's any time left at the end of it we'll delve into some other areas.

MR BEKHAZI: Yes, but I'll just briefly outline some of the areas that I'd like to talk about today. I'd like to look at some international examples of where privatisation has occurred in some of the health sectors and how that's kind of turned out. I'd also like to mention that my point of view doesn't come from the background that privatisation is good or bad; it's actually occurring and, from my point of view, we need to look at the outcomes of privatisation and we need to look at regulation.

I'd also like to discuss the need to move away from a volume-based system of care to a system that focuses on excellence, basically, treatment outcomes. I'd also like to discuss the need for more research, in particular, longitudinal research that actually can support what's actually happening in our system, in our health care system, both private and public, when it comes to treatment outcomes. What I've found is that when it comes to private health, it's very hard to get your hands on the research there. Most of the research out there is pretty much public based.

I'd also like to move on and if I'm able to have some more time I'd like to talk about informed user choice. In particular, I'd like to link that to some of the schemes that the government has come up with in relation to allowing allied health clinicians to have a provider number and become consultants and be able to kind of treat patients in giving them more choice instead of just going to a hospital or a community health centre,

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you can now go see an allied health centre that is able to bulk bill by provider number.

I'd also like to discuss the NDIS and the aged-care system as well. David will talk about this as well because our aged-care system has moved mainly from government-owned to pretty much now NGO and for-profit organisations, both in the health community sector as well as in the residential sector. We'd like to basically just talk about how that's worked, if it has given people more choice and the outcomes.

Then finally, if we have time, I'd like to talk about a way of saving our public hospitals money by looking at how they structure their human resources departments. We've actually come up with some ideas in relation to basically disbanding most of the kind of human resources apparatus structures in all the hospitals and community health centres and whatnot and coming up with one public health sector independent human resources commission that has a statutory authority and that can provide a HR kind of service that's independent and transparent.

MR EDEN: Last year we negotiated a public sector enterprise bargaining agreement which provided 28 full-time careers adviser workplace trainer positions across Victoria. For too long have our, predominantly our members in the health and allied services stream been pigeon-holed into particular positions – so once a cleaner always a cleaner. We want to introduce a system where our members have an opportunity to formalise qualifications and become more mobile within that work environment, depending on the peaks and troughs of patient throughput within a hospital.

I've been sort of partially inspired by some people I've spoken to – the CEO of Tatura Hospital, for example, who started life there as a personal care worker and is now the CEO of that hospital and worked very hard to get there. We've got lots of members that have been trapped in circumstance. Whether it's been a financial circumstance, a family circumstance or a language circumstance, they've been trapped in circumstance. So by introducing these career adviser workplace trainers, we're hoping to enable more people to be given a career path.

We've got an ageing workforce in the public sector in the hospital system. The average age is now 47 and female. We've got to put measures in place to ensure they're able to work until retirement because a lot of these people are working in very physically demanding jobs and we need to enable them to formalise some qualifications to get them into areas that are not as physically demanding to extend their working careers.

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The other issue we have is that we've got kids leaving school, high school is not for them, they might do a VET program, year 10. They get a job at a local hospital. Why? Because they're the largest employer in those regional areas. It's okay to push a broom around, but, 'I'm only here until something better comes along.' Well, why aren't we providing a career opportunity for our youth within regional Victoria to climb up through the hospital system and one day potentially be running one of these hospitals across Victoria?

With a VET program as well – and we're going to see that more and more where high schools will be giving qualifications at a cert III or a cert IV level. It doesn't make sense for someone in Ouyen, for example, to do a certificate III in tourism. We don't see a lot of tourists in Ouyen. But it might make more sense for them to do a certificate III in allied health, for example. Why? Because that hospital is the largest provider in town.

We've identified certain missing links in qualifications as well. If you were to take allied health stream as an example, you can only do up to a certificate IV in allied health at the moment, where you might be implementing a physiotherapist program and you might sit there scratching your head one day and go, 'Well, you know, I'm essentially doing what the physiotherapist does, and I've got a qualification up to a certificate IV level. Why don't I actually go on and become a physiotherapist?' Well, if I was to go and become a physiotherapist, I'd start my course from scratch. There is no RPLs between a certificate IV in allied health and a degree in physiotherapy.

Where there are those sorts of missing links that we've identified through consultations with training providers, we want to create advanced diplomas or diplomas where those would be in areas they want to specialise in. So you might be an allied health assistant and you're working with a speech pathologist. You might want to do an advanced diploma in speech pathology. That's the missing link to then go on and do a degree.

These sorts of things already happen with certain job streams. So I might start as a personal care worker or an assistant in nursing with a certificate III. So I've picked that up at high school in year 10. I've then gone on with RPLs and got my certificate IV and from there I go on and do my advanced diploma. Now I'm an endorsed, enrolled nurse and 18 months from then, I now have a degree in nursing, and I might even finish with a dual degree and become a paramedic as well.

So those sorts of career paths already exist for certain job streams within the hospital environment, but they do not exist for all of them. Our

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union is very, very passionate about joining those dots and creating those career path opportunities for individuals within the health system.

Now where contracting out has occurred – and the Alfred is one of those places where they've contracted out to Spotless – this is a whole pool of potential employees that they could multi-skill and move across their hospital that have been segregated off and not considered part of the hospital team whatsoever. They've been contracted or moved across to Spotless as the contractor.

Although there might be a short-term gain seen from the employer by contracting out those services – you know, the bucket of money just going over there, 'I don't have to manage any of that area,' – I think it is a very short-term vision. In the long term these individuals could actually be trained up and moved across a hospital to work in theatres as theatre technicians or work as an instrument technician in the CSSD department.

There is an another area that we've been working on with some country hospitals where someone might have a certificate III or a certificate IV as an instrument technician doing the sterilising in the CSSD departments. They're now going on and doing a certificate IV as a scrub nurse. So why would you have a formally qualified division 1 nurse standing in a theatre handing these instruments over to a surgeon who doesn't have as intimate a knowledge of these instruments as someone who's actually working in the CSSD department who sterilises those instruments, packs those instruments in a particular manner and has particular instruments in each pack for each surgeon.

Every surgeon has a different pack; they all like their own little favourite set of tools. These people working in the CSSD departments know this and they pack these items, they have them sterilised and sent into another room where this mystery thing happens in surgery where there is a division 1 nurse just handing those instruments over. Now, there could be massive cost savings there from a hospital point of view where they've got people who've got a qualification to work in the sterilising department as well as in the theatre department handing those instruments over to the surgeon that they've got an intimate knowledge about.

There are many, many other examples of where efficiencies could be made. We've got people who have got a passion in relation to health and safety. They've been elected as health and safety reps within their department. They could take great pride in the fact that they're assessing workplaces, their work environments and ensuring there's a safe work environment there and protecting their work mates from workplace injuries. Well why not offer them a certificate III or a certificate IV in

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occupational health and safety or a diploma and let them work in the occupational health and safety departments? Why are we drawing on the private sector to bring people in to work in hospitals that don't have the knowledge, or working knowledge, of how a hospital works?

I think privatisation has got pitfalls. You don't see private hospitals contracting out – quite the contrary. They are on the same rate of pay in private hospitals as what they are in the public sector hospitals. So it's not a cost efficiency thing. The contractors that do exist in the public hospital system, such as Spotless and ISS, pay in accordance with public sector rates. So there's no cost efficiencies made whatsoever. It's simply shifting a financial responsibility from the CEO of that hospital to a contracting firm to manage. I don't know why these CEOs are getting multi-million dollar wages. In one hospital they may have everything contracted out except for the nursing. When you go to another hospital of a similar size and capacity, they have absolutely nothing contracted out and they're on the same rate of pay these CEOs. Why?

If you want to create some cost efficiencies, why aren't you basing the CEO's wages on the amount of employees that are directly employed by the organisation as well instead of just how big their budget is or how big their organisation is? I'll give you some other - - -

MR KING: Sorry, can I jump in just to probe. I will point out, by the way, that none of our draft recommendations do recommend or even suggest additional contracting out or privatisation in the public hospital system. So I'll just make that as an initial point.

MR EDEN: Yes.

MR KING: But the sort of career paths, education paths, that you've talked about, why do individuals need to be employees in the hospital to access them? For example, if I'm working in a hospital as a Spotless employee but I say, 'Well, I really love this environment. I can see there's a future for me in the hospital,' why wouldn't I then access those same education paths even though formally I'm not an employee of the hospital but I'm there every day?

MR EDEN: That's a really good point. So where the likes of Spotless pay in line with the public sector wages, many conditions aren't – they're not obliged to provide the same conditions. So where you've got study leave conditions under the public sector agreement, for example, where you've got access to workplace trainers and careers advisers, quite frankly, the private providers aren't independent in having an educated workforce.

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They wants a workforce that they can direct to do a certain task and that's all that is essentially required of them.

There are other examples of where hospitals have contracted out services and it's just got my absolutely baffled as to why. Wilsons car parking, for example, have got the contract to run the car parking for hospitals right across Victoria. You've got Zouki in just about every public sector hospital across metropolitan Melbourne. They're now starting to make a push into - - -

MR KING: Sorry, which one is that?

MR EDEN: Zouki café. Zouki café projected to make $60 million in profit last financial year. These are revenue streams that should be re-invested back into the hospital. Why are the hospitals contracting out the Zouki that has the potential of making $60 million? Why are they contracting out their car parking to Wilsons that are going to make probably even higher profits than that? This is money that's going away from the hospitals. If they were managed by the hospitals, this is revenue that would be retained by the hospitals and re-invested into the hospitals.

MR BEKHAZI: So I guess we're suggesting that in some instances where hospitals have a monopoly in departments such as car parking and cafes, it's probably in their interests to bring them back in house rather than outsource them and use the profit that they make to re-invest back into the house system. So I guess that's what David was really kind of trying to say there.

And there is another department, such as pathology, that has been outsourced in many public hospitals. For instance, Bendigo Hospital last year outsourced to Dorevitch. Geelong Hospital and I think it may have been Latrobe Regional Hospital as well.

MR EDEN: So Dorevitch Pathology are owned by Primary Health. The pathology addition of Primary Health not last financial year – because those records aren't out yet – but the previous financial year made $130 million in profit in pathology. They have the contract to provide pathology services in hospitals right across Victoria.

Now, someone's paying for it at the end of the day, and it's the Medicare system. It just does not make sense to me that - - -

MR KING: Okay, so I'm sure if we asked the CEOs, whether it was car parking or pathology, they'd be saying, 'Well, even though Wilson parking and Dorevitch are making significant profits, it's still cheaper for

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us to contract to them rather than do it in house.' So would you just say that's just wrong or would you say they're missing something?

MR EDEN: I just don't think it is the case. It's just a matter of them cleanly saying, 'Well, this is no longer my responsibility what happens to this bucket of money because I've contracted my responsibilities out to this particular firm.

MR BEKHAZI: We think it's ideologically driven and it comes from the top down basically. There is no way known that the CEO could tell you that they're losing money on their car parks. I remember when they started introducing – it used to be free car parking in public hospitals. When I was working at the Northern Hospital they said, 'You'll be saying $7 a day from now on.' Then it went up to $11 and staff went on strike and then it moved from Northern Hospital to all the other different hospitals. And whether you work there or whether you're visiting there, you're paying that car park fee. And that car park is there. It might need some maintenance once in a while, but you are definitely making a profit, and that's what Wilson has shown.

With Zouki Café, that's also been shown. Zouki has kind of expanded into almost every single public hospital, not just in Victoria but interstate. And their profits, like David said, are $60 million annually. So there's no way the CEO could tell you that they're not going to make money in those areas because they have a monopoly on them.

When we talk about the pathology department, it's not necessarily about money, but what we have found in pathology, especially in the Latrobe regional area and Bendigo, especially in the rural areas, when Dorevitch Pathology or prior to them Healthscope Pathology took over, what we saw was a reduction in the quality of services provided and increased time lines in relation to when tests were processed and the results were given back to the doctors. What they did was they decided they didn't need all the employees that they had and fired a lot of them. Then they decided they didn't really need labs out in Bendigo or Latrobe Regional Hospital and that their lab in Melbourne would do. And as a result, you have by the time the Melbourne lab gets the specimen from Latrobe Regional Hospital a longer period of time. So doctors were left waiting longer and patients were left waiting longer.

So what we're saying is with the experience of outsourcing pathology from the public hospitals is that hasn't worked. If you look at private hospitals, for instance, St Vincent's Private, they've kept their pathology department in house and it's been really profitable. I had a CT scan not

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long ago and I was charged $480 or something. You know, if you look at Saturday Vincent's Private pathology, they're making a nice profit.

So it seems to me that the private hospitals have got the formula right when it comes to keeping these departments in house and they're profiting from them. But when it comes to government public hospitals, CEOs are basically making decisions that are driven by ideology that have come from the top down rather than based on any factual evidence or profit margins. And that is the point I think we've been trying to make.

MR INNIS: I'm very conscious that there were a broad range of issues to cover and we will run out of time.

MR BEKHAZI: Yes.

MR INNIS: Can I see if I capture this right: we have not recommended further privatisation, but I think what I'm hearing is you're encouraging us to look at whether advice should be provided to government about seriously considering insourcing some of what's already been outsourced?

MR BEKHAZI: Yes, that's right.

MR INNIS: Is that a reasonable bottom line capturing of your advice to us?

MR EDEN: Yes.

MR BEKHAZI: Yes.

MR INNIS: Thank you.

MR EDEN: In Victoria, too, public hospitals are legislated now, it's a legislative requirement, for all of them to go through the tendering process through Health Purchasing Victoria. Health Purchasing Victoria is the single most destructive force in regional Victoria and it is gutting country towns.

Now, a hospital would traditionally have some goods that they need to have provided to the hospital and a local tender would go out for the supply of those goods. Now hospitals aren't allowed to do that. They must go through Health Purchasing Victoria for the likes of goods and services. So what we're seeing is the regional areas, the providers of those goods in those regional areas, aren't winning those tenders. They are going to large companies predominantly out of the Melbourne regions, and those contracts aren't local; they go across Australia and into New Zealand.

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We've got regional towns in country Victoria that are dairy farming areas with dairy farmers going to the wall and increased rates of suicide in country Victoria where there's milk and cheese coming into those hospitals from New Zealand. Now, you want to talk about improving productivity, there is a symbiotic relationship between local business and regional hospitals. You cannot have one without the other. If the largest consumer in that town isn't buying locally, those local businesses go bust. Those individuals have to move to the big smoke in search of work. You lose the populous, you lose the hospital. You can't have one without the others.

So Health Purchasing Victoria is the single most destructive force in country Victoria and it is going to gut regional towns. I will use Hopetoun as an example where Hopetoun used to cook their meals fresh. They used to purchase from one butcher one week, the other butcher the next in their township, keeping both butcher shops open and they used to buy their produce locally as well. They moved to a cook-chill system and they merged to become Rural North West Health with Warracknabeal, now tendering takes place through Health Purchasing Victoria. Guess how many butcher shops and green groceries do they have in Hopetoun now? None.

MR KING: I suspect zero.

MR EDEN: Yes, none.

MR BEKHAZI: So we would be recommending that the Productivity Commission recommend to the government that they look at how purchasing Victoria's procurement process and that they consider the effect of their tenders and their procurement process on country towns and look at in the more broader way rather than just saying, 'Okay, New Zealand's going to give us this contract for $1,000 cheaper than the local company.' It needs to be looked at in a more holistic way and taking consideration their decision and the impact it will have on the local community.

If you add it all up, a farmer goes bust and he becomes suicidal and his family also, they're going to be using mental health services, and that thousand dollars they kind of saved on the contract is going to be spent through the public health system anyway and they're going to end up at a loss. So what we're saying is that Health Purchasing Victoria really needs to refine the way they procure and they need to consider in an holistic way the decisions they have on certain rural towns that provide supplies or that

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used to provide supplies to hospitals that no longer supply. They need to kind of get that balance right.

MR KING: Very conscious of the time.

MR EDEN: Sorry.

MR KING: A couple of the areas that you mentioned in the introductory remarks come up, which I really wanted to make sure we covered off on, which is the move from that value-based system to outcomes, and also you mentioned research for evaluating outcomes. Very keen to get your views on those.

MR BEKHAZI: One article that I've been reading, which is the Deloitte article, 'Global health care outlook – battling costs while improving care 2016'. They explore privatisation within the health sector on an international level. They look at the example that's happened in the National Health Service in the UK. Certain elements of that service have been privatised and they found that there is a lack of consensus on the outcomes in relation to privatisation. So you have some people saying it's worked, other people saying it hasn't. So there isn't any kind of consensus.

