



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

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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?

MR INNIS: 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

services to vulnerable, disadvantaged and marginalised people and make profit from this work.

5 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.

10 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.

15 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.

20 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 bare minimum in service.

25 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.

35 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.

40 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

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.

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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.

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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.

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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.

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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.

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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

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?

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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.

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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.

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MR KING: I understand.

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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.

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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.'

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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.

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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?

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
5 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
10 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.
25 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
35 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
40 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
45 network and form those relationships whereby we can, I guess, negotiate

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.

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MR KING: Thank you for that.

MS WHITE: So we see that transferring. That is our experience.

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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?

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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 - - -

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MR WIEGARD: Community health.

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MS WHITE: Community health, but we're certainly confining - - -

MR INNIS: So you're not commenting?

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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?

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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?

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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
5 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.

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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
15 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.

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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?

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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
30 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
35 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?

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MS WHITE: I'm not sure.

MR INNIS: Fair enough. Thank you.

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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

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.

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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.

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.

5 **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
10 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.

15 **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
20 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
25 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.

30 **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
35 standards. You actually need to factor it into the price.

MS WHITE: Yes, that's true. Exactly.

40 **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

need to do beyond some of the things you've said to make the most of the opportunity?

5 **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
10 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
15 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
20 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
25 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?

30 **MS WHITE:** Yes.

MS KEEFE: Absolutely.

MR WIEGARD: And I think the longer term the funding, the better the
35 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.

40 **MR WIEGARD:** Yes.

MR INNIS: I have no more questions. I just want to make sure that
45 you've covered all the issues you'd like to raise?

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.

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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.

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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.

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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.

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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.

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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.

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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.

15 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.

20 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.

25 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.

30 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.

5 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
10 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.

15 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
20 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
25 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.

30 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
35 information or examples was from the reading and writing hotline.

40 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
45 their name into English script, the way that they might Romanise their

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

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.

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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.

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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.

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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.

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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.

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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

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

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.

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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.

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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.

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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.

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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'?

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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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5 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.

10 **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.

15 **MR KING:** Similarly, do you have any good examples of effective partnerships between human service providers and adult education or community education providers?

20 **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.

35 **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.

40 **MS MACAFFER** And that is in Victoria only.

MS COTTER I think it's actually something that should be built and more connects made.

5 **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.

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15 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.

20 **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.

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30 **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.

35 **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.

40 **MR INNIS:** I understand. I think that's in your written material.

MS MACAFFER Yes.

45 **MR INNIS:** Terrific, thank you very much.

MS MACAFFER Thank you.

MR KING: Thank you very much.

5 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.

10 **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
15 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.

20 **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
25 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
30 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
35 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.

40 **MR KING:** Would you like to make an introductory comment for the inquiry?

45 **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

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,

you can now go see an allied health centre that is able to bulk bill by provider number.

5 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.

10 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.

20 **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.

30 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.

40 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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5 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?

10 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, 15 for example. Why? Because that hospital is the largest provider in town.

20 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 25 start my course from scratch. There is no RPLs between a certificate IV in allied health and a degree in physiotherapy.

30 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. 35

40 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.

45 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

union is very, very passionate about joining those dots and creating those career path opportunities for individuals within the health system.

5 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.

10 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.

20 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.

30 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.

40 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

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?

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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?

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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 - - -

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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.

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MR EDEN: Yes.

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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?

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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.

They want a workforce that they can direct to do a certain task and that's all that is essentially required of them.

5 There are other examples of where hospitals have contracted out services and it's just got me 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 - - -

10 **MR KING:** Sorry, which one is that?

15 **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.

20 **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.

25 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.

30 **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.

35 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 - - -

40 **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

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?

5 **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.

10 **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.

20 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.

30 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.

35 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.

40 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

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.

5 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.

10 **MR INNIS:** I'm very conscious that there were a broad range of issues to cover and we will run out of time.

15 **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?

20 **MR BEKHAZI:** Yes, that's right.

MR INNIS: Is that a reasonable bottom line capturing of your advice to us?

25 **MR EDEN:** Yes.

MR BEKHAZI: Yes.

30 **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.

40 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.

5 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.

15 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.

25 **MR KING:** I suspect zero.

MR EDEN: Yes, none.

30 **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.

40 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

used to provide supplies to hospitals that no longer supply. They need to kind of get that balance right.

5 **MR KING:** Very conscious of the time.

MR EDEN: Sorry.

10 **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.

15 **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
20 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.

25 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.

30 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
35 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.

40 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.

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 disorder,' 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.

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
5 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,
10 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
15 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.
20 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
25 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
30 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
35 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
40 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
45 are a state initiative, aren't they?

MR BEKHAZI: I think they are, yes.

5 **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.

10 **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.

15 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.

20
25 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 - - -

30 **MR KING:** I just wanted to also reflect back on the example you gave with the fixed number of sessions.

35 **MR BEKHAZI:** Yes.

40 **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.

45 **MR BEKHAZI:** I think I've jumped the gun. Initially you get four sessions.

MR KING: Okay.

5 **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.

10 **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.

15 **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
20 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
25 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
30 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.

35
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
40 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

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.

5 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.'

10 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
15 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
20 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.

25 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
30 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
35 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
40 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

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.

5 **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
10 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.

15 **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
25 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
30 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.

35 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
40 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.

5 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.

10 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.

20 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?

30 **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.

35 **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.

45 **MR KING:** Would you see hiring being centralised?

MR BEKHAZI: Hiring being centralised? Yes.

5 **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.

10 **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.

20 **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.

25 **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.

30
35 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.

40 **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.

45 **MR KING:** Although I still have to make the formal declaration and ask.

5 **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.

15 **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.

20 **MR KING:** That's good. Thank you very much.

MR INNIS: These are important issues.

25 **MR KING:** Although it is relaxed atmosphere, I still have to do some formal things.

30 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.