

**ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY
COUNSEL ASSISTING'S FINAL SUBMISSIONS**

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PART 1 INTRODUCTION

1. At the preliminary hearing of this Royal Commission in early 2019, the late Commissioner Tracey observed that:

The Royal Commission is a once-in-a-lifetime opportunity to come together as a nation to consider how we can create a better system of care for elderly Australians that better aligns with the expectations of the Australian people.¹
2. ‘The hallmark of a civilised society’, he said, ‘is how it treats its most vulnerable people’.² At the time we observed that this inquiry is a unique opportunity to create a better system of care for older Australians and others engaged with the aged care system. We, and those instructing us, undertook to assist the Royal Commissioners in conducting the inquiry with which they had been entrusted.³
3. In so doing, we have assisted in the most in-depth and thorough examination of Australian’s aged care system that has ever been undertaken.
4. The Royal Commission’s call for public submissions has been met enthusiastically. Between 24 December 2018 and 9 October 2020 10,203 submissions were received from people receiving aged care services, family members, aged care workers, approved providers, aged care and health sector representative bodies, government organisations and others.
5. The Royal Commissioners conducted community forums in 12 locations nationwide. These were attended by 2,416 people and 228 speakers, who described their experiences of the aged care system. Many of these accounts were difficult to listen to; all were very valuable. We are grateful to these many brave people.
6. There were public hearings in all eight capital cities and four regional centres being Broome, Cairns, Mudgee and Mildura. In total there were 97 days of hearings at which 641 witnesses gave evidence. While many of these witnesses were experts from a wide variety of professional backgrounds both here and overseas, there were also 113 direct experience witnesses: people living in residential aged care, people receiving home care and their families. Again, we salute the courage of these witnesses for sharing the most intimate details of their lives to inform this inquiry. Aged care workers as well as the trade unions that advocate for and represent these workers gave evidence at a number of hearings. The transcripts and the thousands of documentary exhibits are all on the Royal Commission’s website.
7. In 2019, the Royal Commissioners attended 13 roundtables that examined topics including the aged care workforce and aged care in culturally and linguistically diverse

¹ Transcript, Preliminary Hearing, 18 January 2019 at T6.22–24.

² Transcript, Preliminary Hearing, 18 January 2019 at T6.24–25.

³ Transcript, Preliminary Hearing, 18 January 2019 at T9.2–6.

communities, lesbian, gay, bisexual, transgender and intersex communities, and Aboriginal and Torres Strait Islander communities. These were held in various capital cities and 132 people with aged care expertise or experience participated. Together with staff of the Royal Commission, the Commissioners visited 34 aged care services in locations as varied as Bidyadanga and Balaklava. We thank the providers and their staff for being generous hosts; we thank the residents for letting us into their homes.

8. In early 2020, Commissioners Pagone and Briggs travelled overseas to meet with international officials and experts on aged care, and viewed innovative aged care models in several countries. One of the purposes of these meetings and visits was to examine approaches to aged care design and funding in different countries, and consider their applicability in the Australian context.
9. The Royal Commission's research team has overseen a comprehensive research program which will be an important source of information for researchers for years to come. It includes 12 research papers on topics including community attitudes to ageing and aged care, and international and national quality and safety indicators for aged care. The Office of the Royal Commission has produced eight background papers on subjects ranging from carers of older Australians to restrictive practices in residential aged care, and two consultation papers on aged care program redesign and financing aged care. Once again, this wealth of material is published on the Commission's website.
10. The submissions we make today are informed by all of the information that has emerged from this two year undertaking.

Direct experience witnesses

11. These statistics are impressive, but they are so much more than a collection of numbers. The witnesses include:
 - a. **Ms Shannon Ruddock** who gave evidence in Perth explained the personal trauma she suffered in wanting her late father to pass away in hospital rather than return to the aged care home where the palliative care was sub-standard.⁴ Drawing on her experience of the staffing levels at the hospital and contrasting them to the levels at the home, Ms Ruddock advocated for a rigorous form of accreditation before an aged care home could provide palliative care.⁵

⁴ Exhibit 5-32, Perth Hearing, Statement of Shannon Maree Ruddock, WIT.1132.0001.0001 at 0017 [155]; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 2 at 210-211; 216-217.

⁵ Exhibit 5-32, Perth Hearing, Statement of Shannon Maree Ruddock, WIT.1132.0001.0001 at 0018 [171]-[172]; Transcript, Perth Hearing, Shannon Ruddock, 27 June 2019 at T2664.8-17; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 2 at 218.

- b. **Mrs Johanna Aalberts-Henderson** who spoke of her ‘ice cold rage’ at the terrible state of a leg wound her late mother suffered at a residential aged care facility in suburban Melbourne.⁶ A nurse herself, Ms Aalberts-Henderson said she could have reached into the wound and touched her mother’s tibia.⁷ Subsequent investigations found that the dressings had been changed by personal care workers and not nurses. Rosters in evidence showed that there were no registered nurses working on the afternoon or evening shifts for 60 residents most of whom had high clinical needs. A consultant engaged by the provider concluded that registered nursing levels were so low that residents could expect to receive, on average, only seven minutes of nursing care per day.⁸
- c. **Mr James Nutt** who entered residential aged care when he was 22 years old after he was assaulted at a local footy match which left him with an acquired brain injury and paralysed from the chest down.⁹ Mr Nutt gave a heartbreaking account of his time living in a residential aged care facility: on his first evening, Mr Nutt described going back into his room after dinner, held his head in his hands and cried, as he thought to himself ‘I’m 22, I’ve got maybe 65 years left in my life and I’m forced to live here for the rest of it with no ability of ever getting out.’¹⁰
- d. **Ms Kirby Littley** who was in her late 20s when she had surgeries for a brain tumour. As a result of this, Ms Littley had multiple strokes and was severely disabled.¹¹ Ms Littley and her parents told the Royal Commission that residential aged care was presented as the only option for her. She told the Royal Commission that she felt as though nobody wanted her.¹²
- e. **Mrs Rosemary Cameron’s** husband was in his early 60s when he was diagnosed with Lewy Body Dementia. Based in the Macedon Ranges in Victoria, her experience of caring for her husband left Mrs Cameron completely exhausted. She described feeling rejected, as though she was left to fend for herself in caring for her husband.¹³

⁶ Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008 [54].

⁷ Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0008 [54].

⁸ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 2, p 321–322; 326-328.

⁹ Transcript, Melbourne Hearing 1, James Nutt, 11 August 2019, T5157.17.

¹⁰ Exhibit 9–18, Melbourne Hearing 1, Statement of James Nutt, WIT.1237.0001.0001 at 0002 [19].

¹¹ Exhibit 9–11, Melbourne Hearing 1, Statement of Kirby Littley, WIT.1241.0001.0001 at 0001[8]–0002 [10].

¹² Exhibit 9-12, Melbourne Hearing 1, Statement of Carol Littley and Kevin Littley, WIT.1242.0001.0001 at 0005 [43].

¹³ Exhibit 7–4, Mildura Hearing, Statement of Rosemary Cameron, WIT.0309.0001.0001 at 0007 [42]–[44]; Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3888.35–41.