In addition to that, there is disagreement in relation to how we define outcomes. Within the academic section and within government, how you define outcomes is different. The most worrying trend that I have found when I look through a number of reports is that there's very little research that looks at outcomes in relation to privatisation in the health sector. When you're looking at longitudinal research, I couldn't find anything.

So another country that was mentioned in Deloitte and also in another article by Maria Goddard, 2014, 'Competition in healthcare – the good, the bad and the ugly'. It referred to Switzerland and the Netherlands. They have privatised certain areas of their health sector and what they found in those countries was that when the government introduced regulation and oversight and transparency, they found that the areas that they did privatise did actually work or did yield outcomes, outcomes in the sense of saving money and outcomes in the sense of treatment efficacy.

So I guess we can learn a lot from that. What I'm suggesting is that, you know, rather than we don't want privatisation, let's look at outcomes and let's get consensus on what a good outcome is and how to measure that and let's get the government involved with regulation.

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Now, when I say that, I'm on the NDIS, Victorian NDIS, task force advisory group, which is chaired by Minister Foley and Special Minister for State, Gavin Jennings. Although those conversations are meant to remain confidential, I can mention them in a broad perspective. And my understanding is that they don't really see themselves as regulators and that that is something that they will consider at kind of as a last option rather than as something in the beginning. That really is concerning.

In addition to that, I talk about the need to move from a volume-based system, which is what our hospitals and are health services are using now, to a system of excellence. What I mean by that is rather than telling a mental health clinician, 'You have eight sessions to treat this person who's got an anxiety discord,' because cognitive behavioural therapy, which is a paradigm in psychology, says that it can be done. And they won't allow people to use psychoanalytic psychotherapy which really would say, 'Well, 20 to 30 sessions is short term for us.'

So the government turn around and say, 'Well, we can get more people through if we use CBT rather than go via the psychoanalytic area.' So this is what the government is doing. So it links into informed user choice. If you're a person that goes to a community health centre or to an area mental health service, you can't choose what treatment you receive. You're getting CBT and that's that. And the figures in relation to how many people are treated per year are very confusing.

What I have noticed is that people come in, they get their 'PR1', which is a registration form, completed. After eight sessions they get their discharge form completed and they go. They come back a month later and they have another PR1 form completed and so what you're having is the government saying, 'This year we treated 15,000 more people in CBT as compared to last year. Great outcomes.' Those figures include a revolving door where they've counted the same individual on three occasions in some instances.

MR INNIS: Which longitudinal data would fix?

MR BEKHAZI: That's right. But it's not happening. I've been lobbying the government to do this and we are having some – for instance, the Northern Hospital has opened a centre for research which is linked with the University of Melbourne and they are doing some research, but it's not really looking at outcomes; it's more looking at treatment efficacy for chronic schizophrenia and things like that. So we need to push in that direction.

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Now I'm looking at informed user choice. The government has, for instance, you may have heard about the super clinics that the government talked about several years ago, which was a one stop shop for everyone where they can get all their treatments done. What they've done in these super clinics is they've brought in allied health clinicians and GPs and given them a provider number. So when a patient comes in, they are getting treatment by psychologist, by a physio, by an OT, by a GP, but these consultants are not employees of that clinic. They are consultants, they pay a fee for a room and then they bulk bill using their provider number.

This system, although it gives the consumer choice – you don't necessarily have to go to an area mental health service, you can go to see these consultants – they've even added to consumer choice via the GP mental health management plan, which gives you eight sessions a year. So you can go to a GP, tell them you've got some issues, the GP can give you a referral to a mental health management plan and you can look at any psychologist in the *Yellow Pages* and you can go to them as well. Again, the problem is the limit – eight sessions does not fix everyone's problem. But that is all they're getting a year. That's all they're allowing the allied health clinicians to bulk bill via their provider numbers.

One size does not fit all. We're not all created equally. We've all got issues. So if you've got someone in there with chronic schizophrenia compared to a generalised anxiety disorder or compared to a depression which might be acute or someone with a personality disorder, you're not going to treat them all in eight sessions. It's just ridiculous to think that. But because government wants to limit money, they just come up with this figure and they cite one or two articles based on cognitive behavioural therapy and they're saying these people have choice now. They can go to the GP, they can go to the super clinic, they can go to the hospital.

Now, I have one other thing to add.. these super clinics aren't working well. What I see happening is cost shifting. So this community health centre or the super clinic is not spending as much money anymore because they don't have direct employees. Instead, all the costs have been shifted on to the Medicare system and the bulk billing. So they're not actually saving money; they're just cost shifting. And there isn't think research done there either. I've looked and I've tried and I've talked to people in the Department of Health, and it's not happening. So that's why we recommend that the Productivity Commission recommend that there needs to be more research in this area, in particular, longitudinal research.

MR KING: A couple of things I want to check up on: so the super clinics are a state initiative, aren't they?

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MR BEKHAZI: I think they are, yes.

MR KING: I'm wondering if part of it is cost shifting from a state level to a federal level, which we see in other parts of the health system.

MR BEKHAZI: I think you've touched on a very sensitive point. You'd be aware that our public health services are partly funded by the state and partly by the commonwealth. And so this is an example of the states trying to shift more of the funding on the commonwealth through these allied health provider number initiatives.

Are they giving the user more choice? I say they are, but if you were to go to the community mental health service to be treated, you would have a team there. And that team is working in the same building and they are consulting and they are working together and they're multidisciplinary. Whereas these consultants, although they do communicate, let's say somebody needed an OT as well as psychology as well as physio, they communicate, but they communicate maybe once a fortnight via email or via a five-minute telephone conversation. What I find is that the overall treatment outcomes aren't as effective as they would be if that person went to a multidisciplinary team that was in the same place who saw each other every day who could take that person's case to Thursday morning case discussion meetings where they could sit down with consultant psychiatrists, psychologists, you name it, and sit down and come up with a better plan for that person.

So I'm arguing that this system is all about cost shifting and there aren't any treatment outcomes. Now when it comes to informed user choice - - -

MR KING: I just wanted to also reflect back on the example you gave with the fixed number of sessions.

MR BEKHAZI: Yes.

MR KING: I think that's a good example. If I understand it, the point there is you have a very blunt instrument being used. So you can say, 'Well, of course you can take your eight sessions and go to whichever psychologist you'd like,' but there's no appropriate outcomes-based measure so that you can say is that the appropriate number of sessions.

MR BEKHAZI: I think I've jumped the gun. Initially you get four sessions.

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MR KING: Okay.

MR BEKHAZI: That's right. Then the clinician needs to write a report and send it back to the GP. And if the GP is convinced that this person needs another four, then you get your other four.

MR KING: Okay. But it's a maximum of eight per year. So if you need more – okay.

MR BEKHAZI: Look, there are circumstances where there are always special circumstances where some people can get additional, probably a couple more sessions, but not much more.

MR KING: Okay.

MR BEKHAZI: I know that time is flying, and I talked about fee-for-service system compared to a value-based care system. That's being implemented throughout the world, and it's apparently there to kind of increase productivity. Before I say that and talk about productivity, I just want to say that the 'Why Australia: Benchmark Report 2017', which was a paper published by the Australian Trade and Investment Commission, when they looked at productivity of Australian industry sectors compared to global competitors, the health sector came up third highest. So at the moment our health sector is very productive compared to the rest of the world.

I guess one measure just to determine whether your health system is working is life expectancy. What we're seeing in this country is that people are living longer and longer and, in fact, it is going to cause a problem for us with our aged-care sector. In the meetings we have in the NDIS and as well as some other task forces that I'm on, one of the skill shortages that we're going to have is nurses and PCWs working in the aged-care sector. And they're looking at basically bringing people on overseas visas to kind of make up for these shortages.

But back to value-based care, so we're talking about bonuses for clinicians and for hospitals that meet certain treatment targets and we're also talking about punitive measures or penalties for bad outcomes. This is already happening in Australia and happening overseas. But, again, I will raise one issue: how do you measure treatment outcomes or good treatment outcomes? How do you determine that? I will give you one example. When I was working in an emergency department, one of the punitive measures on this value-based care system that the government basically imposed on public hospitals was that you cannot keep anyone in

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an emergency hospital bed for more than 24 hours otherwise the hospital will be penalised, and by that they mean they'll take away money.

So what this did was you'd sit inside triage looking at the patient administration system, looking at all the beds and you'd have a basic clock from yellow, and as it gets closer to 24 hours, it would go red and the face would start to frown basically telling everybody, 'You'd better get this person out of here.'

Now, I'm in psych triage. The psych ward's full. This person is suicidal, might be homicidal, you know, might hurt himself or hurt someone else. I don't think he needs to be discharged; he needs a bed. There's no beds in our health system in St Vincent's Hospital, for instance. So I get on the call, I call Western, I call Royal Melbourne, I call the Alfred, I call everywhere. And they've got no beds. So I tell the ANUM – which is the associate nurse unit manager – or the consultant in charge in the ED, 'This person cannot be discharged. They are suicidal and I am scared for their welfare and I'm scared for the welfare of other people.' But because of this penalty-based system, it's created a culture of where the ANUM is so cold, she doesn't care about this person; all she cares about or he cares about – sorry, they're usually female nurses – is that they are not going to be penalised and they are not going to be the hospital that's had someone in their ED for 24 hours.

So this person is either discharged to their family or discharged on the bloody street sometimes – excuse the language. I say that because it's against my recommendations, but because the ANUM and the consultant can overrule my recommendations, they end up discharging people on to the street so they don't get these penalties. Now, is that a system that's working?

So if you look at it, they didn't breach the 24-hour ED system, but, at the same time, what about the outcomes for the patient and their family? This guy's either gone home and he's on suicide watch. No-one can go to sleep because they are scared he's going to hang himself. And if he is discharged on to a street – normally they don't discharge on to the street, what they do is get emergency accommodation. Really nasty places where you kind of get robbed for cigarettes, and if you don't have them, they rob you for your money. Kind of really, really temporary emergency accommodation. It's just the Flagstaff Inn or something, there's a place there where they like to discharge. And this is only one or two days.

Then this person comes back to the ED. So getting people spending money, you're putting the community at risk so that we supposedly meet

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this volume-based care system where we're doing well. There's no-one in the ED that is been there for 24 hours or more.

MR INNIS: So one of the things we've sought to do in the report is be very clear that in human services there should be outcome frameworks, that they should be around the users of the service, and that's part of placing users at the heart of the service. Clearly in a report such as this we won't be able to go to every single area and issue, but I did want to respond by saying, you know, it seems to me the core of the issue that you've raised is that the system may not be truly placing the user at the centre, and that's something we've tried to be very clear should happen.

MR BEKHAZI: That's right, and there really needs to be accountability, transparency and significant research that's done.

MR INNIS: I understand.

MR BEKHAZI: I would suggest that the people who do the research are independent and are outside of that hospital and they study and investigate some of the examples that David and I have given so that we actually know what's happening.

I know that we've got 9 minutes left to 3 o'clock. There was one issue that David and I really wanted to raise, and that was about the consolidation of the human resources departments within our public health system. Every hospital has their HR. Every community health centre has their HR. Every disability service has their HR. Every aged care has their HR. There's HR all over the place, and they're spending millions upon millions in each of these services with their HR department. When you talk to our members or when we talk to our members or when we put out a survey and we ask our members about HR and whether the HR is helpful in helping them get their training, helpful in supporting them when they're down, helpful in helping them do their job better, they say no.

We see HR as an arm of middle management and the CEO, an enforcement arm basically. They feel most of the bullying is coming from HR and middle management. Bullying occurs, for instance, when it comes to union busting. They don't want unionised work forces because that changes things, that changes their plan. If we can get density in a particular place and get the Fair Work Commission to give us kind of permission to take industrial action, that changes things for them, they're going to have to do things differently. They might have to pay their workers more. They might have to pay them overtime.

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People who question whether or not they're being paid overtime, people who question whether or not things are done differently seem to be on the receiving end of HR. And not just HR; we've discovered that there's a group called the inner circle of management that lies within the inner circle of management. They get preferential treatment and they also are used as proxies for management and HR to go out and bully other staff. This is what we're talking.

What they get is, for instance, if I was working in a community health centre and I've got 35 people on my case load, I'm outside of the inner circle of management. But if I was inside of thinner circle of management, I'd have 25 for my case load as a reward and I might even get a project or something, a quality project, to do. As long as I do what my boss tells me to do – that is, if it involved harassing and bullying another staff member who's out of place, then that's what seems to happen.

So we don't think the HR within each hospital is independent. They are basically there for the CEO. So what we are basically suggesting, which would really help save some money is to basically use most of the money that's being put into each service's HR department and form a new public health service independent human resource commission where the commissioner there would have statutory authority and the money that we're currently putting into our public sector HR apparatus can be moved from there into establishing this commission. So it would be at no extra cost.

MR KING: So this would cover HR for the entire health system?

MR BEKHAZI: For the entire public sector health system. Probably not the private system. As you would know, everybody's on their own. They've got their own boards.

MR KING: Yes, sorry, public system.

MR BEKHAZI: So we're proposing we start with the public system, because it would be a lot easier. And we're not proposing any additional moneys. The moneys that are currently given to each of these HR departments can be used in this one centralised HR department. We're not talking about abolishing HR from the hospitals; just the HR that is involved in disciplinary meetings, the HR that's involved due to any kind of problem. But we could leave a couple of people there that are involved in training, that are involved in really supporting staff.

MR KING: Would you see hiring being centralised?

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MR BEKHAZI: Hiring being centralised? Yes.

MR KING: I've experienced centralised HR in the academic world that I used to be in, and sometimes lines of communication became very bureaucratic, if I can put it that way.

MR EDEN: We don't want to see nepotism. Ballarat Health Service is a prime example where bullying and harassment was absolutely rife throughout that organisation. Back in 2004 they had one HR manager that oversaw all the Ballarat health service, Bill Cunningham. He was a great old fella. He used to sit there twiddling with his tie half the time you were talking to him, but you got your issues fixed. Now there's around nine HR managers across Ballarat health services and they're more interested in buying the silence of workplace victims, moving perpetrators and covering up these actions. I think it's absolutely despicable, and they have to employ independent investigators to come in and uncover all these practices that have been going on to the tune of hundreds of thousands of dollars.

MR BEKHAZI: The Peacemakers was one company they employed. There was another company they employed, and there was the Auditor-General of Victoria also did an investigation in relation to bullying that was occurring in Ballarat as well.

MR EDEN: So if they actually had an independent HR department that had been fixing workplace issues, like old Bill Cunningham used to do, we wouldn't be in this predicament now. But you've got an HR department that's so firmly embedded into the rest of the management system, it is just seen by employees as another hurdle that they have to get over. They're not HR at all; they're not there to resolve issues in the workplace. They're just another problem that they have to contend with.

So HR, the lines have been blurred there about what they're really there to do. And by creating a centralised human resources area where they're not on the payroll of the hospital so they are independent and they can see things from a distance and come in and investigate independently would resolve a lot of these issues a lot quicker and certainly no signs would be taken because they're not on the payroll.

MR INNIS: And I am conscious that we're about to use all of our time. We always reserve a little bit of time for anyone else. As the only person in the room is a staff member, we're assuming she's not going to give evidence.

MR KING: Although I still have to make the formal declaration and ask.

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MR INNIS: Just one final thing in response: clearly there are some concerns that you've raised that this inquiry won't be able to investigate. So I would also encourage you, as I'm sure you've done, to take those concerns to the government direct. The issue that you've raised about having effectively one organisation look after at least an element of HR for the hospital system is something we could potentially consider, noting that, coming back to our very first conversation, it's not necessarily privatisation but it is certainly an outsourcing arrangement. So, as with all outsourcing arrangements, they come with some potential benefits but they also come with some potential costs, and that would need to be considered properly. But thank you.

MR EDEN: Thank you very much for having us.

MR KING: Thank you.

MR EDEN: You've created a very relaxed atmosphere here today, gentlemen.

MR KING: That's good. Thank you very much.

MR INNIS: These are important issues.

MR KING: Although it is relaxed atmosphere, I still have to do some formal things.

Ladies and gentlemen, that concludes today's scheduled proceedings. For the record, is there anyone else who wants to appear before the Commission? That being no, I adjourn these proceedings, and we will resume these public hearings on Monday until Perth.

MATTER ADJOURNED AT 3.01 PM.