- f. **Ms Veda Menaghetti** was 61 when she was diagnosed with a rare variant of young onset frontotemporal dementia. **Ms Lynda Henderson** gave evidence in the second Adelaide hearing of the immeasurable value of the grassroots support and information after Veda was diagnosed. Through their shared experience with Veda's dementia, they realised that most people are horrified when they receive a dementia diagnosis. With the support of their local council, university and Dementia Australia, a pilot program was developed which Ms Henderson helped to launch. This program focuses not just on being dementia friendly, but also dementia inclusive.
- g. In the Broome hearing, held in June 2019, **Ms Madeline Jadai**, an Aboriginal Mangala woman, shared her story of caring for her sister, aged 62, in the remote Aboriginal Community of Bidyadaga. Ms Jadai's sister has dementia and receives aged care services. Ms Jadai spoke of the value of the Bidyandanga Home and Community Care centre.¹⁴
- h. **Mr Peter Harris** gave evidence in Mudgee, in November 2019. Mr Harris, cared for his wife at home for five years. He described his experience as a carer as being like a 'frog on the cooktop being boiled in cold water', he knew things were changing for Beth, but they were slow and he was coping.¹⁵ Mr Harris' experience of caring was like so many of those who have given evidence. Living in the country, Mr Harris explained how important the Multi-Purpose Service was for him and his wife Beth.¹⁶
- i. In the first Sydney hearing, the Royal Commission heard from **Mr George Akl** whose late father reverted to his first language, Arabic, as his dementia worsened. Mr Akl reminded us of the importance of an aged care system that respects and is responsive to cultural and linguistic diversity.¹⁷
- j. **Ms Sarah Holland-Batt** gave evidence in the Royal Commission's Brisbane hearing. Ms Holland-Batt detailed her experience of her father in residential aged care. She told the Royal Commission that she observed neglectful care of her father who has since passed away. She became concerned that her father was being abused by staff at the residential care facility. Ms Holland-Batt raised this with the Aged Care Complaints Commissioner. But was dissatisfied with its response.¹⁸

¹⁴ Transcript, Broome Hearing, Madeline Jadai, 17 June 2019 at T1987.29-34 and T1987.40-43.

¹⁵ Exhibit 12-26, Mudgee Hearing, Statement of Peter Harris, WIT.0593.0001.0001 at 0003 [22].

¹⁶ Exhibit 12-26, Mudgee Hearing, Statement of Peter Harris, WIT.0593.0001.0001 at 0007 [49].

¹⁷ Exhibit 3-4, Sydney Hearing 1, Statement of George Akl, WIT.0108.0001.0001 at 0005 [37-38].

¹⁸ Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0013 [88].

- k. **Ms Deborah Barnes** also gave evidence in the Brisbane hearing. Ms Barnes described her experience of her mother in residential aged care. She also described being disappointed in the complaints process. Ms Barnes could not understand how her complaint could be resolved without any acknowledgement or accountability of what actually happened to her mother.¹⁹
- l. Over the course of the Royal Commission's public hearings many aged care workers, including registered nurses, and personal care workers who work in home and community care and in residential aged care facilities, have given evidence. Some of these workers also work in the disability sector. All of these witnesses spoke with passion and commitment for the work they do and for the older people for whom they care.
- m. Many explained that they are aware that they are the only point of contact the older person has with the outside world on any given day. However, in equal measure, they spoke of the lack of value that is placed on their work. Of always being rushed in their work, and how attending to one resident's needs would mean not being able to attend to the needs of other residents. They described how there is simply not enough staff or time available to support the needs of the residents. Many explained that they would regularly stay back on their own time to meet the needs of people receiving aged care services. Most spoke of the need for improved conditions and training and increased remuneration and respect.
- n. **Ms Kathryn Nobes**, gave evidence in the first Sydney hearing that the working conditions of care workers has a serious impact on the quality of care that personal care workers are able to provide. Ms Nobes described how she suffered from Post-Traumatic Stress Disorder after an incident in the dementia unit at the facility where she worked, which involved an assault by a resident that left another resident dead. Ms Nobes spoke with grace of the challenges of caring for those with dementia and that staff working with dementia residents needed more training.²⁰
- o. In the recent COVID-19 hearing, Ms Diana Asmar, a union official representing personal care workers who were responding to the pandemic, described her members as feeling like they were 'on the bottom of the Titanic ship'.²¹
- p. The role of allied health in aged care is fundamental, as is access to oral and dental, and mental health treatment and services. In these submissions we make recommendations about each of these topics. **Mrs Beryl Hawkins**, aged 91 years, gave evidence in the first of several hearings which were conducted by the Royal

¹⁹ Exhibit 8-39, Brisbane Hearing, Statement of Debra Barnes, WIT.0328.0001.0001 at 0007 [46].

²⁰ Transcript, Sydney Hearing 1, Kathryn Nobes, 8 May 2019 at T1415–1423.

²¹ Transcript, Sydney Hearing 2, Diana Asmar, 12 August 2020 at T8611.4–5.

Commission virtually in 2020. Appearing by telephone, Mrs Hawkins said that she has not been able to afford dentures or to use her home care package towards the costs of dentures or other oral and dental treatment. Mrs Hawkins lives on her own in state housing.²² Mrs Hawkins waited two years for a level 3 home care package.

- q. **Ms Merle Mitchell AM**, aged 85 years, shared with the Royal Commission her experiences of living in a residential aged care facility in May 2019 and more recently, in the COVID-19 hearing. Ms Mitchell explained that she feels that life in a residential aged care facility is not a home, it's an institution, it's where you live.²³
 - r. To conclude this brief overview, the words of **Ms Eileen Kramer** are worth recalling. At 105 ½ years of age, Ms Kramer is the oldest witness to give evidence in this Royal Commission.
 - s. Like all of the older people and their families who have opened their lives to the work of this Royal Commission, who have shared their experience of their struggles with the aged care system, Ms Kramer is a remarkable person. Having had a successful career in modern dance and the arts overseas, Ms Kramer returned to Sydney when she was 99. She now lives in a residential aged care facility and continues to work choreographing a new dance, writing and producing artworks. Ms Kramer is a reminder that there is much to learn from our older people.
 - t. Ms Kramer **memorably** urged us to 'Look after the house so the spirit can enjoy life'. With this in mind, we submit it is the responsibility of the aged care system to support and nurture our older people.²⁴
12. This process of inquiry will conclude when the final report is presented to the Governor-General. This report will represent the culmination of the Commission's nearly two and half year inquiry into aged care quality and safety.
 13. In the words of Prasser and Tracey, authors of a leading text on Royal Commissions, this report 'will be the basis for judging the quality of the inquiry process and the credibility of findings'.²⁵ For this reason, the report must substantiate the recommendations that are made. The conclusions must be justified and we make these submissions to assist Commissioners to achieve those goals.
 14. Through these submissions, we will set out the recommendations that we say are available for Commissioners to make based on our analysis and examination of the

²² Exhibit 17-2, Melbourne Hearing 4, Statement of Beryl Hawkins, WIT.0742.0001.0001 at 0001[6].

²³ Exhibit 3-1, Sydney Hearing 1, Statement of Merle Mitchell, WIT.0107.0001.0001 at 0002 [19].

²⁴ Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 91, RCD.9999.0483.0001; tab 92, RCD.9999.0483.0002; tab 89, RCD.999.0493.0001 at T15.44–45.

²⁵ Scott Prasser and Hellen Tracey, *Royal Commission & Public Inquiries Practice & Potential*, 2014, Connor Court Publishing at p 392.

evidence and information. These submissions are made in accordance with our independent statutory roles as Counsel Assisting the Royal Commission.²⁶

15. The recommendations in the final report will form the basis of authoritative advice to government and to the aged care sector on how to ensure the aged care system of the future aligns with the expectations of the Australian people.