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Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

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

MR R SPENCER, Commissioner
MR S INNIS, Special Adviser

TRANSCRIPT OF PROCEEDINGS

AT MANTRA ON MURRAY, 305 MURRAY ST, PERTH
ON MONDAY, 31 JULY 2017 AT 9.30 AM

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RESUMED **[9.30 am]**

MR SPENCER: Thanks very much, everybody. To begin with, I have a series of things I'd like to read out about the hearing, so I'll go through that first and then we'll move into the day.

Good morning, everybody, welcome to the public hearings for the Productivity Commission inquiry into introducing informed user choice and competition into human services. My name is Richard Spencer and I'm one of the Commissioners on this inquiry, Sean Innis is the special advisor on the inquiry.

I'd like to begin by acknowledging the traditional custodians of the land on which we're meeting today, I would also like to pay my respects to elders past and present.

The Commission was requested by the Australian Government to undertake this inquiry in April 2016. This inquiry was to be undertaken in 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 communities, public hospitals and public dental services.

Following the release of the study report the Commission commenced its inquiry to identify and assess reform options in each of the priority services. A draft inquiry report was released in June which presented the Commission's draft recommendations for each of the services.

We have talked to representatives from the Australian, State and Territory Government, 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 580 submissions over the course of the inquiry. We are grateful to all the organisations and individuals that have taken the time to prepare submissions and to appear at these hearings.

This is the fourth and final public hearing for this inquiry. We've heard public hearings last week in Sydney, Canberra and Melbourne. Following the hearings we will be working towards completing a final report, having considered all the evidence presented at the hearings and in submissions, as well as other informal discussions.

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

The purpose of these hearings is to facilitate public scrutiny of the Commission's work and to give feedback on the draft report. We like to conduct all hearings in a reasonably informal manner, but I remind participants that a full transcript is being taken. For this reason comments from the floor cannot be taken, but at the end of today's proceedings I will provide an opportunity for anyone who wishes to do so to make a brief presentation.

Participants are not required to take an oath, but are required under the Productivity Commission Act to be truthful in their remarks. Participants are welcome to comment on the issues raised in other submissions. The transcript will be made available to participants and will be made available from the Commission's website following the hearings. Submissions are also available on the website.

For any media representatives attending today some general rules apply. Please see one of our staff for a handout which explains those rules. I don't think we have any members of the media here, do we? No, right, okay, thank you.

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 exit through the main hotel entrance. A Mantra staff member will coordinate the evacuation of the room. Please follow the instructions given by the designated staff member at all times. The meeting point is on the Murray Street Mall to the right of the hotel, in front of the train station, corner of William and Murray Street. Please assemble there and await further instructions.

I would now like to welcome the WA Council of Social Service, and just as to how we conduct the hearings, if you could, for about five minutes or so, give us your opening statement, the points you want to draw our attention to, and then we'll enter into some discussion. So thanks very much. To begin with, could you each state your name and position so that we can record that for the transcript please?

MS GIOLITTO: Louise Giolitto, CEO of WACOSS.

MS GRAY: Jennie Gray, Deputy CEO, WACOSS.

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MR TWOMEY: And Chris Twomey, Leader Policy Development and Research for WACOSS.

MR SPENCER: Thank you.

MR TWOMEY: I'd also like to start by acknowledging the Whadjuk people of the Noongar Nation as the traditional owners, (Aboriginal language spoken).

We very much welcome the shift in direction that we've seen with the discussion paper that's come out. I wanted to comment on just a couple of points very briefly. I thought one of the interesting things in the discussion was that it seemed to come to this fundamental question about how best to put the user of the heart of social services.

I suppose our feeling is that contestability of services, competition and different forms of user choice are some of the different mechanisms for doing this. I also wanted to highlight that we've focused on some other mechanisms here in Western Australia and reforms as well, where we've looked at co-design processes, where we've looked at greater service integration, particularly across disciplines and portfolios and different program areas.

One of the concerns I suppose that we've had is for choice and competition to be fair and effective it really needs to be based on reliable information about service outcomes. Our concern is that in the lack of good information on outcomes you either end up getting competition that's based on price, where it comes down to service user discussions, it's obviously focused around what's the advertising, what's the perception of the service rather than good information on the outcomes. Or otherwise you see where that competition is in the contracting arena, it's who can write the best contract.

One of the concerns that we've had evolving has been as we've seen a loss of capacity at the kind of regional and local level within the different government departments and agencies, and this particularly happened as well with Commonwealth agencies, around that local knowledge and expertise, both in service delivery and in knowing who's there on the ground, you can see some perverse outcomes where if someone writes a nice tender and claims to have very good relationships with local services, but doesn't actually have them, you can actually see that loss of local capacity.

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So certainly around how, making sure that you've got that quality in decision making, but also then what are we doing to make sure that we're actually looking at and effectively measuring the outcomes of services, and then what's the process by which we share that information with service users so they can make informed choices. We think that stuff's really critical.

We've also thought that the co-design stuff is really important, so we've been putting a lot of work into that area and we've recently released a co-design toolkit, which we'll be happy to share with you on notice. There are two parts to that, one of the parts is how do you much better engage service users in the design and evaluation of services, how do you make sure that you've got services that are meeting their needs and aspirations, how do you make sure that where you've got that lived experience of dealing with the problems and interacting with the services, you can actually bring that in to make sure you're improving the quality of service.

The second part of that is how do you make sure that you've got service providers and service funders and some experts in outcomes and evaluation all interacting on talking about the service model. One of the places we particularly focused on that is how do you do the regional and local stuff about that place-based service integration where you're trying to break down individual programs and have more of a wrap-around approach.

So we think those areas are some of the places where we can best drive, getting that better quality of services, better integration of services. One of the biggest challenges that we've seen there is how do we get more transformative and sustained outcomes out of services. Which is why we focused on more intensive kind of wrap-around services and also about how do you use better information about the risks that people face so you can actually find that sweet spot where you can intervene early to be more effective without having services that have a very wide catchment and aren't actually catching those most at risk.

So I guess those have been the areas where we've seen that there's the greatest opportunity. One of the other things that I noted was picked up in the report was this stuff around service mapping, actually being able to understand what services were in the community and also how they interact with each other.

The other thing I wanted to comment quickly on was the discussion around family and community services. We tended to agree with your argument, saying that the characteristics of those services do not lend themselves at the moment to that move towards greater user choice. But that greater user input into those services, in the form of co-design and

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co-evaluation, we think is really needed, and certainly being able to look to a way we can move forward so that people have great input into those services and can get greater information back to tell them what's effective in meeting their aspirations and the outcomes they're after.

I suppose our concern was that the focus should not simply be just on better provider selection, but also actually getting to that element of program design, how do we make sure that we're doing that side of things effectively. And really so far while we've heard some aspirations around co-design coming from the Commonwealth, we actually haven't seen those processes hitting the ground, and the approach still tends to be very top down and very consultative in that way. We think to be able to drive that to the next step, there needs to be more work done on how do you actually develop meaningful and useful outcomes frameworks that are driving that and helping you measure the outcomes.

We also agree with the comments about systematic mapping and looking to move to longer term contracts, we think this is a good idea. The one concern or caution that we have there is around the sustainability of funding in those contracts, particularly where we've seen a lack of adequate indexation being applied to funding and also then very rigid contracting environments that can effectively lock you into a service model that may work in the first couple of years, but over time, without the indexation, you're actually struggling to maintain the levels of service or the levels of quality.

So I suppose there needs to be that element of flexibility and a process whereby you can come back and review and reform so that you can have continual improvement over the life of the contracts.

Finally, I also wanted to comment around the discussion on services in remote Aboriginal communities. We thought the comments that you had there were really quite good. I suppose there were a couple of other things we wanted to highlight, one was this idea around the need to have an Aboriginal human services workforce development strategy, which is one thing that we've been very much kind of advocating and emphasising at state level at the moment.

Certainly we've seen a lot of focus around some kind of general areas at the state government level of more contracting to Aboriginal organisations, but what we're not seeing is actually a strategy around how do we build and develop the capacity of Aboriginal community controlled services. And we think there's a lot that can be learnt there from building on the developments that we've seen in Aboriginal Community Controlled

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Health Services and partnerships between those health services and family and community services at a local level.

We also draw your attention to the partnership principles that have been developed by the national peaks, ACOSS and the national Aboriginal peaks, have been involved in. I suppose we've been concerned, how do you make sure that you bring those principles into your contracting of services so you can have effective partnerships between developing Aboriginal local services and larger mainstream providers that actually effectively allow you to transfer control over time, so that you can genuinely build those services up over the life of a seven or 10 year contract to look to the end of it, they're delivering the service with maybe some minor back office support.

Yes, I think that's probably more than enough to be going on with.

MR SPENCER: Great, thanks very much. Any other comments that you would like to add to that?

MS GIOLITTO: I think Chris summarised our paper pretty well.

MR SPENCER: Thanks very much, thanks, Chris. Just to dive in to explore some of those issues, the one of selection of providers and provider attributes. You had raised the issue about what could assist government to be able to deliver more on those aspirations of selecting the right providers in the right circumstances and to minimise some of the risks you talked about in terms of losing local knowledge, local capacity.

You raised the issue of performance indicators within government; could you tell us more about how you think that might help, from the government's point of view, to be more attuned to the right provider for the right situation and what that could look like?

MR TWOMEY: I suppose one of the challenges is how do we make sure that when it comes down to reporting on and evaluating services, we're genuinely doing outcomes and not outputs. But one of the challenges that we've had there and one of the kind of stumbles, I suppose you might say, in the move to outcome-based contracting at the state level has been unless you've actually got some independent work being done around developing outcomes frameworks, you've got every different service, every different program coming up with its own outcomes, and they're not necessarily commensurate, they're not necessarily linking up to tell you are you actually achieving the outcome that you want to get at an individual cohort or a community level.

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So I suppose both making sure that the resources are there within the programs and contracting, but perhaps also that there's some independent expertise being developed that actually sits outside of both services and the funders, that it's actually providing some of that evaluation.

One of the things that's been interesting has been some of the developments that we've seen in New Zealand where they've had a separate SUPERU, Social Policy Evaluation and Research Unit, which was their old Families Commission, that's actually kind of had a level of independence. We don't know if that's necessarily the best model, but certainly, how do we bring some kind of independent expertise there and also how do we provide some of those outcomes frameworks that can help drive some of that consistency.

I suppose what we've seen here is that out of the genuine desire to deliver better services and to better integrate their own services internally, a lot of our larger providers have all gone out and looked for and grabbed hold of and developed their own different outcomes frameworks or different things, from results-based accountability, social return on investment and so on, but they're all being implemented slightly differently and they're not necessarily measured.

That does I suppose highlight another thing, in that often when government is looking at service delivery it's looking through the lens of what are the programs we're delivering, without necessarily being aware, well, we've got a number of service providers here who are actually delivering a service at the community level which is funded out of five or six different programs and grant streams, where that kind of integration and wrap-around has happened at the local level, that government may not necessarily be aware of because it's funded across different departments and at different levels of government.

MS GIOLITTO: I'd like to add to that. I still think there's very much a strong focus on the outputs not the outcomes, and especially when you're contracting at a national level, so what works – I'm sure you've heard this before – what works in Sydney doesn't necessarily work in Karratha. So there's still a focus on you must employ X amount of people, this is the service that you must be delivering. Instead of allowing that community to actually manipulate – or not manipulate, to sort of work that contract which will best meet the community.

I think there's some good examples of that in the youth space, and getting young people back into school, where these are the guidelines, this is how you must work with those young people, which won't necessarily work within that community. So it really needs the focus, we keep talking

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about outputs versus outcomes, but the focus still very much is on outputs. So I think that's a major shift that needs to occur in the contracting, to give those people, within local communities, the knowledge and the power of working within their communities of how they deliver that service will work best.

MR SPENCER: Can I just explore there a couple of issues you've raised. The length of the contracts, as you noted, we're suggesting seven years in family and community, 10 years in remote Indigenous. But combined with that, more time up front for better analysis of what the needs are and therefore better planning up front.

Chris, you mentioned that as you progress through those seven years, things change, so we're suggesting that some of the concepts of relational contracting should come into that space to avoid the rigidities that you referred to. Can you comment on that as to how you think that can be done really effectively, or what we might be able to add to our comments on that to make it a more dynamic relationship, if you like, between providers and government through the course of a contract of that length?

MR TWOMEY: Sure thing. You may have something to add to this in a bit, Jennie. Certainly that idea of spending more time at the front is really important, but particularly setting it up so that you've got that cycle of design and evaluation, and that you've actually got the opportunity through your seven or 10 year contract to actually be kind of progressing and evaluating what you're doing.

So in terms of how you actually get that relationship between the provider and the government right, I suppose a key part of that is what's your governance or oversight mechanism that's actually involving some independent evaluation and some engagement with the service users. I think kind of having those two parts in there could be really critical.

Again, it depends on where's your area, where have you got service users who have both kind of the lived experience but also the ability to engage. In some places that's current ones, in other places, for instance say like youth services or young people who have come through the child protection system, it's a little bit further down the track where they get to the point where they can kind of engage in that way. But certainly seeing how you can develop some effective mechanisms for doing that through the life of the contract I think is really important. Do you want to add to that?

MS GRAY: Yes, probably not much more, other than to say building in the mechanisms for review throughout the life of the contract as well, sort of for checking in points, and just to reiterate what Chris said around

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appropriate lead in time, not just for collaboration between the contracted and the contractor, but also chances for local agencies to develop partnerships, which is an imperative in lots of our tendering right now.

But often we find that agencies simply don't have the time to develop the collaborative pathways to deliver joined up service delivery.

MS GIOLITTO: I'll pitch it again, in the co-design toolkit that we've just actually developed, we always speak of tendering and the procurement processes, only at the very beginning and only account for a very small proportion, but it's where our concentration seems to focus on. So we do need a longer lead-in time, we do need good data and good research and it does need to be co-designed, but then as Chris has already mentioned, building in that mechanism that we're constantly reviewing. It becomes more of a partnership between the service providers – and often there's multiple – and government about how do we constantly improve this. So actually there's an information sheet we've also built in that co-design.

So taking those principles and behaviours at the beginning and threading that all the way through the contract. It could be something as simple as, at the beginning of the contract, you were concentrating on 10 to 12 year olds, for example, but then through the life journey it might be a different cohort within that particular community that you need to concentrate on that's the touch point, so building in that flexibility in those contracts.

MR SPENCER: Sean?

MR INNIS: Thank you, guys. I guess we're swirling around what we captured under the banner of stewardship in the report, and I was interested in the role the partnership approach has in WA and whether that's a type of mechanism that could do some of these things around being a springboard for the analysis, being a springboard for the outcomes framework et cetera. I'm just interested in your views about that.

MR TWOMEY: Certainly that's what we've been thinking and aspiring towards. We're in a little bit of a hiatus, redesign thing, a change of government at the moment, but that's been a good opportunity because it's allowed us to reflect on both what were some of the promises and achievements but also where we'd seen some of these barriers. And certainly where we'd seen the barriers in being able to do that integrated in placed-based stuff really came down to two things: one was around the ability to have that flexibility around funding.

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So it was how do you actually enable the pooling of funding at a local level across multiple government departments or even just multiple programs, and youth services is a classic example of that where you can have 15 different government agencies funding youth services in one particular location, none of which are coordinated, all of which are short term, fragmented and don't have identified outcomes.

Which is the second part, I suppose, that we focused on; was that we had developed an outcome-based contracting mechanism but we didn't actually have anything that was informing the outcomes at a kind of systematic level. So we had seen those two things, the ability to pool the funding, the ability to set some very clear and meaningful targets, but then how do you get the accountability right, so that that's accountability across government, that's whole of government, to the Parliament and to the people, rather than going back through the individual ministerial channels or departmental channels that tended to fragment things back out into individual areas.

Do you guys want to add to that?

MS GRAY: I guess just to add to what you were saying, Chris. The piecemeal approach to developing outcomes is very commendable; the individual agencies are doing it. There is a lot of synergy between different outcome frameworks, but the reality is they're not connected in – you know, explicitly connected across agencies or across the community service sector and government departments, and they're not connected in time either.

So I think definitely we've seen moves towards outcomes, but the implementation has been fragmented.

MR TWOMEY: I'll add one more thing on the partnerships, because I think the starting point that we had were some very high level partnerships with the premier, DGs and some sector leaders, but what we haven't got right yet is how we do we do those partnerships at a kind of place-based or regional level? How do we actually get those partnerships happening in a very practical way? And I suppose one of the barriers that we had found was that we were having these high level discussions that weren't connecting through to implementation as effectively as they needed to be.

MR INNIS: So just pursuing that just for a second. In health we're seeing quite a sophisticated regional planning approach emerge. It's got a long way to go, but with the PHNs and the local hospital districts or health districts, depending on where you are in the country, is that sort of structure something that would be worth considering in the broader social services delivery world?

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MR TWOMEY: Yes, with some reservations, I suppose I'd say. Certainly we've seen that as progression, and while we haven't gone into looking at what the primary health networks are doing here in great detail, it seems to be a good step forward. I mean, we've got the challenge here they are – kind of local region is greater than most of the rest of the country.

MR INNIS: Yes, it's too big.

MR TWOMEY: But at the same time we've also seen very good collaboration happening at the state level across the primary health networks. So certainly we think that's a good model. We have some concerns then as well about what's the interaction between what's been contracted through primary health versus the overlap into some community services, how does that work in mental health, how does that work in Aboriginal services, do you actually have the knowledge and expertise being tapped into in the primary health networks to enable you to do that most effectively. But certainly we think that model and approach is a step forward. Would you guys add to that?

MS GRAY: Yes, I'd agree with that. But I guess – yes, just what you said, Chris, some reservations, and some kind of cultural shift probably needed to see it fully realised.

MR SPENCER: I just wanted to come back to this issue of – because look I think for many years the aspiration of getting beyond silos has been there.

MR TWOMEY: Yes.

MR SPENCER: So I suppose the obvious question is why haven't we been able to get beyond that. You mentioned at a high level, at premier, ministerial, head of department level there's obvious – there's usually quite strong agreement that, "Yes, of course we must do that", but it doesn't, for want of a better term, operationalise at another level.

So I guess that raises two things, and I'd be curious as to how you see it. One is the capability of those people who have to actually try and bring this into reality. Is there a capability issue within government? Secondly, there could be a structural element as well, that good intentions is one thing, but are we set up to be able to make this happen? So could you comment on both of those?

MR TWOMEY: Yes. I think you are right in saying that there's issues around capability and there's issues around structure. I suppose I was alluding to a couple of those structural issues where I was saying one of the

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problems is around how do you actually access resources, and if your resources are locked into announcements made by individual ministers around individual programs, that can actually be where you get stuck, because all the effort goes into how do we make a quick announcement, how do we get this on the ground quickly, which is one of the interesting things that you've seen that they kind of shifted that nexus a bit in New Zealand with having longer term strategic plans for their agencies.

But then there's an issue around capability and there's an issue around cultural change that you would say. So certainly making sure that you've got that knowledge and expertise within both the public and the community sectors around how you do that. Often the barriers to that are about risk as well. And people when they're feeling cautious or threatened around what if something goes wrong, here's something new, tend to want to fall back onto, well, this is how we've done it and I know if I do it this way I don't get into trouble.

So I think some of that, there's a level of inertia there, just around this is how we've always done things. I think there's a challenge about how do you get consistent messages actually kind of moving through the services to actually say, no, we really are changing the way that we do things, this is about how you do it.

I suppose that's also why we've kind of focused on doing some of this practical work that we've started around the co-design toolkit, so it's not just a high level message saying, well, we're trying to do things more collaboratively. You've got to, actually, got to give some people, well, here's some examples around how you do this, here's a process, here's a timeline, here's some tools, here's who you might talk to, how you might step through things.

MR INNIS: As we're talking about the toolkit, something I'd be interested in. In a lot of evidence we've heard, people aspire to co-design but the conversation seems to be government/providers. I can see that you've stepped to users which is very, very welcome. I'm interested in what needs to happen to make that work well. And apologies for - - -

MR TWOMEY: We'll come back to you in a sec. I'd say we've been pushing and trying to step towards engaging the users, it's been done well in a couple of areas in Western Australia, so disability services and mental health in some places have done that very well, particularly some of the mental health stuff more recently around the 10 year plan. There's still been a barrier around how do you get from the plan to implementation that's around resources and decision making.

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But really when it comes to most community services, we're still pushing to actually see greater engagement of service users in those co-design processes. There's also then the challenge around what processes and what forums do you have, at which points in the decision making are you engaging service users versus providers and funders. And there are a pile of discussions around a lot of the kind of administration and logistics and so on which for a lot of service users aren't particularly meaningful. But the stuff around their lived experience of how the service looks like, what are the targets and aspirations, those sort of things can be really critical.

So there are challenges there, and part of what we've tried to pick up in the toolkit is saying, who do we involve when, how do we kind of inform them, prepare them through the processes, how do we make sure we're capturing that by capturing it in a way that people actually at the end of it can say, yes, we've really been heard, we feel like our views are being reflected in this.

MS GIOLITTO: I think for this one it's really important to actually link that to having the outcomes framework, because knowing what you actually want to achieve, it sounds quite simple, and then taking it to the consumers and they themselves tell you how to actually get there. So it's a bit like understanding the outcomes framework, what we want to get, and going straight to the consumers.

I think in the youth field and the youth industry they've actually done this for years. Youth workers and service providers in the youth industry have always connected with young people and listened to them and heard them, and that's how they've actually developed their programs. I think this also links to when we were talking about Aboriginal communities and self-determination, about what is it that community wants to achieve, what are the outcomes they want to achieve. So hearing their voices first and then how we get there will naturally follow.

But going back to the other question about being a structural issue, I think is the point when we talk about co-design and integration of government services and working in silos. I think structural is the biggest barrier that we're actually coming across in that particular space. Again, if we take it back to a co-design process, it takes time, so often people will call it co-design but it's just simply a consultation or information that's actually provided.

But it also takes a bit of resources up front initially to make sure you actually do it well. Then one of the issues that I will talk about structurally was accountability within government. We're seeing it more and more at a

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State level, but governments are going back into their silos in some respects as money is getting tighter, so this is our primary responsibility.

We saw it recently in the youth space in detention centres and young offenders, that their primary purpose was to work with young offenders, so that all the youth diversionary type work that was done, that money got lost. So as money gets tighter I think the structural issues of the silo thinking is becoming more apparent and we're actually going back in some senses.

So one way I believe that we can combat that, when we talk about an outcomes framework there needs to be an outcomes framework around governance and integration of government services. So making government departments accountable themselves that how they collaborate, work together and provide really good evidence that leads back to an overarching outcomes framework that they're all feeding into.

MR SPENCER: Just another question about the directory for emergency relief that you have created, and I'm just curious as to how – what lessons can we take from that or what advice would you give us when you're doing service mapping? That seems to be an initiated directory, if you like, by the sector itself.

But how easy is it to do that, how difficult is it to maintain it, how does it actually operate in practice and how might that help us if we're giving advice to government about wider service mapping?

MR TWOMEY: Do you want to comment on that, Jen?

MS GRAY: Yes. So the platform that you're referring to is called ER Connect, and it is an opportunity for services to register and give quite a detailed account of the sort of things that they provide and it allows anyone to go on and use different search functions, algorithms, to get the specific service that they want. I think the beauty of ER Connect is that it's a bit like a Wikipedia where it relies on individual providers to upload their details, which means they're also responsible for the maintenance and the upkeep.

So if details are incorrect, then the consequence is there. And that's also probably the greatest challenge of ER Connect. So from WACOSS's point of view, our maintenance is really encouraging the people who are on to keep their details up to date and then encouraging other people, other providers to also list their services. I guess what we see, particularly in the community relief and resilience space, is that it has a critical mass where you're disadvantaged if you're not listed. So we'd really like to expand that to include broader services as well, so it started in emergency relief, it's

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been broadened to community relief and resilience, so it includes services like accommodation and financial counselling.

But the more that are on, the more that actively maintain their details, the more people that use it, then the better it will become.

MR TWOMEY: Certainly I suppose that contrasts with, we know of at least half a dozen existing service directories within individual government departments or programs where you've got one or two people working constantly on updating those, and as soon as they're updated they're out of date.

MR INNIS: Out of date.

MR TWOMEY: One of the biggest challenges that we've had is that often the contracting information that we have access to simply tells you where head office is. There's very little information to tell you this is where on the ground these services actually sit. There's been an exercise the state government have done as part of their regional reforms where they've had a team of people spending 18 months just trying to find out what services are actually on the ground in the regions.

So I suppose what we've been arguing is, is the model of something like ER Connect, where it's almost a kind of social media platform in terms of people have got the responsibility and the opportunity of updating their services, if you can link it through to making sure in your contracting you're actually requiring the provision of simple but informative information about what the services are, where they actually are.

Once it gets to that kind of critical mass where it's actually really useful to the service providers to be there for people being able to access the services, we hope that'll get around some of those issues. The more that you can have a single point where you go into, that's giving you information across a whole suite of services, potentially the more useful that is, but certainly whatever we can do to make it so that there are things that drive the information being up to date, that it's very easy for people to keep their information up to date, and it's in their best interests.

MR INNIS: Do you see, and I'm conscious we will run out of time, but do you see this potentially evolving to include user ratings of services? Could it be evolved into that direction to provide – we talk a lot about users need more information, is that a potential?

MS GIOLITTO: It definitely could be a potential that the users themselves, after using a service, could – a bit like hotel bookings that you

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go in and say how you actually found the service. I think we're still a fair way off from there, as Chris has already mentioned. In this State alone it's more than five, we did a bit of a scan of the amount of databases that are out there about finding services, and if you include local government as well, it's very extensive and a lot of money is spent in that space.

So I think our real interest in this point is obviously for the consumers to have really easy access to the services they actually need, but we see a lot of mapping and a lot of mapping occurring by consultants that cost government, State and Federally, a lot of money. If we had a really good database or a directory system, the technology's there, getting the analytics out of it behind the scenes is really quite easy and it can answer a lot of questions. So I think that's our real push about – and that will enable us to see, where there are holes and gaps in services.

MR TWOMEY: But certainly that thing around service user rating, provided you had the checks and balances around there so it couldn't be gamed, could be a very useful thing to have.

MR SPENCER: Great. Thanks very much indeed for coming in today to share those insights with us and extremely helpful for us to get that feedback to our draft, so thanks very much again.

MS GIOLITTO: Thank you.

MR SPENCER: Could I invite the representatives from Community Employers WA to come to the table please, and then if you could both just state your name and your position, just for the record, thanks very much?

MR BOUFFLER: Sure. Thanks, Commissioner. My name is John Bouffler and I'm the Executive Director of Community Employers WA.

MR KYRWOOD: My name's Ross Kyrwood, and I'm a board member on Community Employers WA.

MR SPENCER: Good. If I can hand over to you then for an opening statement.

MR BOUFFLER: Thanks very much. We'd like to begin also by acknowledging the original custodians of the land on which this hearing is being conducted, the Noongar people, and pay our respects to the elders, past and present. Thanks very much for the opportunity to present, and for coming to WA to conduct some public hearings, we certainly appreciate it. For the record, Community Employers WA represents not-for-profit employers in the non-government community services sector of Western

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Australia. We currently have 135 members who in turn employ over 24,000 staff.

We'd firstly like to commend the Commission on the opportunity for the open consultation and note that the recent drafts, as Chris touched on, seemed to evidence an increasing appreciation for the complexities of the human services sector. Having said that, there's a couple of formal areas we'd like to highlight, and then we can have a bit of a conversation.

Also, just to follow on from what WACOSS was saying, we work closely with WACOSS as well, we certainly concur with the benefits of the co-design toolkit, with the need for a greater focus on integrated services. We believe that there's a need for a strategic framework, an overarching view from government. We found in the DSS tender, going back to 2014 for example, that it was quite disjointed. There wasn't any effective co-design or meaningful consultation. We had situations where, one example, financial counselling was moved from Margaret River to Bunbury, which is 100 kilometres away and there's no transport between the two. And to expect people to be just popping over to Bunbury, they probably looked at a map and didn't quite understand some of the distances and nuances and local issues. So just one small example.

But greater need for co-design, and Louise touched on, co-design takes time, it's not just about having a consultation and then we'll roll out the tender. That can take months and months and months, or longer. So we're certainly supportive and encouraging of that.

The three areas in particular I wanted to touch on, first one is about models of service provision, and I know the Commission in the draft report has spent some time touching on this as well. We've included it in each of our three submissions to the Commission, around the construct of civil society. We've outlined the differentiating characteristics, which go well beyond the economic and efficiency drivers that are key aspects of the inquiry.

Without listing all of those differentiating characteristics, three of the key ones that we see, which you have to get your mind around a bit and think about, are around social capital, social cohesion, and social connectedness, social cohesion and connectedness, and these are often what we call by-products of the provision of service but are really important.

We note that the Commission made a comment that no one type of organisation has a monopoly on doing good, and in box 2.6 of the report there were detailed comments around provider motivations and different types of service provision. Whilst the comment about doing good sounds

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fair enough, our perspective is that good isn't just about being efficient and effective in service delivery. We know that there's a lot more.

So I thought in trying to explain it I'll give you one small example from one of our members. It's a small $250,000 revenue organisation based in a working class suburb of Perth, they've got two part-time workers providing emergency relief and welfare to people in need in the community. They recently collated data on the in-kind support they receive from a wide range of activities, and I'm sure this could be broadened to many organisations across the sector, from free premises that they operate from, volunteer financial counsellors, $10,000 worth of bread per annum that they receive, 500 Christmas packages at $50 a package, a multitude of other donations and time from schools, school students, local service clubs and various churches.

They estimate that that total dollar value is $750,000 of in-kind support. So they receive 250,000 and they generate a further 750, so they're putting a million dollars back into the community in one way or another. And all of that's not to mention the unmeasurable social connectedness that I referred to before and the goodwill instilled in a lot of the people who provide that support. There's a lot of support, what we call the feel good factor, in a men's shed putting things together for a local community service, volunteering time, resources and skills.

So I'd like to think that the majority of us would be supportive of such an organisation doing good works in the community, both for the people that they support and the people who support their good works and it would be a real shame if it closed down. And yet, that's that crossroads they face at the moment. Their limited government funding which keeps them going is at imminent risk of loss, the tenders are looking for consolidation of partnering for even greater efficiencies, more reporting and more compliance.

My point is that for-profits in many cases are highly unlikely to go that extra mile unless there's a dollar in it. They're also highly unlikely to get the sort of support that this organisation receives. They're driven by return on shareholders' funds and they won't attract the goodwill and support of the nature I've just described. Furthermore, any assets of a not-for-profit by law are required to be used for charitable or community purposes, as prescribed in their constitutions. This is not the requirement faced for for-profit entities.

There's no doubt that for-profits do have a role in society, we've invested in them, we're supportive, many of us are shareholders of them. However, in the human services sector, as we've seen in other jurisdictions,

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any perceived short term savings around efficiency and effectiveness can be lost quickly and longer term implications for the sort of community support many of us believe is good and where we'd like to live.

As we've previously highlighted and you touched on briefly, Sean, in your comments, the partnership principles as detailed in the Delivering Community Services in Partnership Policy – it's a bit of a mouthful – the DCSP Policy, provide a good framework to start recognising the importance of improving outcomes, and we believe they should be incorporated into the Commission's recommendations.

I'm sure Stewart and Anna have seen that, there's a document that you can see online, and it sets out at one page about the principles and behaviours and the nature of the relationship that go more broadly to the construct of what we call civil society.

The second point that I'd like to make is around indexation, and I know WACOSS touched on it, so we'll expand a little bit more on that. We note and are supportive of the Commission's draft recommendations, 7.5 and 8.1, that the default contract length be set at seven years for family and community services and 10 years for human services in remote Indigenous communities.

We concur that this will enable service providers and service users to have a period of certainty and stability to implement services, build relationships, enhance and further develop service design and achieve outcomes over the longer period. However, one aspect we'd ask to be included in your draft recommendation is a comment on the need for annual indexation.

Over recent years many service providers have found that the Federal Government has provided no or minimal indexation, forcing service providers to either cuts costs, which are predominantly wages, or reduce services when demand as we know already exceeds supply. If contract terms are extended to seven and 10 years, questions around the sustainability of services will undoubtedly arise through the term of those contracts.

Most recently, the 3.3 per cent national wage case decision has resulted in significant increases for not-for-profits at a time when many are already struggling. By way of example, and it's a little bit State-based, but it still has relevance to the Federal sphere, the Equal Remuneration Order handed down by the Fair Work Commission in 2012 legislated pay increases of between 23 and 45 per cent over a nine year period for workers covered by the SACS Award.

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Fortunately this has been partially off-set by the Commonwealth but not by the State. Additionally there are State wage cases handed down each year. As I mentioned earlier, wages generally comprise between 70 to 80 per cent of the total expenses of a service provider, so you can perhaps appreciate the challenges for boards of organisations in balancing budgets when salaries are increasing by 5 to 6 per cent per annum and there's no increase in your revenue line, particularly if you extrapolate that over a seven to 10 year contract.