The structure of these submissions

16. Part 2 of these submissions summarises the evidence about what is wrong with the existing aged care system and why. It will be seen that there are multiple, overlapping causes of the existing problems, many of which have been present for some time. Others have emerged more recently. Most if not all have been identified in previous reviews and enquiries. We submit that it is important to understand why the various deficiencies have developed to ensure that the prescriptions for reform will be targeted and effective.
17. Part 3 contains 18 sections, each one of which addresses a different aspect of the aged care system broadly following the terms of reference addressed to the Royal Commissioners. In each section, we set out the recommendations that we submit the Royal Commissioners should make to meet those terms of reference. We also draw attention to the evidence that supports the submissions we make.
18. We submit that the Royal Commissioners should make 124 recommendations. While all of them are important, among the more significant are:
 - a. a new Act based on human rights principles for older people
 - b. a new planning regime for aged care which provides demand-driven access rather than the current rationed approach
 - c. a new and independent process for setting aged care quality standards
 - d. a new enforceable general duty of care on approved providers
 - e. mandated staffing ratios in residential aged care
 - f. compulsory registration of personal care workers
 - g. an independent pricing authority that will determine aged care prices appropriate to the provision of high quality and safe aged care services, and
 - h. an independent Australian Aged Care Commission that will be responsible for administering and regulating the aged care system.
19. Finally, in Part 4 we look to the future and outline our submissions about the process by which the current aged care system should transition to the new system. We also make

²⁶ Counsel Assisting were appointed under s. 6FA of the *Royal Commissions Act 1902* (Cth).

submissions about implementation of the proposed reforms and how that implementation should be independently monitored to maximise the chances of success.

PART 2 NATURE, EXTENT AND SYSTEMIC CAUSES OF SUBSTANDARD CARE

Substandard care

20. The Terms of Reference require an inquiry into the extent of substandard care being provided to Australians receiving aged care services, including mistreatment and all forms of abuse.²⁷
21. We submit that the evidence before the Royal Commissioners supports a finding that the level of substandard care being delivered in the current aged care system is far too high.
22. 'Substandard care' is not a term defined in the legislation governing the aged care system. In these submissions the same definition adopted in the Royal Commission's Interim Report is used, namely:
 - a. care (or complaints about care) which did not meet the relevant quality standards under the *Quality of Care Principles 2014* (Cth) (the *Quality of Care Principles 2014*) and other obligations under the *Aged Care Act 1997* (Cth) (the *Aged Care Act 1997*), and
 - b. care (or complaints about care) which, although meeting the relevant quality standards under the *Quality of Care Principles 2014* and other obligations under the *Aged Care Act 1997*, was not of a standard that would meet the high standards of quality and safety that the Australian community expects of aged care services.
23. Types of substandard aged care include instances of mistreatment or abuse and deficiencies in the quality of routine and complex care provided.
24. The accounts received across the hearings, public submissions and community forums rarely raised only one form of substandard care, and often highlighted the compounding impacts of poor care. For example, malnutrition can lead to reduced muscle strength and increased frailty, increasing the chances of falling. Pressure injuries can result from poor continence management due to incontinence-associated dermatitis.

Abuse

25. Abuse is the most extreme category of substandard care and includes the use of restraints (both physical and chemical) and assaults (physical, sexual and emotional).
26. Of the 10,203 public submissions received by the Office of the Royal Commission, the following concerns were most commonly raised: neglect [39%]; emotional abuse [21%]; physical abuse or assault [15%]; restrictive practices [13%]; financial abuse [13%]; and sexual abuse or assault [3%].

²⁷ Letters Patent, 6 December 2018, as amended on 13 September 2019 and 25 June 2020, paragraph (a).

27. The Royal Commission has received many disturbing accounts raising allegations of abuse of people living in residential aged care at the hands of caregivers and fellow residents.²⁸
28. In the Interim Report, Commissioners Tracey and Briggs made findings about the degrading and criminal assaults of a man living with dementia in a residential aged care facility which involved aggressive physical contact by caregivers with his head, and the use of unreasonable force while changing his continence pad.²⁹ This is far from an isolated case. Such occurrences should never occur in the aged care system.
29. The Australian Law Reform Commission examined elder abuse as part of its inquiry into protecting the rights of older Australians from abuse. The resultant report, released in 2017, highlighted the prevalence of abusive practices within the aged care system and criticised gaps in the regulatory and reporting systems that allowed these practices to persist.³⁰ Despite this, abuse remains rife in residential aged care.
30. Restrictive practices are activities or interventions, either physical or pharmacological, which restrict a person's free movement or ability to make decisions.³¹ When applied inappropriately, they amount to a form of abuse.
31. Restrictive practices have been identified as a problem in residential aged care in Australia for more than 20 years. Their use has been considered in several reviews. Many recommendations for reform have been made, but not fully implemented.³²

Routine and complex care

32. As people age, simple tasks such as moving, eating, using the toilet, bathing, showering, getting dressed and teeth brushing often become more difficult. Assistance with these

²⁸ See, for example, Exhibit 5-9, Perth Hearing, Statement of Noleen Hausler, WIT.1124.0001.0001 at 0010-0011 [79]–[83], 0013 [105]–[106]; Exhibit 6-20, Darwin and Cairns Hearing, Statement of Lisa Backhouse, WIT.0221.0001.0001 at 0005 [27]–[28]; Exhibit 3-33, Sydney Hearing 1, Statement of Marian Anderson, WIT.0135.0001.0001 at 0007 [42]–[43]; Submission of Fatima-Iman Boustani, Public submission, AWF.001.02225; Submission of Shirley Fong, Public submission, AWF.001.00331; Submission of [Name withheld], Public submission, AWF.001.00699.02 at 02_0005; Name withheld, Public submission, AWF.001.00464.

²⁹ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, p 207.

³⁰ Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, Report No 131, 2017, pp 112–113, 144–147 (Exhibit 1-27, Adelaide Hearing 1, RCD.9999.0011.0302 at 0417–0418; 0449–0452).

³¹ See, for example, Exhibit 3-2, Sydney Hearing 1, General Tender Bundle, tab 2, CTH.0001.4000.4879 at 4883.

³² See, for example, Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, Report No 131, 2017, pp 112–113, 144–147 (Exhibit 1-27 Adelaide Hearing 1, RCD.9999.0011.0302 at 0417–0418; 0449–0452); Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, 2014; K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833).

tasks, often called 'routine care', is critical to ensuring older people's basic needs are met and their independence and quality of life are preserved as long as possible.

33. Most commonly, complaints before the Royal Commissioners about substandard routine care related to the following areas:
 - a. skin care
 - b. mobility
 - c. oral and dental health
 - d. medication management and prescribing
 - e. continence and incontinence
 - f. social and emotional needs
 - g. diversity and cultural needs.
34. People in aged care settings often have complex care needs.³³ Meeting these needs goes beyond assistance with routine care and may need input from a range of health care providers, including specialists. Complaints about substandard complex care raised before the Royal Commissioners most commonly involve:
 - a. support for dementia and changed behaviours
 - b. palliative care
 - c. mental health care.
35. Recently, the devastating impact of COVID-19 on elderly people living in residential aged care facilities has highlighted the importance of proper infection control as an element of the care that is provided.³⁴

³³ Productivity Commission, *Caring for Older Australians*, Vol 1, p XXVI and XXX (Exhibit 1-31, Adelaide Hearing 1, RCD.9999.0011.0943 at 0968-0972); Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0003 [24]; Exhibit 14-25, Canberra Hearing, Statement of Leon Flicker, WIT.0616.0001.0001 at 0001–0002 [5]–[6]; Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0003 [19]; Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0002–0003 [12]; Exhibit 14-12, Canberra Hearing, Statement of Carolyn Hullick and Ellen Burkett, WIT.1298.0001.0001 at 0004–0005 [23].