Unlike other service systems, not-for-profits cannot offset such costs by increasing the price of services to their clients or customers. It is this aspect that makes the adequate indexation crucial to organisational sustainability for not-for-profits, especially in regards to long term contracts.

The third and final point is that we believe the Commonwealth should change its policy on the clawback of unspent funds. Briefly, if an organisation enters into a funding arrangement to deliver services and achieves all the outcomes agreed upon, and there are funds left over, our understanding is that the Commonwealth Government in some sectors requires the funds to be returned.

In WA State funding arrangements, this isn't the case. WA Government policy is that as long as funded organisations achieve agreed outputs and outcomes, then, like any other contracted provider, surplus funds can be retained by the NFPs to assist in other service areas or to provide for new initiatives.

Our recommendation would be that the Commonwealth changes its current policy, its existing approach risks creating a culture which encourages the inefficient use of excess moneys rather than encouraging the enhancement of service systems and the extension of existing interventions or the creation of additional programs.

So they're our opening comments, if you like. Ross, did you want to add some other comments from your perspective?

MR KYRWOOD: No, I'll pick my comments up in any questions you might ask.

MR SPENCER: Thanks very much, John. This issue of the provider type, I mean, we've obviously been wrestling with this one as well, and I think what we've really tried to do in our draft report is to really encourage government to be very thoughtful about what are you trying to achieve in a

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particular situation, what type of provider attributes will maximise the chances of achieving what you're setting out to and therefore, motivation and some of the issues you've raised in respect of not-for-profits comes into that.

Do you think we've gone far enough? Are there other things we should be putting in there to help government make wise decisions about when they do, if you like, favour one provider type over another?

MR BOUFFLER: It's not easy; I certainly acknowledge that, partly because some of it is not easily measurable. You asked earlier on a different question about how do we encourage them to do it. If it's measurable and accountable and people are held to be accountable for it, then you're more likely to do it.

A lot of this goes to the construct of civil society and what sort of society do we want, and is it just about contestability, user choice and competition and how do we increase it and how do we get more efficient and effective? Or is it about broader relationships and how do we build and maintain and sustain those relationships. We believe that it's more about the latter, but you need the former as well. You need to be efficient and the tax dollars are limited and we need to use them wisely, we understand that.

It also involves the broader aspect of how we're improving lives for the community, and as a whole, that integrated community, not just the siloism. We're trying to break down the siloism across government, which is hard in the Westminster system, because the minister gets a budget they're accountable for their budget and Treasury aren't going to give them any more, and so it flows down.

In WA they've just merged four departments, if you like, so that will be really interesting to see how housing and disability and community service and DLGC come together to be more integrated in what they do. And if they can make it measureable and accountable, then it's more likely.

So your question around not-for-profits, I think you could go further. I think it's about more actively supporting the work that not-for-profits do, which isn't easy because it's not always measurable, and yet we know that it's there. We know that the men's sheds do good things, we know that a lot of those volunteer charities out there that are household names that have been around for 150 years do good work, but it's not always on the bottom line and how we actually say that they've gone out and done those 30,000 home visitations and Vinnies or wherever it be, that that is evident and transferable into a dollar outcome, and it's how do we continue to do that.

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So the partnership principles and the behaviours are perhaps one way to look at that more closely. So I'd encourage you to read through that document and that part in particular, and that might help elicit a bit more thinking in that regard.

MR KYRWOOD: I think potentially it's also the wrong question. I don't necessarily think the question is about does for-profit or not-for-profit bring about – or competition bring about greater quality. The YMCA in WA would be called by others a social enterprise. Our enterprise is in the childcare sector where there's clear for-profit and not-for-profit players going on. What's increased the standards, which means that in regional or remote WA a childcare centre would have the same quality standards as in downtown Perth, is actually the fact that there's a curriculum, there's actually a learning framework that's owned right across the whole of Australia and by all the players that play in that particular space.

It also has an angle that talks about the development of the industry. So what's also happened in that transition is moving from childcare to early learning and the professionalization of what it means to actually be an educator, we now have requirements where you must have a school teacher in every single child care centre across Australia. So there's this potential big myth that competition creates that uplifting (indistinct), where in fact working the system or working the process and having a similar curriculum and a similar framework and outcome framework is what creates that.

The other comment I'd make, picking up on perhaps outcome and frameworks and culture, that both WACOSS and – and we've spoken about and you discussed earlier, is there's a recent report that talks about what makes a successful hierarchy at an organisational level is actually the culture that you create in the organisation from the board ownership down. And that's the preparedness to invest, it's the preparedness to change your capacity, it's also a preparedness to be able to make harder and more effective decisions based upon the outcomes you're realising you're getting through an actual assessment of that process.

I think there's a challenge where government needs to shift that culture as well. My assumption would be, and I don't know if I've got hard empirical evidence around that, that point would be the same for government as much as it is for an organisation. There actually has to be a genuine culture shift to value and understand the outcome and impacts, and to change the way you do things as a result of measuring against that outcome and impact.

My president, the PWC person, he'd talk about the culture of failing fast and learning quicker. We don't have that dynamic. My concern around

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the seven or 10 years is we don't create a space where we're actually able to learn what we're actually achieving and how we might adjust over a seven to 10 year cycle. We create this in the human services sector, this furphy that we can design an impact or a program that's going to last for seven or 10 years now, back – and right now it gets three or so years, but we don't actually allow ourselves to fail, we don't actually allow ourselves to be able to evaluate the business, and then readjust as you go along.

Again I'll give an illustration around that, the YMCA recently had run a significant Indigenous program called Swim for Life, it basically taught young Indigenous kids how to become lifeguards and solved both a problem for community because it actually brought lifeguards in swimming pools and prevented drowning. It was a model that seemed to work in the Pilbara, through a recent innovation fund grant; we tried to apply it across four other regions in WA. What's interesting around that is there was no conversation around what we've learnt or failed around that, it just didn't work. So we had to give the money back.

What comes out of innovation in every other business concept is how you learn, fail and try to apply again. I think they're some of the cultural differences that can take place when you talk about an outcome hierarchy decision making process, and also when you're looking at getting better inefficiency is through the improvement of the industry, not just the improvement of an association. I would argue that not-for-profits overtly want to play in that space in partnership with universities to achieve those outcomes.

MR INNIS: Thank you. I think you've touched on some very important issues and I want to explain one of the things our recommendations were trying to do. At the moment it looks like the only way to innovate is to run a new tender. Part of what we're trying to do with the longer and more certain contracting framework is to encourage more partnership approaches and more innovation within contracts. So some of the flexibilities you talked about, we don't see waiting until the end of a seven year period and then you'll include the new innovation. In fact what we want to create is an ability to innovate as you go, focused on the outcome rather than the outputs. So I just wanted to explain that.

Come back to this issue of not-for-profits and supporting civil society. The Commission has previously, and said in this report, that it's very important for governments to support civil society, but we've got a tension between how it's done. So you gave a lovely example of a service that drew on a lot of community support to deliver outcomes, government can either rely on that and say, "Well, you've got to get all your support from elsewhere and we'll give you a little bit of money to deliver a fundamental

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service", or government can do as we've recommended and say, "This is now a fundamental service, we need to fund it fully and properly". And indeed, your indexation point I think goes to the heart of funding services fully and properly.

So the support for pure community civil society activities comes through things like the tax concessions et cetera, et cetera that exist. We've been trying to effectively say, where government thinks it's a fundamental service, actually has recommended you fund it fully. Take the point about indexation, I think it's implicit in what we write, but maybe not explicit, and I'll just get you to comment on that.

MR BOUFFLER: So just on that, I think it would be good if it was explicit rather than implicit, because it's easier for people to miss those.

MR INNIS: I understand that.

MR BOUFFLER: I hear what you're saying with regards to government could and should fully fund those services. The reality, I feel, is that government's never going to have enough money to fund all those services, and the funding is only one aspect of it.

So even if the government in that very small example gave a million dollars, right, the 250 that it gives and the 750 in-kind and said, "Here's a million dollars, go and do good works", it's not just about the money. It's also about the social connectedness that those people have in coming together to support people in their communities. And it's much broader than the dollar aspect of providing that. Because if the government provides the money - and this is one of the concerns, I think, about NDIS - if the government provides the money then the community is more likely to say, "Well, you've got all your money, what do we need to have the Activ Run for, or why do we need to have the Rocky Bay or the Million Paws Walk or the whatever else it is, because you've got $22 billion, please, I'm out of here". It's about the community and society coming together to help those that are less fortunate.

And that helps me when I'm on the phone, at Lifeline for the last 25 years, talking to people about – as a volunteer, about their issues, or about other things that you or everybody does in their lives. It's that feel good factor or that contribution and that connectedness that we make that goes well beyond the dollar value and trying to prescribe a dollar value to it.

MR INNIS: No argument.

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MR BOUFFLER: The other risk, just to finish on that, in my perspective, is that government will have to make hard decisions. The budget is in significant deficit already, and programs will and are being cut. So somewhere in the system someone will say, well, that's $250,000, I'm sorry, we just don't have that money, that will now be covered by some other organisation somewhere else, they have to send somebody in. The effectiveness of service delivery will atrophy, that's what we've seen in other circumstances.

MR INNIS: So, John, are you suggesting about that service money, this other community - - -

MR BOUFFLER: It will disintegrate, that's the core that keeps it going, and then these people have enough energy - - -

MR INNIS: So what if the money was not given via a service it was given as support to community organisations?

MR BOUFFLER: We continue with that example you mean, the $250,000? If it was given to others then the connectedness and relationships that have been built up over the 30 years that they've been going may well just dissipate. It's not to say therefore everything has to stay status quo and we can never change and things don't change, they do, but we do it very judiciously and we try our best to recognise the added benefits to civil society that not-for-profits bring.

MR SPENCER: John, just to pick up on that theme, because once again it's a great example that you described earlier, it seems to me, perhaps be slightly provocative, that a lot of organisations will talk about that but not actually measure it in the way that you did and that organisation did, which makes for a quite compelling argument as to, well, how do we not lose the value of that and what role does government have to play in that.

So do you think it would be helpful – and this is a little bit leading up to when governments go out to purchase services through tender rounds, the time to prepare for that, for organisations to put their case forward, and I suppose it's a bit of the co-design element in here, that what is government purchasing at the end of the day, and if that's part of what it wishes to purchase, the leveraging of its funds more widely into community civil society, that there's an opportunity for that to be considered.

MR BOUFFLER: I agree, and I think the sector and organisations need to get better at doing that as well, at telling their story of the value that they add to the community. Some do it well and some there's room for improvement, I guess.

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MR KYRWOOD: One of the things I think it's left to the organisation to lead that. So if it was driven by an external driver, so as part of the tender process, the amount you actually value of your ability to articulate your connection to your community, the ability that you are able to articulate the value-add to what you're doing through your fundraising and your connections. If that was given greater focus, and potentially more points in terms of decision making frameworks around who wins and who loses a tender, I think that behaviour will see – or that would drive the behaviour that would see not-for-profits starting to articulate that, giving value to measuring those sorts of, type of outcomes.

I've been in the sector for 30-odd years; I think our sector is amazingly good at following the lead of government in their tenders. On a micro of that, we work with local government, we know when a local government in their decision making framework gives 20 points of their 100 points to a decision making outcome that says you've got to show that you're connected to your community, versus competing against the for-profit provider in that space who, quite frankly, can't, they'll kill us on efficiency, they'll kill us on their ability to get other funding and maybe investment funding through the share market or whatever, but we absolutely beat them on community connectedness. But if they only give it five points and they give financial 70, then that's where its priority is.

MR SPENCER: Do you think, to follow on from that, it's fair and reasonable if government says, right, okay, we get that and that's what we're going to proceed on that basis, therefore, within those arrangements, that are to be accountability for the organisation about delivering on its goals for social capital building and there'd be some measurement and accountability around those?

MR BOUFFLER: I do. I think both on government and on the sector more broadly, there does need to be measurement and accountability. If you don't measure it and you don't track it, how do you know that it's happened. And that's why many are struggling with outcomes, everybody's talking about outcomes, right, we've moved from counting it to measuring the outcomes. Outputs was kind of easy, outcomes is really hard, and government is really struggling with it and lots of universities are doing research and writing papers and you can line up a room full of professors to talk about it for a week. It's very hard. It's a great idea and a great concept and you've written 438 pages and a fair bit of it, but it's very hard.

MR SPENCER: Absolutely. Sean, any final questions?

MR INNIS: No, I think that's been very useful, thank you.

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MR SPENCER: Thanks very much, John. Thanks guys.

MR BOUFFLER: Appreciate your time.

MR SPENCER: That's really helped out, thank you.

MR BOUFFLER: And also to acknowledge the work of Stewart and Anna, because I know that often the people that do a lot of the work don't get recognised, so I also wanted to put on record, we appreciate them also.

MR SPENCER: That's very good of you to do that, you're absolutely right, and thank you for doing that.

MR BOUFFLER: We all say you're not doing a lot, you are.

MR SPENCER: No, we know who the true workers are. Thanks very much. We'll take a short break and then we'll resume in another 10 minutes or so. So thank you.

ADJOURNED **[10.41 am]**

RESUMED **[10.59 am]**

MR SPENCER: Thanks very much, everybody. We are attempting to do something about the varying temperature of the room, so hopefully we'll achieve a comfortable level soon. So we'll resume this public hearing and invite Shelter WA now to present, and just for the purposes of the transcript, Michelle, if you could identify yourself and your role, that would be great, thanks.

MS MACKENZIE: Good morning, everybody, I'm Michelle Mackenzie; I'm the Manager of Policy and Strategy and Shelter WA here in Perth.

MR SPENCER: Thanks, Michelle. Michelle, would you like to, for about five minutes or so, really just outline the points that you would like to explore with us today and what you would like us to be aware of? Thank you.

MS MACKENZIE: In terms of my presentation here to the Commission, I was under the impression I had half an hour, so I've actually got a 20 minute discussion.

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MR SPENCER: No, exactly. If you want to take a bit more, by all means, yes, and then there's time for discussion. Thank you.

MS MACKENZIE: Great. Firstly, I'd just like to thank the Commission for your work and in particular for the opportunity of meeting here in Perth. For us we believe social housing is the only housing system that guarantees housing affordability, and certainly the social housing system ensures that those who are otherwise unable to gain and to stay in housing through the private market can do so.

Like the Commission, we agree that the market has failed to deliver the housing required, in particular for vulnerable renters, and we absolutely agree with the Commission that the social housing system is broken. We also agree there is a need for greater user choice for social housing tenants and that consumer choice should be at the centre of any social housing system. Like the Commission, we agree that there is a need for rental subsidies for social housing because the market does not supply housing at an affordable cost for low income and often higher need tenants.

In terms of our approach, we had a number of guiding principles, and that was that system changes should not result in any negative impacts on consumers, such as an increase in rental stress, the risk of homelessness or any locational disadvantage. The disconnect between national, state, regional and local housing policy settings must be overcome and there needs to be an integrated whole of system approach to affordable and social housing.

We believe that consultation with the social housing and homelessness sector, tenants, State and Federal Governments, is essential to ensure the whole housing system is configured in a way that will work, and we believe that any recommendations put forward by the Commission should not lead to a loss of funding to existing homelessness or social housing streams or any cost shifting from Australian to the state or local government authorities.

In terms of your draft recommendations, we question that increased competition and contestability will lead to greater user choice in the absence of mechanisms to increase appropriate housing supply. I think that's one of our key points. And we're really pleased in looking at the AHURI submission that they have noted the likelihood is that these reforms will fail to be implemented or realised until supply side constraints are resolved.

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So that's probably just an opening statement. If you like, I can walk you through some of the statistics and then some comments in particular relating to some of your recommendations. What's your preference?

MR SPENCER: I think we could probably just jump straight into some discussion, which would be great.

MR INNIS: But if we're not getting to the issues want to put on the record, please stop us and - - -

MS MACKENZIE: Okay, great.

MR INNIS: Thank you.

MR SPENCER: I suppose to go to that first major issue, that in the absence of addressing supply you, I think cast out, on what we're recommending. And you put this into the context of a much bigger issue than simply the one that we've been asked to look at. So I think one of the things we've been struggling with is how to come up with a set of recommendations which over time could be part of a better, more effective system right across Australia.

So we've been positioning essentially some of these recommendations around a longer term goal, but if I understand correctly, you're really saying you'd prefer not to move on any of those at this point. Or am I understanding that correctly?

MS MACKENZIE: Well, I think it's a fantastic report in terms of some of the research, but it's conditional. So you do this, and then you do this, and then that will lead to supply. We absolutely reject that rents should be shifted from income-based to market rents as the premise to then increase the RA. So I think if you increase the RA, that would be fantastic.

Fifteen per cent is not enough, we've done some modelling for suburbs here in Perth, and if you were to shift from an income-based rent at the moment, which is what the State Housing Authority provides and some of the community housing providers, to a market-base rent, some of the suburbs that people will think are affordable, like Kelmscott and Gosnells, even with a 15 per cent increase, will mean people are still in rental stress. They'll be paying over a third or their income on rent, which is just inappropriate.

One of the beauties of the current system is that people can live in Fremantle or Northbridge because there is social housing in some of those more affluent suburbs. Our worry is that with the marketization of rent,

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people will not be able to live in those areas if it shifts to an income-based to a market-based rent. Some of the modelling we've done is that you'd probably need like a 90 per cent increase in CRA not a 15 per cent to compensate, to if you look at the average rent in those suburbs, just not affordable.

We did some research last year with REIWA, the Real Estate Institute of WA, and we found that only 3 per cent of private rentals in Perth were affordable to those on a low income – 3 per cent, and 1 per cent were affordable to those on government income support. So we've absolutely got a market that is not supporting people who are vulnerable and on low income, and our worry is that your recommendation to shift will make that even worse, that it has the potential to make people move to the far-flung suburbs, that that increase will be absorbed in terms of just rent.

We've got a vacancy rate at the moment in Perth of 7.3 per cent, so whilst there are rental properties that are empty, the stock does not meet the needs of people who do need housing, and those are the people in social housing. So absolutely support an increase to the CRA, but it shouldn't be conditional on the shift.

Other things that we don't support in your report is shifting to the non-government – the private sector providing social housing. We think one of the fantastic solutions is supporting the community housing sector. All of the research shows that they're efficient, they're effective; there are great examples here in Perth, like Foyer Oxford in Leederville, where they demonstrate innovation in terms of providing housing for vulnerable people.

I think at the moment the Commonwealth Government is looking at ways through the National Housing and Affordability Agreement to support the growth of the community housing sector, and we'd be worried with your recommendations of making it more contestable, because I think that could undermine that growth and then have an adverse outcome in terms of social housing supply.

MR INNIS: Can I ask a couple of questions, but I make a statement, I hope our report doesn't say that our recommendations are the answer to the supply question, because we clearly do not believe that's true. In fact we seek to, but perhaps not completely enough, contextualise our recommendations as being part of what needs to happen, not the whole of what needs to happen. I just wanted to say that.

Second thing is in our recommendation we talk about the development of a high needs payment that is state-based, so the CRA change was to be a

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contribution from the Commonwealth, and we're certainly recommending the Commonwealth lift is contribution. But we also see great merit in states making their contribution to rental affordability much more explicit, including potentially varying it, depending on where people live.

I'll explain just what was behind that. So we were quite conscious that we've got more people living outside social housing who are theoretically eligible for social housing than living inside, and we couldn't see a way where a supply response was going to deliver rental affordability to those people efficiently and effectively. So I guess I'll get you to comment on the issue of how do we reach the people who are outside social housing today?

MS MACKENZIE: I think you're looking in demand side, which I understand, and I think what we were looking at is that the premises all seem to make sense in theory. So absolutely consumer choice and greater contestability. But the issue is you can't have greater consumer choice and all of the things that you're posing if you don't have enough supply to enable that to occur. So we looked at your recommendation but we couldn't just look at the demand side, the supply side needed to be addressed.

So at the moment, absolutely right, there's inequity in terms of the subsidies that people can get, and it shouldn't matter the nature of the dwelling, it should be your personal circumstances. In terms of the state providing a higher top-up, I'd be interested in where you're able to demonstrate that there's been that discussion with the states and there's an appetite for that to occur. If you look at the way that housing works here in WA, they've got a kind of closed model where the money that they generate internally from land sales and development is used to underpin their public housing system.

So I think at the moment there's a new National Housing Affordability Agreement, I'd be interested in your thoughts on whether your proposal for the state-based top-up subsidy, how that relates to a national agreement where they're looking at how they can provide more social housing. Are you saying it should be substituted or – how does that all work?

MR INNIS: Potentially entirely separate discussions.

MS MACKENZIE: Yes, and I think that was a - - -

MR INNIS: So they don't need to be – so just to understand, I think your submission may suggest, and if I've got this wrong, please tell me, that a concern is that the Affordable Housing Agreement money would be used to

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fund the high needs payment or the CRA. I don't think we've made that link.

MS MACKENZIE: It just wasn't clear in terms of the injection of new money, the appetite by the states to do that. So our worry was in the absence of any modelling and discussion that showed how the money would flow – so how it currently flows to support tenants in terms of their need for a subsidy so they can rent, and how it flows to increase supply, so that's like a whole system approach, how your recommendations then had the money flowing. I think in terms of a response from us, that would have been a useful thing to see.

MR INNIS: So a little more detail would help?

MS MACKENZIE: Absolutely, yes.

MR INNIS: That's a fair comment.

MS MACKENZIE: I think it gets back to again people are vulnerable in Perth in the private rental market, and one of the other things that we highlighted in our submission was a report done by CHOICE, I think it was earlier this year or last year, where they interviewed renters and they found that 83 per cent of renters in Australia have no fixed term lease. So if you were thinking about focusing on the private rental market, there's a whole lot of institutional reforms that need to happen, looking at security and stability of tenure, things like that need to go hand in glove.

I know you mentioned that in the report, but we need to go back to first principles and say, what will provide the most security of housing for vulnerable people in the social housing system, and that seems to be the community housing sector at the moment. There have been great schemes like NRAS, but I think the beauty of those schemes has been when community housing have taken over the management of those, not private landlords.

MR INNIS: In our report we would consider community housing private – just to let you know, because it's not government, if that makes sense.

MS MACKENZIE: Okay.

MR INNIS: Appreciate the distinction you're making.

MS MACKENZIE: I think that's a really important point of distinction because we don't see the – we see it as a non-government sector housing provider, not a for-profit sector, and I think to be absolutely crystal clear,

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because they have a social purpose, and I think the community housing sector have a value-added area that private for-profit providers don't have. Making that point is very clear in terms of how we do describe private.

MR SPENCER: No, that's a very good point, there has been some confusion about – private has sometimes been taken to mean for-profit, and private, we've used as being non-government, whether it's for-profit or not-for-profit.

MS MACKENZIE: Yes.

MR SPENCER: I suppose just to really try and understand the – where is it possible to make some progress around this extraordinarily tough issue through the lens of our report. As I said earlier, I guess we were trying to identify some areas that will - over time, could address the inequity. So just so I understand, if there was much more action, if I can put it that way, on the supply side, do you see the sorts of things we're talking about ultimately making sense, or do you have a more fundamental objection to moving away from an income-based rent system?

MS MACKENZIE: So the modelling that we've done and it's a bit like your calculations, a bit back of the envelope, here in Perth is that a shift from an income-based rent we just could not support because it will push people into poverty.

MR SPENCER: Can I just explore that a bit further? So even with a high needs payment appropriately - - -

MS MACKENZIE: But until you do that modelling and show us how that would look, it was difficult. So as a principle we do not support a shift from the income-based rents at the moment, because that means people have enough money for the cost of living, because it's linked to their income and it's really critical. I think if you were to say, look, even with the high costs of paying, let's got to a market-based rent, there is a huge chance that even over that 10 year time horizon, that people will be worse off. It's almost like going to the worst case scenario and equalising everybody badly, as opposed to saying let's have a best case scenario and equalize everybody well.

So we don't support that. Absolutely think an increase to the CRA is warranted, but it shouldn't be conditional to a shift to the way incomes are calculated. So if you can get a CRA increase, that will be sensational, because it hasn't gone up, it's not enough at the moment. But then I think also – and this wasn't your Terms of Reference – you need to look at the

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whole income support system. Because it's a subsidy for renters, as a other Commonwealth benefit, so they how they all kind of lock in together.

MR INNIS: Michelle, can I just confirm? So our recommendations are that existing social housing tenants effectively be grandfathered for 10 years.

MS MACKENZIE: Yes, that's right.

MR INNIS: And we're proposing that new people get access to both the CRA and potentially the high needs payment. They're certainly not worse off as against their current state, because they're living in private rentals now. Is that right?

MS MACKENZIE: But I think what we're saying is that people that are living in private rentals, like you pointed out, are financially not as well off. So the best case scenario is using income-based rents, because then there's a guaranteed your rent's this net of your income, and then you've got money to afford other expenses in life. So why can't that system be the one that's chosen as opposed - - -

MR INNIS: So just help us understand how you would propose that be implemented.

MS MACKENZIE: We haven't done that modelling, so what we're proposing to you is that we think that would be a useful piece of work for the Commission to do, to look at other scenarios as opposed to just the scenario that you've put forward. And again, I get back to the point that if you look at the rental market in Perth, it's not affordable for people on low and very low incomes, so it's hard to see even with the top-up payment and the way that rents are set over time that that won't be eroded.

MR INNIS: So just to make sure I understand the message, you're saying that even the potential level of injection into affordability that we propose that's unlikely to be enough to address affordability, noting that you can deliver affordability by giving people money to spend on housing as well as building new houses and then subsidising the rent that way.

MS MACKENZIE: Yes.

MR INNIS: So it's just not enough.

MS MACKENZIE: I think it gets back to the fundamentals, that people have a right to have housing, so there should be enough supply so then there is opportunities for user choice. So net of all of theoretical stuff around the

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modelling, in the absence of having enough supply, it becomes a bit of a moot point. So we're not sure how the demand side work or increase the supply side need, and we're saying the supply side need is critical.

So in terms of opportunities to grow supply, we think harnessing the strengths of the community housing sector is fantastic. Some of the budget initiatives the Commonwealth put in place that will flow through the National Housing Affordability Agreement are great, like the bond aggregator, the managed investment trusts, things that are trying to support the community housing sector to grow.

Some of the things in your report around tendering and things we're a little bit concerned about because one of the value – some of the value of the community housing sector is the niche providers, like the Indigenous housing organisations and those that support clients with high and specific needs, so we haven't talked about the tendering process, but we certainly don't support the way that you've recommended that supply is tendered, moving forward. Have I answered your question, or have I rabbited on?

MR INNIS: Yes, I think so. And I'll just try and confirm, Michelle, that you would see the priority for government needs to be developing additional stock for community housing providers to manage. That's the best pathway in your eyes to addressing the problems of social housing.

MS MACKENZIE: Of supply, absolutely, yes. Along with increasing CRA and maintaining income-based rents.

MR SPENCER: Can I go to a slightly different issue, because once again our Terms of Reference, as we mentioned earlier, are fairly specific and this is part of a much bigger issue.

MS MACKENZIE: Yes.

MR SPENCER: So the element of choice, you raised an issue around choice with community housing providers. You had some concerns about choice and that compromising community housing providers' ability to select who would be – within a community who was appropriate to be in a community. Have I understood that correctly?

MS MACKENZIE: No. I hope that's not what I indicated. So we posit that community housing providers, there's a spectrum of them. Some of them are quite large, some of them are niche providers. And moving forward, there needs to be the opportunity for niche providers to continue to exist. Our concern is with some of the procurement models outlined in your report that even if the tendering processes aren't appropriate, that

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there's a great chance that some of the smaller niche providers may not come out favourably against some of the larger providers in terms of cost and value. So it's just being very sure that procurement models aren't a competitive tender.

We've got some great examples here in Perth of collaboration. There's been a lot of work done on co-design processes. So it's just thinking about the outcome required and how you harness the strength of the NGO sector in a non-competitive way.

MR SPENCER: Yes, my question went I guess more to the individual who's offered the property and that they have choices to which property they will go to. A little bit informed, a little bit like the UK experience. But I thought there were some reservations about the choice that an individual can make.

MS MACKENZIE: No.

MR SPENCER: Not at all?

MS MACKENZIE: No, we support choice-based letting, as long as it's real choice. The concern, and I think this was highlighted in your report, is that there's the opportunity under choice-based letting potentially to choose the clients that are less disruptive or seen as less disruptive. So there needs to be a degree of equity so marginalised people aren't disadvantaged in that choice-based letting. I suppose while it may be a clumsy comparison, if you look at the private rental market, that's an absolute choice-based setting market because anyone could choose whatever they want, and we've seen the outcome in terms of vulnerable people, they cannot get houses, they cannot afford houses. So in principle we support choice-based letting, as long as you've got enough supply

MR SPENCER: Yes. So I suppose, Michelle, just to in a sense turn the question around, given our Terms of Reference, what would you be recommending? What would you like to see us recommending, as opposed to perhaps what we've got there at the moment?

MS MACKENZIE: An increase in CRA, so do some modelling and 15 per cent is a great first start. Is it enough? And that's a question I'd ask you - - -

MR INNIS: You don't see the states making a contribution to – effectively a subsidy to – tenants through a contribution they make?

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MS MACKENZIE: I think that gets back to our, in our submission saying we require the broader modelling, because they do at the moment. It's an implicit subsidy; it's not one that's seen. But they provide public housing, it's income-based, and so tenants pay, and they don't get CRA. So I suppose you could say that that's the balance of what the state - - -

MR INNIS: Community housing providers get CRA.

MS MACKENZIE: Sure. But tenants in public housing don't. So it's like an implicit subsidy that the state would provide, and I suppose that's where our concern is, if you're talking about top-up payments and now public housing tenants get CRA, how does all of that money flow so people aren't disadvantaged? So it's just getting a degree of understanding of what your recommendation means in terms of the money flow through the system, current state and future state, to enable us to see, yeah, it does make sense, just that understanding from the states in terms of their appetite to do that top-up payment.

Are you saying that top-up payment will be equivalent to their kind of implicit subsidy? I'm not sure how that would work. And given we are in the process of having a new Affordable Housing and Homelessness Agreement, how your recommendations kind of dovetail in with that figure, SPP, that's about housing.

I think one of the other things that's probably not in your Terms of Reference but it's stepping back and saying there's a whole housing system, what will increase social housing supply. And I look at my colleagues here from WALGA, things like planning reform is really critical, taxation reform, harnessing the private sector in a way that will deliver benefits from tenants. So it's a whole system and I think it's hard to talk about one component without looking at the whole system. And given supply is so broken, it makes it even harder to comment about your demand-side approach.

MR SPENCER: Just a question, this is changing topic slightly, but family and community services, I'm just wondering, the recommendations were made in there that – this is slightly, but does overlap I think with areas of your interest – but have you got any thoughts on the recommendations we're making around family and community services and the commissioning processes?

MS MACKENZIE: We didn't look at that section of your report.

MR SPENCER: Okay.

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MR INNIS: But you've got a general concern about tendering processes.

MS MACKENZIE: We think there's an opportunity to harness the NGO sector through more of a collaborative approach as opposed to a competitive tendering approach. There are examples here in Perth, and I'll use the RUAH 50 Lives 50 Homes, where it's a huge alliance of over 20 NGO providers who are taking a consumer choice focusing on the tenant and then providing the wrap around services from a housing first perspective. So provide people with the house and then provide the services to sustain the tenancy.

I think in a competitive tendering environment, that sort of collaboration is a lot more difficult to negotiate. So it's just looking at more creative ways.

MR INNIS: We'd agree that the system should be more supportive of collaboration and try to at least frame some recommendations that would help. Can I ask, if tendering is not the right way for selecting providers, what would you recommend? Because governments will have to choose who gets money, how much money they get somehow, so what's the mechanism?

MS MACKENZIE: You do need a robust and transparent procurement process. So there's a spectrum of your hard, competitive tendering which are dollar driven, through to a more collaborative approach, where people can form alliances, they can work together with government in kind of like a co-design process. I think WACOSS probably will talk more about that, they're seen as experts in WA in terms of co-design. In a way where you're not pitting people who have a lot to offer against each other, that's drawing on the strengths of the NGO sector and what they can offer.

MR INNIS: If I hear this right, your primary concern about the tender approach is governments get too focused on price and price alone, and as a result, miss some of the other value that people might bring. Is that fair?

MS MACKENZIE: That is fair. And I think in terms of if you have a tender process, it's who's involved in designing the tender without compromising integrity down the track in terms of the tender itself.

MR INNIS: Sure.

MS MACKENZIE: And it's making sure that the needs of the consumer is front and centre in that tender and it's not just dollar-driven. As I said earlier, there are niche providers and it's quite often a cost to put in tender bids, so how do you not disadvantage those that have a lot to offer? Also

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in terms of the tender process, tenders have a certain life, so if you're a consumer, what's the issue and the impact on you in terms of tenders that may roll over or you may get different providers. So it's thinking from the consumer perspective.