³⁴ See, for example, Royal Commission into Aged Care Quality and Safety, *Aged care and COVID: a special report*, 2020, p 15; Australian Department of Health, Coronavirus (COVID-19) current situation and case numbers, <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-casenumbers#total-cases-recoveries-deaths-and-new-cases-in-the-last-24-hours>, viewed 20 September 2020; Australian Department of Health, COVID-19 cases in aged care services – residential care, <https://www.health.gov.au/resources/covid-19-cases-in-aged-care-services-residential-care>, viewed 20 September 2020; Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 15, RCD.9999.0394.0001 at 0018; Exhibit 18-2, Sydney Hearing 2, Dorothy Henderson Lodge tender bundle, tab 10, CTH.1000.0004.7114 at 7121; Exhibit 18-3, Sydney

36. The weight of evidence from people receiving aged care and their families as well as from general practitioners, geriatricians, nurses, academics, policymakers, advocacy bodies and approved providers establishes that substandard care is far too prevalent in each of the areas identified.

The extent of substandard care

37. Identifying the precise extent of substandard care in Australia's aged care system is a difficult task due to deficiencies in the data available to measure the quality of care. This should not be the case. It should be a straightforward task to assess the quality of care provided in our aged care system. That it is difficult says much about the maturity of the sector and the lack of curiosity of the government that funds and regulates it.
38. Until very recently, there has been a surprising absence of any mandated quality indicators for Australia's aged care system. This contrasts with the health sector where there is a long history of measuring quality.³⁵
39. Quality indicators can be used to measure important aspects of quality of care that can affect the health and wellbeing of people receiving aged care services.³⁶ Measuring the quality of care is vital to enable deficiencies to be identified and improvements effected. The need for aged care system-wide quality measures has been the subject of previous reviews into Australia's aged care system dating back to 2007.³⁷ Despite this, aged care quality indicators were not introduced in Australian residential aged care until 2016 and were not made mandatory until 1 July 2019.³⁸ There are still no quality indicators for the home care sector.
40. In 2017–18 when participation in the quality indicator program was voluntary, only 8% of approved providers submitted reports.³⁹ For the 2019–20 reporting year, mandatory reporting was limited to three measures: use of restraints, pressure injuries and unexplained weight loss.

Hearing 2, Newmarch House tender bundle, tab 121, CTH.1000.0005.8876 at 8901; Transcript, Sydney Hearing, Melanie Dicks, 10 August 2020 at T8420.26–34.

³⁵ Transcript, Sydney Hearing 2, Henry Cutler, 22 September 2020 at T9624.25—29; Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0002 [13]–[14].

³⁶ Department of Health, *National Aged Care Quality Indicator Program*, Australian Government, <https://www.health.gov.au/initiatives-and-programs/national-aged-care-mandatory-quality-indicator-program>, viewed 13 August 2020.

³⁷ See, for example, Campbell Research & Consulting, *Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes*, Australian Government, 2007, p x, xiv; K Carnell and R Paterson, *Review of national aged care quality regulatory processes*, 2017, pp 99, 101, 147 (Exhibit 1-25). Exhibit 8-32, Brisbane Hearing, Statement of Amy Laffan, WIT.0282.0001.0001 at 0022.

³⁸ Exhibit 8-32, Brisbane Hearing, Statement of Amy Laffan, WIT.0282.0001.0001 at 0022.

³⁹ Australian Department of Health, *2017-18 Report on the operation of the Aged Care Act 1997*, 2018, Australian Government, p 77.

41. In the absence of clear data regarding the quality of care, staff of the Office of the Royal Commission have examined the following data sources:
- a. information provided through public submissions and community forums
 - b. evidence at public hearings
 - c. accreditation, compliance and complaints data
 - d. the datasets on medication management and falls maintained by the Australian Institute of Health and Welfare
 - e. surveys conducted by the Royal Commission, including:
 - i. the Service Provider Survey, where all approved providers were asked to report on occasions or complaints of substandard care during the period of 1 July 2013 to 30 June 2018
 - ii. commissioned surveys of people living in residential aged care and people receiving home care or their proxies exploring the prevalence of substandard care
 - iii. research, including research commissioned by the Royal Commission.
42. This has been a complex and resource-intensive task and it enables inferences regarding the prevalence of substandard care to be drawn from the facts revealed by the data. For example:
- a. Aged care accreditation and compliance data from 2018–19 shows that nearly one in five audits of residential aged care services, and more than one in five assessments of home care providers, identified a failure to meet at least one expected outcome.⁴⁰ For residential aged care, the most common failures were ‘human resource management’, ‘information systems’ and ‘clinical care’. For home care providers, they were ‘regulatory compliance’, ‘assessment of service users’ and ‘care plan development’.
 - b. In 2018–19, there were an average of 23.7 formal complaints made to the Aged Care Quality and Safety Commission per 1000 people receiving permanent residential aged care. This equates to an average of 2.12 complaints per residential service.⁴¹ However, approximately 3% of residential facilities had over 10

⁴⁰ This data relates to assessments conducted using the former Standards. Based on aggregated 2018-19 sector performance data published by the Aged Care Quality and Safety Commission: Aged Care Quality and Safety Commission, *Sector performance data*, <https://www.agedcarequality.gov.au/sector-performance>, viewed 1 June 2020.

⁴¹ Aged Care Quality and Safety Commission, *Annual report 2018-19, 2020*, p 44; Department of Health, *2018-19 Report on the Operation of the Aged Care Act 1997, 2019*, Australian Government, pp 44–45.

complaints.⁴² The most frequent types of complaints were about medication administration and management.⁴³

- c. The care provided to people experiencing behavioural and psychological symptoms of dementia, in particular the use of restrictive practices, appears to be a prevalent form of substandard care. For those approved providers which received sanctions in 2018–19, one of the most commonly not-met expected outcomes was ‘behavioural management’.⁴⁴ Fifty-three residential aged care services were the subject of sanctions during that period and of those, 45 services were assessed as failing to meet the behavioural management expected outcome.
 - d. During 2018–19, an average of one notice of non-compliance was issued per 11 residential aged care facilities (noting that some facilities received more than one such notice).⁴⁵ However, instances of non-compliance identified through accreditation and compliance data may understate the extent of substandard care being provided. In the Interim Report, Commissioners Tracey and Briggs made adverse findings in two case studies about the quality of care provided to an individual in circumstances where the approved provider was, during the relevant time, assessed by the regulator as meeting all expected outcomes.⁴⁶
 - a. Almost half of the more than 10,000 online public submissions received during this inquiry were marked by their submitter as relating to substandard care. However, this likely understates the total number of submissions which describe issues that this Royal Commission has considered to be substandard care, such as abuse or the use of restraint, but were not marked as such by their submitter.
43. The prevalence of abuse of people receiving aged care services is partly revealed by the Australian Government’s data regarding reported allegations or suspicions of physical and sexual assault that occur in aged care facilities.
44. In 2018–19, residential aged care services reported 5,233 allegations of assault, including 790 allegations of sexual assault.⁴⁷ Almost one in two residential care services

⁴² Office of the Royal Commission into Aged Care Quality and Safety, *Data validation report 5 – Frequency of complaints about residential aged care services to the Aged Care Quality and Safety Commission*, [DOC ID to be provided by OSA when available tomorrow], 2020, p 1.