MR SPENCER: Good.

MS MACKENZIE: One of the things I wanted to touch on was the cost savings to government of providing housing. And I'm not sure if that came up in your report, but there's been some great research here in WA that have shown the savings to government of providing a house to people. It was done by AHURI and it looked at the impact on the health system of people who are chronically homeless that continue to go to hospital. And they worked out that it was a $16 million saving to government by providing people with housing, as opposed to having them churn through the health system. It's not insignificant.

I know Eileen Baldry has done some work in New South Wales on Lifecourse, cost of homelessness, and I think one of the opportunities in your recommendation might be looking at the savings to government, medical savings to the individual, of investing in appropriate housing for people. I'm happy to provide links to those reports as required, but their costs were around the reduction in stays in emergency departments and et cetera, et cetera.

MR INNIS: Michelle, thank you, and that sort of investment approach, taking those costs into account is very important. A final question from me, in looking at all of the people who are potentially eligible for social housing, and homelessness or risk of homelessness is a small group within that pool, is that the group that governments should focus first on and most on within that broader group?

MS MACKENZIE: It's interesting, because housing is often spoken of as a continuum, and part of a reason there's a pressure on the social housing system is there's not enough affordable housing so people kind of slide down. So one of the key things is getting all the policy levers right so we have an affordable housing system that reduces the need for social housing, and I think that's part of the broader context that we're interested in your work being situated in.

So absolutely, people that are homeless, that's a sign of a failed housing market, in our eyes. So you need to look across the spectrum, you need to have the right sorts of dwellings and stock in the right locations that's affordable, with the right policy settings, so people don't fall off the housing continuum into homelessness.

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One of the things I haven't touched on is people in the private rental market. I think one of your recommendations was that they should have access to the services that people have in social housing, and we absolutely agree with that, that no one should be disadvantaged based on their dwelling type. It's just a matter of getting the right structures in place so people who are in the private rental market can access those services. Though the caution again goes back to the CHOICE report that shows that people when they front up for a private rental, who may be in receipt of a government benefit or may have a mental health issue, are very disadvantaged in the private rental market.

Again, it's thinking where do you focus your effort to get – your best effort to give your outcome, and we would say it's community housing not the private rental market.

MR SPENCER: Thanks very much, Michelle. That's been helpful.

MR INNIS: Sorry about the confusion on location.

MS MACKENZIE: No, that's me; I'm from Perth and should have picked the right Mantra on Murray. Thanks to the fellow that I rang, pointing me in the right direction.

MR SPENCER: Stewart, who's sitting at the back of the room.

MS MACKENZIE: And I'm glad I wasn't around, Jodie.

MR SPENCER: Thanks, Michelle. Could I ask the Western Australian Local Government Association representatives to now come to the table? Good morning. So just for the transcript, could I ask each of you just to say your names, please, and your position with WALGA?

MS HOLBROOK: Certainly. If I may, I would like to put in apologies first. This week is our annual convention and our annual general assembly, so our CEO Ricky Burges wanted to express her apologies for today. My name is Jodie Holbrook; I'm the Policy Manager of Community at WALGA.

MR SPENCER: Thank you.

MS HEWSON: I'm Nina Hewson, Senior Policy Advisor at Community.

MR SPENCER: Thank you, welcome. So perhaps if we could hand to you at this point to identify the issues you'd like to focus on.

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MS HOLBROOK: Certainly. We do have a submission, we have not finalised it yet. Our board meets in a couple of weeks so we need to go through a process before we can provide it. However, we did provide Stewart with some dot points. We would like to take the opportunity to say thank you for a great piece of work, it was a huge piece of work for us to go through, and in terms of what is within both this report and the former report, we have quite broad comments to make and we do go across most of the areas, so we're happy to have a discussion across all of them today. Nina, did you want to add any?

MS HEWSON: We were just going to give an overview on WALGA, if you'd like, to start off with?

MR SPENCER: Yes, thank you.

MS HEWSON: So the WA Local Government Association represents 138 local governments within Western Australia, to support the business of local government. We're a part of a network of local government associations within Australia, so at current we liaise often with the other local government associations, as well as the Australian Local Government Association.

We're in a state of reform at the moment, so in terms of WA as a State Government, we're going through changes within the machinery of government, as it were. We're also in a reform process within local government itself; we're currently reviewing the Local Government Act. I just wanted to provide some focus on what we'll be talking about today, around the Local Government Act and the roles of local government.

Importantly, local government obviously has statutory obligations within the Act, but local governments also have some flexibility as to the services they provide their communities, dependent on each individual local government. So local governments are not homogenous, which is a really important point I think, which will be brought out through each of the categories that we talk about today.

MS HOLBROOK: So if you like, what we can do is just go through a couple of the key points.

MR SPENCER: Yes, thank you.

MS HOLBROOK: It may be useful actually to start on social housing, just following from Michelle. In terms of our support for the recommendations, we too had concerns that the recommendations fostered

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a disconnect between affordable forms of housing and affordable living. We have done a lot of work in terms of what local governments can do under our planning frameworks and how we work with our partners also. So we do work with Shelter WA, we do work with AHURI as well, and one of the key concerns for us is around supply.

So Michelle made the point earlier that there's a greater focus on community housing and we too would be supportive of that. Our focus in terms of the local government and what we provide is around infrastructure. So depending on where our housing will be, it's usually cheaper in areas that typically are fully serviced by infrastructure, so I'm talking about the public transport, talking about key opportunities for employment or key opportunities for health.

When you look at Western Australia, we are a really large State, and this is also an additional challenge that we will find. It's always for us foremost around equity, and we do have supply issues. We do also acknowledge though the paper is very much focusing on demand. We do also support the need, and Michelle, we reference it as well, around the 150 lives, talking about the wrap around service. I think that gets back very much to the other part in the report around family services and community services, but also servicing Aboriginal communities. We see that as a model that would be most readily used in discrete Aboriginal communities too.

So in terms of the association's position on measurements around moving – we use the word transitioning – transitioning people away from social housing, our planners at the association put forward the recommendations around the state's Keystart Home Loan. They think as a model it's an excellent model to look at, and there's a body of work that the association has done around housing affordability, what planning controls can be changed, policy levers, how we can align them better across state, local government and the Commonwealth, and that body of work is also reflected in our submission.

In terms of moving on to family and community services, there's a lot of work that's been done in the state, probably over the last decade, and there was a great body of work, which was actually led by Michelle back in 2007, looking at the role of the not-for-profit sector and looking at the role of local government and where we came together and where we separated.

WALGA has referenced this body of work in our submission, because it was an interesting discussion around if we were to be changing the role of the not-for-profit sector and the not-for-profit sector leading more community service delivery, what would that look like for local

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government. So what we've seen over the past decade is a number of local governments are stepping out of direct service delivery and moving more into a facilitation role. And that's been brought about as well from changes in the Local Government Act, so local governments have to do strategic plans now, it's been in since 2013.

But because they are responding to the community, they're looking for partners on how they can deliver the services that the community are identifying that they need. On the flip side of that though, is there are communities that are identifying issues that may not reflect the aspirations of council as well, so that's where they have to make a decision.

A great example that I'll use is in Manjimup. So Manjimup had a service provider which was Silver Chain delivering home and community care services. Silver Chain could no longer deliver those services so local government had to make the decision of where they invested their money. Was it going to be in support for what Silver Chain was delivering or were they going to continue with business as usual. The council decided to, in the interests of the community, to pick up the services that Silver Chain was offering, but that is again, at the cost of something else. So local governments often will become the provider of last resort, but there is a cost for them to do so.

MR INNIS: It's probably worth just to keep – you go through the lot and we'll interact at the end, if that's all right.

MS HOLBROOK: No. No problem at all. We did have a lot of conversation as well, in WA we are a little bit different with the introduction of the NDIS and the impacts on HACC services. At the moment we're still not clear whether the state government will remain with the local NDIS or move back to the Commonwealth-directed NDIS. But nett of that we've done a body of work to look at what the role of local government is, and we will provide that to the Commission. It is a report-in-confidence, but we did provide it to you as well for your NDIS inquiry too.

MR SPENCER: Excellent, thank you. That's very good, thank you.

MS HOLBROOK: My pleasure. In talking about that though, one of the things that many of our members have raised is gap filling, and also concerns around legislative frameworks. So at the moment local governments deliver a range of services and they do so under their disability access and inclusion plans, which are legislated under our State Disability Act.

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Local governments are wanting a way to broaden their role to include other vulnerable people in the communities, and we see it more so on the East Coast, where you have access and inclusion plans, and then looking at how you deliver wrap-around services. So that's just something that we would want to see moving into the future, and then how you actually develop frameworks to measure the outcomes that are being achieved.

That's probably an overarching comment from the association about the need for better consistency and better outcomes and abilities to measure those outcomes long term. They're often very short term and they're often pilot funding that comes and it's very hard to maintain long term outcomes.

The other thing that we'd like to talk about as well, in terms of public hospitals, of course local governments don't deliver hospitals, however, we have a very strong role in supporting health services, particularly in regional and remote areas. We do support the general intent of the recommendations, but we'd probably just want to highlight that local governments are providing funding, and the funding that they do provide is either from their general operating revenue or from their financial assistance grants.

There is new legislation in Western Australia which is the Health Services Act, which had a great model in it, and I do think it's changed, but we will clarify this, for health services boards. These health services boards were to direct what the needs of the community were in a certain region, wherever the hospital may be. They've changed now back to hospital services boards, so we're not quite sure what their policy change will be, but what we did like about that as a structure was that the community were more involved and more able to influence the services that would be delivered in that hospital setting.

So if I use an example here is the Fiona Stanley Hospital, that board was looking at what wrap-around services would be needed to be delivered either in the public hospital or around the public hospital, and the representation was very much from the community. There has been a slight change to the language and now they're hospital boards, and I think that's changed the intent, which is a shame, because it would have been a very good example for you to see how we're actually delivering on that.

We haven't said a lot about dental in the submission, it's not a space that our members have been involved with, other than to say they would always want more services, particularly to regional and remote areas.

The last one that we really wanted to talk about was service delivery to Aboriginal communities. In Western Australia we do have a strategic

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framework in place which has been delivered by the state government through the Regional Services Reform Unit and there's a significant investment that has been provided to that unit to deliver in the next 18 months. In terms of local governments impacted, there's 26 local governments that are impacted in looking at service delivery to Aboriginal communities.

The Commonwealth used to provide funding to the states for the delivery of essential and municipal services, and that ceased in 2015 under the National Partnership Agreement on Remote Service Delivery. At the moment what we're looking at is trying to determine what essential services looks like and what municipal services looks like. Essential is quite easy, and I say that very simply. But looking at what needs to be in a community and how it's delivered in terms of your power and your water and your sewerage, we're very clear that needs to be there.

What we did support in your paper was the development of community plans. So as I mentioned before, local governments develop community strategic plans. The state government is also looking at developing community plans with 10 identified Aboriginal communities at the moment in the Pilbara and the Kimberley. They're then looking to roll that out into the Ngaanyatjarra Lands, so 13 communities out there.

The concern for local government in respect to this is the funding is finite, the funding ends in October 2018, and the definition of what services need to be provided at a municipal level – and I use the word municipal very broadly – any services that need to be delivered to the community is not clear. So I think there's been a failure, and we all acknowledge and your paper acknowledges as well that there's been a number of different policy changes over the past 20 years and we still haven't really got it right yet.

One of the things that the association will always put forward is that it's the governance that needs to be looked at, community governance. I think broadly across the paper and it's recognised that governance needs to be considered and probably look at not just the outcomes that are being achieved but do the people that are governing the communities have the right access and support to training. You do mention it in your report and you talk more about raising opportunities for improved governance, and we do see it as well with community services.

So recently the state government cut a range of funding for parenting services across WA, had a huge impact on smaller not-for-profits, and once that was done, one of the key things that came up was a number of smaller not-for-profits had then gone to their peak bodies and said, "We need

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greater support, we don't actually understand the tendering process" – as Michelle raised earlier – "We don't actually know how to go up against the big players, we're not as slick, we don't have the resources, we're a volunteer-based organisation". So we see a real opportunity to improve governance for not-for-profits, particularly smaller not-for-profits, and then how they can work well with the other spheres of government as well.

The tendering process has gone out now for all of these community services and, as Michelle alluded to in her presentation, it does appear that the larger not-for-profits are receiving the bulk of the funding that's been provided and the smaller niche providers aren't getting a look in, which is of great concern to us an association because often it's the smaller niche providers that are in our more remote areas. So I'll use an example, being the Kimberley. There's a huge cost to deliver in the Kimberley or in the Pilbara, so you often find it's niche.

MR INNIS: Yes, and we're travelling to the Kimberley tomorrow, so we'll be first hand.

MS HOLBROOK: There you go.

MR SPENCER: Thank you for that for running through all those services, that's a terrific overview. Just perhaps to start with the last issue you raised, we've often heard today and on other days about this tension around tendering processes and the tension between sometimes the larger providers who can bring scale and resources to the tendering effort and the particular skills and attributes of the small local provider being overlooked or undervalued. What's your experience of why government – when we talk about it, it sounds very logical to want to recognise the value of the local where there's the trust, there's the confidence, the relationships. In your experience, why does that get overlooked? Why doesn't it get valued and what can we do about that to make sure it is valued in these processes?

MS HOLBROOK: From a local government perspective, so I'll talk about local government because that's where we're from, we do value the local more and I think that is probably a point of difference with local government, say, versus state government processes. We will always look to the local foremost and we design our service delivery based on the local because we know if you don't have the right people on the ground actually in the community, things always fall over.

So in terms of the association, we've actually developed a whole procurement framework very much based on the local and we will go out and source providers across WA to ensure that local first. So we have our policies all geared to local first, and then if you can't have local, then you

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can go further. Its efficiencies I would imagine, like you say, it's availability, you go big, but in going big you lose that local impact.

There's many examples of larger organisations, not necessarily not-for-profit, that have been provided funding but the outcomes haven't been there. And I think great examples of that can be seen in the Indigenous Expenditure Report and the Overcoming Indigenous Disadvantage, where there's been significant dollars invested for very little returns, and the last Closing the Gap Report I think represented that as well. It's easier, I would say. It's actually a little bit harder to look local and to know.

I think throughout the submission there were some great conversations in here about data, I don't think we have the right data sets because we don't know who is local and we don't have that necessarily. You can't come to one or two spots and know where to go, who's on the ground. So you're reliant on understanding what you know, what you think you know of that community, and who's delivering in there.

But there was great work done by this last state government in terms of exploring who was providing what in the Kimberley and how it was being delivered and the overlap. But that only came about because we went looking for the data.

MR SPENCER: Sometimes when we look at issues we end up back wanting to amend the Constitution, because we have federal, state and local. And it's fantastic you're here today to give very much the local perspective. But in terms of joining up services, coordination of services, you obviously commented on that, alike the different silos which sit both within particular layers of government, but also sometimes between levels of government.

What in your experience helps to facilitate it – you mentioned that word facilitation earlier – about what you're doing, what the state's doing and what the Commonwealth is doing, is in a more integrated, more effective set of services for that community, what advice would you give us about how we should approach that in our report and the recommendations we're giving to government about how can that be better done? I guess perhaps are any examples that come to mind where that has been well done and why and what's made it effective.

MS HOLBROOK: I'd love to say there was some tri-lateral that I could say this is a great example, bi-lateral I probably can. In terms of service delivery, I think we are very good if we all know what our roles and responsibilities are. And I think often we don't know what we're actually trying to achieve before we go into a community. It sounds like a great idea but we don't spend enough time at the front end looking at what the issue

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is that we're trying to solve. We don't actually go back and look at, with clarity, what we need.

So we always get back to the three Es, is what we like to call them – what are you trying to engineer, how are you going to educate it, and then how are you going to enforce it. If we took that across the three spheres of government, you would actually be very clear, everyone would know what they are wanting to achieve, what resources they need to achieve it, and everybody gets on and does it.

There's some examples of long term partnership agreements that the state government has had with local government, a couple of those would be like public libraries, and that would be reflective across Australia. I don't think there's anywhere where there's not a very longstanding relationship between the two tiers. Child health clinics would be another one, where there's been really good engagement from both the state and the local. But also the state and the local working together to deliver child health clinics, but then also measuring back against national partnership agreements set by the Commonwealth government.

So as long as we know what outcomes are being achieved, then we should be able to then engineer what the process needs to look like. And then it gets back to the education, that there is this process and how it goes up and how it goes down, and enforcing it when it's not happening. So actually making sure that we're – and that costs money. Not saying it needs to be regulated, but there needs to be oversight and a framework developed to do that and to do it well.

I would imagine – I'm trying to imagine which one in the last 10 years that I would say would be a really good example, from a state perspective, having the ability to have our Disability Access and Inclusion Plans tabled each year is very useful to see how we are being measured against seven outcomes. The Closing the Gap is another one. We're not doing that well yet with those outcomes, but hopefully at least there's a measurement in place to do so, and they're something that all tiers of government are working towards. And if they're not working towards it at least it's there and that's where the education and enforcement would come in as well.

MR INNIS: Thank you very much, and I'm going to focus for a little while on the remote Indigenous part of our report and part of the conundrum we face. So we talk a little about community planning and using that much more strongly as the basis for trying to get alignment with service effort and complementing the changes to contracting that are in the draft recommendations. The question that we are wrestling with is it sounds

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brilliant but where we seem to fall down is not enough effort up front and possibly not enough capability to do it well in lots of places.

So that's an impression we've got. You guys are close to the ground, you see these things from a different perspective, be interested in your comments around do we have the capability to do good community-based planning in a remote context?

MS HOLBROOK: I personally think we do. I think our focus has been a little bit – we've been a little bit out of focus, so I think there are some things that would be very pragmatic to tackle first that we haven't done traditionally. So an example that I would use is waste. Waste in Aboriginal communities is a really significant public health issue, and often the services that we are putting in, like new housing, people come in, people build the homes, and then they go.

There's a whole heap of waste that's left over from building new homes, and consistently building new homes under National Partnership Agreements, you have to hit a magic number of homes to release payment to the state. What we do find though is nobody has responsibility for the maintenance of waste and the tidying up of waste that's left over. So we have huge health issues there.

I think the reasons why we don't look at waste as an example – I'm using this as an example – is because it's in the too hard basket. But if you get your waste right you actually improve health outcomes. You improve health outcomes, that leads to other improvements as well. So one of the things that we've been looking at and we're hoping to work with the state on, particularly in WA, is looking at what's actually in the waste stream.

At the moment we have no idea what's going in to the waste streams apart from building, household rubbish, whatever it may be, and where it's going and how it's being done, and we're looking at opportunities to actually unpack that. So it's looking at what's in the waste stream. Once you know what's there, once you know what you're looking at, then you can actually unpack it and say, okay, well if most of the things that are going into waste are for example glass, what can we do to recycle that. Are there economic opportunities as well?

So I'm going to say it's Bidyadanga, but I think I'm incorrect, but I'll come back to you which one it is, there's one of the communities in the Kimberley at the moment that's going through all of their waste and looking at opportunities to do like op shops. So instead of sending it away, what can we do with it and how can we repurpose it.

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I do think that we try and look at everything at once, whereas we could be tackling one issue, addressing that, and then seeing what the flow-on effects would be, hence my reason for saying waste first. It's probably one of the long term issues, nobody has responsibility for the management of waste, and when they do, does a very poor job of it.

MR INNIS: Thank you. Second question I guess, and again trying to bring your unique perspective to the table, is we often hear that there's a tension between – even within the not-for-profit world – between the bigger organisations and the smaller organisations. One of the things with smaller organisations is that they are not always understanding what the leading edge of service provision is, and that's not denying the other attributes. So how do we effectively bring, when you want a local-first strategy in your language, how do you ensure that local is also leading?

MS HOLBROOK: That's a really good question. From a local government perspective, everything that we do is from our community strategic plan. So for us, any organisation that would come to a local government seeking support in that community, that would be the first place that we would direct them to. We'd also then direct them to any of the legislation that is specific to the area or any of the regulations that we have around there.

Making sure that things are leading edge. Often there's just not the capacity to do it. By the time you're busy as a smaller organisation employing people, making sure that you're sustainable, making sure your books are right, making sure you're meeting your grant agreements, there's actually little time to do that. So I think the leadership has to come – I think that's probably also a role for government, there's more time for government to actually be looking at where the leadership edge should be, what are the key innovations that are happening and also looking at where investment is going as well.

If we're talking a really small NGO, probably run by volunteers, they really don't have the time to be doing that as well. I think they need support to do that, and that probably gets back to the conversation earlier about governance and supporting improved governance. If your governance is right for the smaller NGOs, or the smaller local governments, then they have time, it frees them up to be looking at leadership and innovation.

MR INNIS: Thank you.

MR SPENCER: Just a final issue, once again regarding remote Indigenous communities. We've recommended 10 year contracts, a range of issues around that, and we're very conscious that there have been many inquiries,

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many initiatives to address what are profoundly complex issues, so we are treading cautiously and hopefully respectfully in this space. But the sorts of things we're putting forward about skills development, transfer, capacity building, the long term nature of those contracts, do you have any comments about where we're going with that? Does that feel we're in the right direction or are there other things you'd advise us to be considering or thinking about in that context?

MS HOLBROOK: From the association's perspective and from local governments', we're supportive of that approach. We often find that contracts aren't long enough, as they are at the moment, so having a 10 year lead time is very good and embeds people into the community as a service provider. In terms of capacity building we're very supportive of that as well, but we really want to focus on governance.

One of the longstanding discussions that we've had with state government when we started talking about service delivery to Aboriginal communities was there was always this understanding that local governments would be delivering services, rather than not-for-profits or for-profit organisations, and over time that's changed, because there's been a change in the way that we deliver services in WA. But still, the issue remains around the governance and supporting the Aboriginal organisations that are there to be delivering these big 10 year contracts and to deliver it well, and actually to have the confidence as well, when it's not going right, to say, listen, it's really not going right up here.

Often when issues are raised with poor service, they're not acknowledged. And I think, again, that gets back to those three Es, you've engineered it, you're educating, now you've got to enforce it. So if there are providers that have been given 10 year contracts, and I'm going to use waste again because it's my pet issue at the moment, if they're not removing their waste properly then there needs to be consequences for that type of behaviour as well.

We are very fortunate that WA has had our new public health plan introduced, it's been a long time coming, it's been at least 10 years that we've been working on it, and it's replacing our 1911 Act. So there is a framework within that that if there's an issue that's identified on Aboriginal communities, and we'll use waste again, and that the service providers haven't done what they said they would do, they have a five year plan where they have to clean it up. Wait to see. But I do think there needs to be greater rules around enforcing and education, and consequence.

MR SPENCER: Thanks very much, Jodie. Thanks very much, Nina, that's very helpful, very good to have that perspective too.

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MS HOLBROOK: Thank you.

MR SPENCER: So that brings to a conclusion those that had been arranged previously, but if others wish to now make a presentation at the hearings, and I know that Vicki Barry is keen to do so. So if I could ask Vicki now to come to the table. So thanks again, Jodie, and thanks, Nina.

Just so we know for planning, is there anybody else who wishes to make any comments to the hearing? No, thank you. Thanks, Vicki.

MS BARRY: I must thank you.

MR SPENCER: Vicki, would you just for the transcript, could you just your name please and who you're representing?

MS BARRY: I'm Vicki Barry and I represent the interests of Palliative Care Western Australia. We're the peak body for palliative care in the state. We're a not-for-profit membership-based organisation, so we either have individual members who are professional health care workers, we have researchers, volunteers, students – so a broad range from the sector and also we have member organisations. So they are service providers generally, but could be universities doing research, could be allied organisations like Carers WA, COTA and the like, so very broad-based, I guess.

I'm here really looking at your end of life care part of the paper, and it was very in-depth, which is great. Certainly what I've heard earlier from WACOSS and the need for co-design, service integration I think is paramount. What I think I'm seeing in our sector is there's fierce competitiveness, and it kind of is a barrier to good collaboration. I think that goes back to just tender processes, dominant players, the corporatisation I think of a lot of service providers is getting in the way as well.

So some of them get public money and also private funding as well, and there's a tension there, which I think also is a barrier for people to access good quality palliative care. We already heard from local government that Silver Chain withdrew its services in Manjimup, and I would say that's probably because it's running at a loss to operate there. Even some of our – you know, it's interesting, we have a service provider like Silver Chain who we're very lucky in WA because they provide home hospice basically, our rate of people dying at home is around 35 per cent compared to the national average of about 15.

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But even at the end of life, they're only able to provide two hours a day, even in the last 12 weeks of care. Palliative care, let me say, begins the minute that you are diagnosed with a life limiting condition, and apart from cancer, it's very cancer specific, we have neurological conditions, complications of diabetes, we have dementia, it's very broad.

Also the other complication is we're talking about primary health care, secondary, tertiary, acute care, specialist care, we're talking about community care, we're talking about aged care. So how do we get integrated service? Where's the mechanism to encourage collaboration? I don't think we're short on resources, I think we're just not leveraging resources. There's not a will to cooperate nor collaborate, and we really need some good cross-sector leadership and we need a mechanism to encourage that.

One of the models, I guess, that I'm very keen to look at is a collective impact model and a coalition of care. I was previously operations manager at Headspace for youth mental health and we had a consortium, which was really great, because where we've got some clients where it's just hard to get the support they need, you would have a consortium of other service providers and you would literally be brokering what care do we need to have to wrap around this individual.

So for me, we don't talk about person-centred care at palliative care, we're talking network-centred care. We believe it's not about even the person or one service, it's how do we activate the networks we have. And they can be formal or informal. So for example we're talking about in this report community-based palliative care services. Well, a lot of community-based service, and particularly if we're looking regional-rural, comes down to if mum's doing chemo and she's a single mum, who's going to pick the kids up from school, who's going to take her to her appointments. That's going to be her informal network.

So what we're interested in, how do we work and develop a compassionate community where we've got that – building that social capital to ensure that there is support for people when they need it, as they need it, and we can respond appropriately. So we're actually working with local government at the moment, we're running some symposiums here later and building on the back of the age-friendly communities, looking at how do we actually encourage a compassionate community. And that's not just for people at end of life, that could be someone with a disability, it could be any condition that requires other supports.

I was very keen, and I'm not quite sure, in the draft recommendation 4.1 it talks about "use competitive processes to select providers or a single

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provider to deliver additional community-based palliative care services", and then "Monitor and evaluate performance of community-based palliative care service to ensure that those services deliver integrated and coordinated nursing, medical and personal care and provide access to care and support on a 24 hour a day, seven day a week basis".

Well, that is very aspirational indeed, and I don't know how you're going to do that, and that's where I feel we need this collective impact model that is place-based, looking at what exists in the community, how do we use GP afterhours, how do we look at some programs of excellence, like New South Wales Ambulance care service providing palliative care too, so that people aren't being admitted to hospital unnecessarily, we're not calling ambulances unnecessarily.

I think there's a lot more that we can be doing to say, well, we've got all these good services that already exist, how can we facilitate and who's going to take that responsibility and make us all accountable actually for what we're doing? So I think there's a lot of work around that collective impact space that needs to happen.

Also we look at sector development as well as community education, and this idea that a GP will be rewarded and there will be a Medicare item number for initiating a conversation around advance care planning at age 75, I think is a bit of a nonsense. That is an output indicator, not an outcome. If you want to improve the uptake for advance care planning, you need to be rewarding completion of an advance care plan or health directive. Very difficult, but we have in Wisconsin, and across Wisconsin, for many, many years, 96 per cent of the population that die actually have an advance care plan in place.

That doesn't rely on a health professional to actually organise that, they actually have an ambassador in community program where non-professionals are actually activated in the community to actually have those conversations and initiate that. I very recently went – I found a GP who holds workshops in his practice, and he had 30 clients at a workshop, he does them twice a year, he's now a retired GP. And whilst I commend him for the initiative, he was referring to the work of Molloy done in the '80s and using a video with guys wearing mullet haircuts and – it was really old.

Having said that, the messages are still consistent with what we would give people today. I had to say that whatever the GP said, I think there was something in that, was gold. I mean, his clients were only interested in what was – he had that voice of authority. So there is something around that as well. I think we do need a national campaign to educate people, they don't know what they don't know. And they don't know where to go for services.

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I would take, when I'm in the office, and we're not even funded and it's not our job to do this, but most of our calls are from carers of elderly parents who they've gone back to a nursing home, having been in acute care, they are no longer being hydrated or fed and they are very concerned, they want them back in hospital because they actually want them to be rehydrated, and clearly have no idea that their loved one is in the end stages and is actually actively dying.

That is a hard conversation to have, but no one's having that conversation. So we redirect them back to their care team, but people in the profession aren't even comfortable having that conversation. So how do we then reach people and educate? Death is a number 1 killer, none of us are exempt. So where are you going to get good quality information? And someone who's across all of these different providers, to give them the information and direction they need when they need it.

So for me there is the gap in connection. And I heard there was that directory for emergency relief, well, you can have all the service providers – and I've been in – we've mapped services, we've got directories. That doesn't mean people are going to access. They actually need someone to be helping them to navigate and actually providing the information to do that. So you need a sort of coordinator/navigator role, and that could be the social worker, I don't know. It doesn't need to be a new position, just needs to become. Someone has that responsibility to do the stepped up, stepped down and in between care that needs to just support families who are in that situation.

I think I've just about covered. I'd just like to say I feel that we need a lot more innovation and I think that time at the beginning, how do we – I'd love to, and I think as our organisation, being in sector development, we're in a perfect position to broker some of these partnerships, but we certainly don't have the capability or the resources to do it. But we're neutral, we represent the interests of all the players, I think there needs to be somewhere; it doesn't need to be us, but somebody that is actually tasked to do that.

I don't think we need any more mapping. I mean, every grant, every tender is mapping services, doing all that; it's been done to death. You guys know all the stats, you know pretty much – there's plenty of information, applications, databases. Somehow we do need to even integrate those so we know who's doing what, where, and again, place-based. I think that's probably it.

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MR SPENCER: Thanks, Vicki, that's terrific. A couple of things that I have taken from your comments, and then Sean may like to comment as well. Initially it's the who. Who's responsible for end of life care, and I think that that's at two levels, and we've commented on this in our report, but maybe need to say more about it, and that's more at a government level. So who does take responsibility for all of this and for having some kind of national agenda around it?

Then secondly, to your point about coordination, a broker role, navigating, that idea of the collective impact, how do you integrate, bring together a whole range of players? Because I think what we're conscious of is as you described extremely well, this is one of those issues where everybody needs to be engaged, and that leads us to your comments about an education campaign or a cultural shift, which is obviously a long term issue in Australia, this is an issue people don't tend to talk about.

But I was very interested, and I'm not sure if I'm aware of the Wisconsin example that you gave, which sounds very impressive and it sounds like the ambassador program they've actually thought long and hard about how do you influence more conversations, more joining up of services and people actually being proactive around this rather than reacting at a crisis moment.

So I think my sense is those – and you've given us some very good practical issues to grapple with to go perhaps more from theory to well actually what will move this agenda in a practical way, and that's extremely helpful. Sean, do you have any comments or questions you'd like to ask?

MR INNIS: No, thank you. I think clearly the Commission feels that end of life care in Australia is not where it needs to be and that as a wealthy modern society, there's a lot of work to do. I think the tension we always face is we can see some magnificent things happening in particular parts of the country, but we've got to write recommendations for the whole of the country, and we're very keen to make sure that there's reasonable evenness in the services people receive in one spot versus another spot.

That probably explains why we've come back to things like really understanding need, really understanding what exists, and planning around that. Absolutely agree that the very best services account for the support that exists around community, but there's a tension we need to wrestle with between the extent to which you set things up that have to rely on that existing, because in some places and around some families, it doesn't, and so that – hear the things you're saying and agree they are things that we're all wrestling with, I guess.

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MS BARRY: I just feel it needs a cross-sector leadership. It's lacking. There's a real lack of cross-sector leadership.

MR SPENCER: No, I think we perhaps have commented on that and will have more to say, but it's a very good point, this is an area that's classically seems to need much higher leadership and then more practical ways about how to bring services together. So as somebody once said to me around a whole range of services you see in Australia, you see bright spots, and the challenge is how do you turn the bright spots into a bright system. And that raises some of the issues that Sean's talking about, to be able to design a system which can work nationally and equitably across a whole range of differences. So thanks very much, Vicki.

MS BARRY: Thanks for the opportunity.

MR SPENCER: So at this point, if there are no further comments, and I thank the three of you for being with us right through the day, that's very good of you, we've appreciated your presence. So just formally, I adjourn the proceedings, and this concludes the Commission's public hearing for the human service inquiry for today and for the inquiry. Thanks very much, everybody.

ADJOURNED **[12.20 pm]**

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