⁴³ Aged Care Quality and Safety Commission, *Annual report 2018-19*, Australian Government, 2019, p 44.

⁴⁴ Department of Health, *2018–19 Report on the Operation of the Aged Care Act 1997*, 2019, Australian Government, p 95; Australian Government, *My Aged Care – Non-Compliance Checker*, <https://www.myagedcare.gov.au/non-compliance-checker>, viewed 20 October 2020.

⁴⁵ Aged Care Quality and Safety Commission, *Sector performance data*, 2019, <https://www.agedcarequality.gov.au/sector-performance>, viewed 1 June 2020.

⁴⁶ See Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 221, 286.

⁴⁷ Department of Health, *2018-19 Report on the Operation of the Aged Care Act 1997*, Australian Government, 2019, p 84.

(approximately 45%) had reported an allegation of assault in 2014–15.⁴⁸ This increased to almost 2 in 3 residential care services (62%) in 2018–19.⁴⁹

45. We are particularly concerned about the number of allegations of sexual assault. The Royal Commission has received 588 submissions mentioning sexual abuse. There were 426 allegations of sexual assault reported to the Australian Department of Health in 2014–15, which increased to 790 in 2018–19.⁵⁰ This is more than two reports per day on average, every day of the year.
46. The increase in the reporting of allegations of assault was far greater than could be accounted for by the increase in the number of permanent residents over the same time period. The rate of alleged assaults, that is the number of reports per 100 residents, nearly doubled from 1.13 to 2.16 in the four years between 2014–15 and 2018–19.
47. As concerning as these figures are, they understate the real extent of the problem in at least two ways. First, as the Australian Law Reform Commission noted in its 2017 report into elder abuse, ‘reportable assaults capture a narrower range of conduct than may be described as elder abuse’.⁵¹ There are examples of this in the evidence before the Royal Commissioners. For example, in the Perth Hearing, a senior representative of approved provider Japara explained that Japara did not report cases that were characterised as mere ‘rough handling’.⁵² This is despite the definition of ‘reportable assault’ in the *Aged Care Act 1997* including any ‘unreasonable use of force’.⁵³
48. Secondly, an assault is not reportable if the alleged perpetrator is a fellow resident with a diagnosed cognitive or mental impairment, and the approved provider puts in place arrangements to manage the alleged perpetrator’s behaviour.⁵⁴ Considering that approximately 50% of people receiving residential aged care have a diagnosis of dementia,⁵⁵ the effect of this exemption is likely to be significant.

⁴⁸ Exhibit 22-27, Final Hearing, Frequency of complaints about residential aged care services to the Aged Care Quality and Safety Commission, RCD.9999.0499.0006 at 0007.

⁴⁹ Exhibit 22-27, Final Hearing, Frequency of complaints about residential aged care services to the Aged Care Quality and Safety Commission, RCD.9999.0499.0006 at 0007.

⁵⁰ Department of Health, *2014-15 Report on the Operation of the Aged Care Act 1997*, Australian Government, 2015, p 115, https://www.gen-agedcaredata.gov.au/www_ahwgen/media/ROACA/2014-15-ROACA.pdf, viewed 1 June 2020; Department of Health, *2018-19 Report on the Operation of the Aged Care Act 1997*, Australian Government, 2019, p 84, https://www.gen-agedcaredata.gov.au/www_ahwgen/media/ROACA/2018-19-ROACA.pdf, viewed 1 June 2020.

⁵¹ Australian Law Reform Commission, *Elder Abuse – A National Response (ALCR Report 131)*, 2017, p 109 [4.37].

⁵² Transcript, Perth Hearing, Julie Reed, 24 June 2019 at T2333.35–36.

⁵³ *Aged Care Act 1997* (Cth), s 63-1AA(9).

⁵⁴ *Aged Care Act 1997* (Cth), s 63-1AA(3); *Accountability Principles 2014* (Cth), s 53(1).

⁵⁵ Australian Bureau of Statistics, *4430.0 Disability, Ageing and Carers, Australia: Summary of Findings*, 2015, <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features1022015?OpenDocument>, viewed 1 October 2020.

49. KPMG was engaged in 2018–19 by the Australian Government to estimate the number of resident-on-resident assaults. It surveyed 178 residential aged care services (6.6% of total services) and extrapolated from the data.
50. Based on this data, KPMG made what it described as a ‘conservative’ estimate that there were 26,960 alleged assaults in 2018–19 in Australian residential aged care services that were exempt from reporting.⁵⁶ This estimate was based on the exclusion of one approved provider with a particularly high number of assaults.⁵⁷ If this provider was included, then the estimate rose to 38,898 alleged assaults in 2018–19. This was the figure that KPMG ultimately decided was the best estimate.⁵⁸ Applying the same approach to extrapolation of the figures, KPMG estimated that there were 1,730 resident on resident incidents involving sexual contact in 2018–19.⁵⁹
51. When these estimates are added to the reported 5,233 assault allegations for the 2018–19 financial year, the likely number of alleged assaults in residential aged care was between 32,193 and 44,131. The estimated number of incidents of unlawful sexual contact in 2018–19 is 2,520 or 50 per week. In percentage terms, the incidence of reports increases from 2.16 reports per 100 residents on official figures to between 13 and 18 incidents per 100 residents. This is a national shame.
52. Many witnesses have explained that they placed their loved ones into residential aged care because they felt that it would be safer for them or because safety was a concern.⁶⁰ It is therefore entirely unacceptable that people in residential aged care face a substantially higher risk of assault than people living in the community.
53. As disturbing as these figures are, the evidence of the lack of follow up by the Australian Government department that receives the reports is, if anything, worse. We will examine that evidence in our submissions about quality regulation. We propose a recommendations aimed at increasing the range of assaults that must be reported and improving the Government’s response to the reports it receives. The high levels of assault also have implications for regulation of the aged care workforce, a topic that we will also examine later in these submissions.

⁵⁶ KPMG, Prevalence Study for a Serious Incident Response Scheme (SIRS), 2020, pp 36-37.

⁵⁷ One approved provider with 16 services reported 446 incidents which equated to 35% of all incidents reported.

⁵⁸ KPMG, Prevalence Study for a Serious Incident Response Scheme (SIRS), 2020, p 38.

⁵⁹ KPMG, Prevalence Study for a Serious Incident Response Scheme (SIRS), 2020, p 38.

⁶⁰ See, for example, Transcript, Sydney Hearing, Eresha Dilum Dassanayake, 6 May 2019 at T1188.13-14; Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, 26 June 2019, WIT.0220.0001.0001 at 0002-0003 [8]-[12]; Transcript, Melbourne Hearing 1, Kirby Littlely, 11 September 2019 at T5096.25-28

Patterns in the data

54. An analysis of the data about substandard care exposes differences in the extent of substandard care between different residential approved provider types.
55. For example, a finding that government-run residential aged care services outperform services operated by both private for-profit and not-for-profit approved providers on many quality measures is supported by the following evidence:
 - a. A University of Queensland study commissioned by the Royal Commission analysed the cost of delivering care. The study divided residential aged care services into three different bands, with Q1 indicating higher quality, Q2 indicating middle quality and Q3 lower quality.⁶¹ Government-owned facilities were more likely to be in Q1. The study concluded that the correlation 'was strong and consistent'. For-profit providers were over-represented in the Q3 group relative to their numbers in the sector.⁶² The aged care services most likely to be in the best quality group were small-sized or government-owned. For example, the highest quality group contained 41% of homes with 1-15 beds, but only 17% of homes with 31-60 beds and just 5% of homes with 61-120 beds. The highest quality group also contained 24% of government-owned homes, 13% of not-for-profit homes and just 4% of for-profit homes.⁶³
 - b. A Residential Care Survey commissioned by the Royal Commission found that residents with the greatest number of concerns were those living in for-profit residential aged care services. Life satisfaction was highest in government-run services, followed by not-for-profit and then for-profit.⁶⁴
 - c. As part of the research conducted by the Office of the Royal Commission, granular data from different parts of the aged care system were analysed. This data is not publicly available but was able to be acquired using the Royal Commission's powers of compulsion. The data was used to compile quality and safety indicators for individual residential facilities. The indicators included clinical, regulatory, and workforce outcomes. Government-run facilities had the best results on 31 of the quality and safety indicators where differences with other provider types were confirmed as statistically significant. Government-run facilities also had the best result for an additional 4 indicators but the results were not significantly different

⁶¹ The University of Queensland, *The cost of residential aged care*, Research Paper 9: A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 3.

⁶² The University of Queensland, *The cost of residential aged care*, Research Paper 9: A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 3.

⁶³ The University of Queensland, *The cost of residential aged care*, Research Paper 9: A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, pp 3; 25–27.

⁶⁴ F Batchelor et al, *Inside the system: aged care residents' perspectives*, 2020.

from one or more of the other provider types. Not-for-profit facilities returned the best result on 2 indicators applying the same processes as mentioned above, and a further 6 indicators where the results only passed some of the statistical tests. For-profit facilities had the best result for 1 indicator using the same processes.

- d. A review of 2018–19 regulatory data by the Office of the Royal Commission reveals that for-profit residential aged care services performed the worst on average in accreditation audits and received more sanctions when compared with government and not-for-profit services. For-profit services failed to meet expected outcomes relating to health and personal care at almost twice the rate of government services and over 1.5 times the rate of not-for-profit services. They were also more likely to have a finding of serious risk made during an unannounced accreditation audit (3.8% of for-profit services compared with 3.4% of not-for-profit services and 2.1% of government services).
 - e. Data regarding the issuing of sanctions in recent years indicates that for-profit residential aged care services have received proportionately more notices of a decision to impose sanctions than their government and not-for-profit counterparts. Between 1 June 2016 and 8 March 2019, the Australian Department of Health issued 76 notices of its decision to impose sanctions to residential care services, operated by 57 different approved providers. Thirty-nine of these notices, or 51% of the total number of notices issued, were issued to for-profit services. However, the for-profit sector represented only 33% of total residential care services during this period.⁶⁵
56. The relatively better performance of the government sector is all the more notable because the evidence reveals that, on average, people living in government-run residential aged care facilities, at least in Victoria, have higher care needs than those in the private sector.⁶⁶
57. Two features of the Victorian government-run sector are worth highlighting in this context. The first is that Victorian residential aged care services have participated in a compulsory quality indicator program since 2006.⁶⁷ The second is that there have been prescribed ratios of nurses to residents in Victorian government-run services since 2000,

⁶⁵ Exhibit 20-1, Sydney Hearing 5, General Tender Bundle, tab 7, CTH.1000.0004.9017 at 9092; Exhibit 1-34, Adelaide Hearing 1, RCD.9999.0011.0120 at 0220; Exhibit 10-1, Melbourne Hearing 2, General Tender Bundle, tab 118, RCD.9999.0220.0001 at 0076.

⁶⁶ Exhibit 9-22, Melbourne Hearing 1, Statement of Kym Peake, WIT.0420.0001.0001 at 0003 [20].

⁶⁷ Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0012–0013 [82]–[83]; Transcript, Sydney Hearing 1, Joseph Ibrahim, 16 May 2019 at T1798.27-29.

initially as a result of enterprise agreements.⁶⁸ Since 2015, the ratios have been prescribed by statute.⁶⁹ We will return to both of these matters later in our submissions.

58. It should also be noted that Victorian government-run facilities receive considerable additional funding from the Victorian Government on top of the funding available from the Australian Government and residents.⁷⁰ This additional funding no doubt enables such providers to employ more staff and especially more nurses to meet the mandated staffing ratios.
59. The data also support a finding that smaller residential aged care services generally outperform larger services on a range of measures of quality all else being equal.⁷¹ The quality indicators compiled by the Office of the Royal Commission found that aged care facilities with 1-30 places returned the best result on 24 quality and safety indicators where differences between them and other facility sizes were confirmed as statistically significant. The results of an additional 14 indicators showed facilities with 1-30 places returned the best result but the differences were not statistically significant as between one or more of the other facility sizes. Facilities with over 180 places returned the best result on 6 indicators, but each result was not statistically different when compared to the remaining facility sizes.

Conclusion

60. Discovering the nature and extent of substandard care in an aged care system should be quite straightforward. In Australia's aged care system it is exceedingly difficult. The staff of the Royal Commission have had to examine a wide variety of evidence and data sources and to commission research to assist the Royal Commissioners to respond to the areas they have been authorised to inquire into by the Terms of Reference.
61. The weight of the evidence before the Royal Commissioners supports a finding that high quality aged care is not being delivered on a systemic level in our aged care system and the level of substandard care is unacceptable by any measure. At least one in five people receiving residential aged care have experienced substandard care. Australians cannot be confident that they, or their loved ones, will receive the care that they need, whether

⁶⁸ Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0017 [111].

⁶⁹ Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Peake, WIT.0481.0001.0001 at 0017 [112]; *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 (Vic)* s 19.

⁷⁰ Exhibit 11-29, Melbourne Hearing 3, Further information in relation to statement of Kym Peake, WIT.0481.0002.0001 at 0003; Transcript, Melbourne Hearing 3, Kym Peake, 16 October 2020 at T6064.45–7.

⁷¹ The University of Queensland, *The cost of residential aged care*, Research Paper 9: A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 3.

it be in relation to their health, social, cultural or emotional needs, or that they will be kept safe from restrictive practices or abuse.

62. Those who run the aged care system do not seem to know about the nature and extent of substandard care and have made limited attempts to find out. They seem reticent to measure quality. Australians have a right to know how their aged care system is performing; their Government has a responsibility to design and operate a system that tells them; and approved providers have a responsibility to monitor, improve and be transparent about the standard of care they provide.
63. The findings that we urge the Royal Commissioners to make about the nature and extent of substandard aged care inform many of the recommendations that we submit should be made to address the identified deficiencies in the aged care system to which we will shortly turn. Many of the proposed recommendations in these submissions go to these matters.
64. Before we do that, we examine what the evidence and research say about the systemic failures that lead to substandard care in the aged care system and the causes of those failures.

Systemic failures

65. As noted earlier, the terms of reference require an inquiry into the causes of any systemic failures and any actions that should be taken in response.⁷²
66. The substandard care identified above in Australia's aged care system reflects recurring failures in the accessibility of aged care and the way it is delivered. Systemic failures exposed by the work of the Royal Commission include the following:
 - a. Access to aged care, including difficulty entering and navigating the system, access to home care and respite care, poor continuums of support and unequal access to other services.
 - b. Delivery of aged care, including reactive approaches to care, issues with care planning, a lack of transparency, and particular failures in delivering care for people of diverse backgrounds and for those living with dementia.

Access to aged care

67. People have difficulty entering and navigating the system. There is a lack of localised, face-to-face assistance, including coordination to help plan and manage people's care.⁷³

⁷² Letters Patent, 6 December 2018, as amended on 13 September 2019 and 25 June 2020, paragraph (a).

⁷³ See, for example, Transcript, Broome Hearing, Ruth Crawford, 18 June 2019 at T2112.19–2113.11; Transcript, Broome Hearing, Leon Flicker, 17 June 2019 at T2035.20–39; Exhibit 4-8,

People often do not know how to access aged care or what services they can receive from their home care package when a package is allocated.⁷⁴

68. The process of assessment for aged care is complex and prone to inefficiency, duplication, poor resource utilisation and unsatisfactory service experience.⁷⁵ It may result in confusion in assessment and outcomes for older people.⁷⁶ People accessing the aged care system reported the experience as time-consuming, overwhelming, frightening and intimidating.⁷⁷ It is difficult for people seeking aged care to be certain that services deliver care that is tailored to their specific needs. For example, while an aged care service may state that it caters for particular communities and cultural groups on the My Aged Care website, there is no process to ensure approved providers actually offer, or are capable of delivering, those services.⁷⁸ The number of approved providers that specialise in caring for people with diverse needs is limited and they often operate on a small scale.⁷⁹
69. There is a particular lack of pathways and appropriate support structures within the aged care system for people who receive a diagnosis of dementia.⁸⁰ The referral pathway for access to support and services generally ceases after their diagnosis and many people are confused or unaware of supports available to them.⁸¹ This impacts on how people living with dementia, and the family and friends who care for them, manage their care and their interactions with the aged care system.

Broome Hearing, Statement of Graham Aitken, WIT.1134.0001.0001 at 0009 [71]; Exhibit 7-09, Mildura Hearing, Statement of Donald Laity, WIT.0313.0001.0001 at 0006 [48] - 0007 [50].

⁷⁴ See, for example, Exhibit 10-25, Melbourne Hearing 2, Statement of Catharina Nieuwenhoven, WIT.0515.0001.0001 at 0005 [37]–[38]; Transcript, Mildura Hearing, Don Laity, 30 July 2020, T3962.19–38; Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2020, T4025.31–4026.2; Transcript, Mildura Hearing, Barbara McPhee, 29 July 2020, T3916.5–12.

⁷⁵ See, for example, Transcript, Mildura Hearing, Suzanne Hodgkin, 30 July 2019 at T4036.12–36; Transcript, Mildura Hearing, Lyn Phillipson, 30 July 2020 at T4027.8–13; Transcript, Mildura Hearing, Maree Woodhouse, 31 July 2019 at T4083.32-39; Advanced Personnel Management, Public submission, AWF.660.00122.0001 at 0007.

⁷⁶ See, for example, Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3880.15; Transcript, Mildura Hearing, Suzanne Hodgkin, 30 July 2019 at T4036.12–19; Transcript, Mildura Hearing, Maree Woodhouse, 31 July 2019 at T4083.32–39; of Access Care Network Australia, Public submission, AWF.660.00093.0001 at 0004.

⁷⁷ See, for example, Helen Tucker, Public submission, AWF.001.00231; Joanna Shaw, Public submission, AWF.001.01660; Transcript, Adelaide Hearing 2, Marie Dowling, 20 March 2019 at T908.1–4.

⁷⁸ Exhibit 10-3, Melbourne Hearing 2, Statement of Samantha Edmonds, WIT.0396.0001.0001 at 0024 [110(b)]; Exhibit 10-5, Melbourne Hearing 2, Statement of Noeleen Tunny, WIT.0422.0001.0001 at 0012 [36].

⁷⁹ See, for example, Exhibit 10-5, Melbourne Hearing 2, Statement of Noeleen Tunny, WIT.0422.0001.0001 at 0017 [44].

⁸⁰ Exhibit 3-82, Sydney Hearing 1, Statement of Trevor Crosby, WIT.0142.0001.0001 at 0002–0003. Transcript, Sydney Hearing 1, Kate Swaffer, 17 May 2019 at T1929.37–44; T1930.5–25.

⁸¹ Transcript, Sydney Hearing 1, Glenn Rees, 13 May 2019 at T1550.30–37; Submission of Dementia Australia, Public submission, AWF.665.00010.0001 at 0001_0003.

70. There are not enough Home Care Packages. The Home Care Package Program is not funded to meet the level of need and demand. As a result, older people wait on the National Prioritisation System for a package of home care services to become available so that they can receive the care they need.⁸² The announcement of funding for 16,105 additional Home Care Packages following the Interim Report is insufficient. This announcement has simply brought forward the release of packages with only a minimal change to the forward estimate of the number of packages to be available in 2024.⁸³ There has been no change to the ratio of packages that will be available for the population of Australians aged over 70, nor the growth rate of packages that will be available in coming years.⁸⁴ The more recent announcement in the October budget of a further 23,000 packages is welcome but we note that few of those are high level packages particularly level 4.
71. Without access to services, people face and many have suffered, declining function, preventable hospitalisation, carer burnout, premature entry to residential aged care, and death.⁸⁵
72. Too often respite for older people and their informal carers is either not available, inadequate in nature or duration, or the services offered are substandard.⁸⁶ Funding for residential respite care is not comparable to permanent care funding, creating a disincentive for approved providers to offer respite.⁸⁷ Lengthy and time-consuming admission processes also create a disincentive. Approved providers often only offer respite when there is a bed vacancy that cannot be filled by a permanent resident.⁸⁸ Consequently, respite is often not available for informal carers when it is needed.⁸⁹

⁸² Productivity Commission, Report on Government Services 2020, 2020, Table 14A.26, <https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/community-services/aged-care-services>, viewed 13 August 2020.

⁸³ Transcript, Sydney Hearing 4, Nicholas Hartland, 2 September 2020 at T9056.21–46.

⁸⁴ Transcript, Sydney Hearing 4, Nicholas Hartland, 2 September 2020 at T9056.8–46.

⁸⁵ See, for example, Transcript, Adelaide Hearing 2, Lynda Henderson, 18 March 2019 at T685.2–20; Transcript, Adelaide Hearing 2, Ruth Harris, 21 March 2019 at T950.6–16; T954.18–34; Transcript, Mildura Hearing, Barbara McPhee, 29 July 2019 at T3918.30–34.

⁸⁶ See, for example, Exhibit 7-14, Mildura Hearing, Statement of Lyn Phillipson, WIT.0287.0001.0001 at 0009 [37]; Exhibit 7-12, Mildura Hearing, Joint Paper of Catherine Thomson, Trish Hill and Myra Hamilton, WIT.0286.0001.0001 at 0012 [8]; 0025 [15].

⁸⁷ See, for example, Exhibit 7-21, Mildura Hearing, Statement of Jennifer Garonne, WIT.0295.0001.0001 at 0007 [31]–[33].

⁸⁸ See, for example, Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3868.30–32; Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3890.10–12.

⁸⁹ See, for example, Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3849.26–27; T3849.43–3850.2; Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3882.22–38; Transcript, Mudgee Hearing, Susan Hood, 5 November 2019 at T6497.26–31. Transcript, Mildura Hearing, Dorothy Frances Holt, 29 July 2019 at T3865.15–20; Exhibit 7-12, Mildura Hearing, Joint Paper of Catherine Thompson, Trish Hill and Myra Hamilton, WIT.0286.0001.0001 at 0026–0027.

73. The needs of informal carers are not being met by the current system. This is despite estimates that overall informal care is worth \$77.9 billion to the Australian Government and that a substantial proportion of that is from informal care provided to older people.⁹⁰ Informal carers' needs are not being adequately identified and assessed; carers' needs are assessed separately from those of the person receiving aged care, if they are assessed at all.⁹¹ This means that carers' needs are often only considered at crisis point, which is too late. Currently, informal carers also face significant social and economic disadvantages as a result of caring, which can cause burnout and undermine their ability to continue caring for loved ones in a sustainable way.⁹²
74. There is a lack of continuum of support and care for people receiving aged care services; the aged care system does not guide and track a person and their changing needs over time. There are three main options for aged care: the Commonwealth Home Support Programme, the Home Care Package Program, and residential aged care.⁹³ The design of the aged care system, its funding and the availability of services dictate what a person receives and when they receive it.⁹⁴ The care available for someone living in the community, even at the highest Home Care Package level, is significantly less than that which is available in residential aged care. There is no funding for people requiring higher levels of care to stay at home, which means that, for these people, the only other funded option available is residential aged care.⁹⁵
75. People living in residential aged care have unequal or insufficient access to health services compared to people living in the community. Often, it is difficult for people to access:
- a. general practitioners, due to impediments preventing general practitioners from regularly and promptly visiting people receiving aged care at their places of

⁹⁰ Deloitte Access Economics, *The Economic Value of Informal Care in Australia 2020*, p 19; Transcript, Adelaide Hearing 1, Susan Elderton, 12 February 2020 at T181.14–30; Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia: Summary of Findings, 2018*, Table 40.1 (Catalogue 4430.0), <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0>, viewed 7 July 2020.

⁹¹ Transcript, Mildura Hearing, Dorothy Frances Holt, 29 July 2019 at T3860.29–33; Transcript, Mildura Hearing, Danijela Hlis, 31 July 2019 at T4070.24–38; Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3878.18–28; Exhibit 7-14, Mildura Hearing, Statement of Lyn Phillipson, WIT.0287.0001.0001 at 0008 [36].

⁹² Exhibit 3-4, Sydney Hearing, Statement of George Akl, WIT.0108.0001.0001 at 0005 [41]; Transcript, Mildura Hearing, Joan Rosenthal, 29 July 2019 at T3900.19–22.

⁹³ See, for example, Transcript, Adelaide Hearing 1, Claerwen Little, 20 February 2019 at T494.44–495.5.

⁹⁴ Transcript, Adelaide Workshop 1, Patricia Sparrow, 10 February 2020 at T7687.8–17.

⁹⁵ See, for example, Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 69, RCD.9999.0347.0001 at 0004–0005 [11]–[12].

residence and, even when they visit, from engaging in the type of preventative and holistic care required⁹⁶

- b. allied health professionals, such as dietitians, exercise physiologists, mental health workers, occupational therapists, pharmacists, physiotherapists, podiatrists, psychologists, speech pathologists and specialist oral and dental health professionals⁹⁷
 - c. specialist health practitioners such as geriatricians, psychiatrists, cardiologists, and specialist palliative care practitioners⁹⁸
 - d. the State and Territory public health services they need, including palliative care and older persons' mental health services.⁹⁹
76. While lack of access to services such as allied health is most prevalent in residential aged care, access issues also affect people receiving aged care services at home. Despite there being greater choice and flexibility in the services available for people living at home, inadequate funding, long wait times for home care packages and poor use of available funding are all barriers to the availability of these important services.¹⁰⁰

Delivery of aged care

77. As detailed in our February 2020 submissions about the aged care workforce, there are not enough aged care workers. Inadequate staffing, skill mix and training are some of the key contributors to substandard care in the current system.¹⁰¹

⁹⁶ See, for example, Transcript, Canberra Hearing, Rhonda Payget, 13 December 2019 at T7593.35–7594.22; Transcript, Canberra Hearing, Rhonda McIntosh, 9 December 2019 at T7201.38–45; Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7421.39–42.

⁹⁷ See, for example, Exhibit 1-56, Adelaide Hearing 1, Statement of Anthony Bartone, WIT.0015.0001.0001 at 0008 [42]; Transcript, Darwin Hearing, Catherine Maloney, 12 July 2019 at T3407.43–3408.13; Transcript, Adelaide Hearing 1, Gerard Hayes, 21 February 2019 at T573.9–20.

⁹⁸ See, for example, Exhibit 14-1, Canberra Hearing, General Tender Bundle, tab 66, RCD.9999.0280.0003 at 0012; Transcript, Adelaide Hearing 1, Harry Nespolon, 18 February 2019 at T385.16–20; Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7430.35–47.

⁹⁹ See, for example, Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7460.7–11; Transcript, Canberra Hearing, Kristine Stevens, 9 December 2019 at T7228.24–7229.10; Exhibit 14-18, Canberra Hearing, Statement of Catherine Davis, WIT.1304.0001.0001 at 0008 [50]–[51]; Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen Macfarlane, WIT.0740.0001.0001 at 0007 [54].

¹⁰⁰ See, for example, Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.999.0315.0001 at 0009–0010 [7]; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0004–0005 [9].

¹⁰¹ See, for example, Exhibit 1-60, Adelaide Hearing 1, Statement of Gerard Hayes, WIT.0019.0001.0001 at 0005 [23]–[29]; Exhibit 1-52, Adelaide Hearing 1, Statement of Melissa Coad, WIT.0018.0001.0001 at 0008 [50]–[52]; Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, WIT.0006.0001.0001 at 0008 [28].

78. The prevailing model of care in the current aged care system is a reactive one. Aged care services are not sufficiently geared towards people's enablement and do not promote the maintenance and improvement of people's health.¹⁰² Many older people have complex health needs and experience problems with mobility and performing activities of daily living.¹⁰³ However, health services, particularly those delivered by allied, mental and oral health professionals, are often only delivered in response to acute needs or a sudden decline in health condition.¹⁰⁴ The current funding structure provides incentives for reactive care over proactive care.¹⁰⁵
79. Care planning is often of poor quality and ineffective. Care planning should be used to meet people's needs, goals and preferences and to optimise their health and wellbeing. Approved providers are required to prepare and maintain care plans.¹⁰⁶ Yet too often in residential aged care, the focus of care planning has become obtaining evidence to support funding decisions.¹⁰⁷
80. Poor communication and coordination between approved providers, external health care professionals, people receiving care and their loved ones compromises the quality of care.¹⁰⁸ Documentation and record keeping are important aspects of communication, especially between care staff and external health care providers. Failures in these areas can result in older people being prevented from getting the care they need.¹⁰⁹
81. The management and governance of approved providers has a direct impact on all aspects of care. Deficiencies in the governance and leadership of approved providers have resulted in serious shortfalls in the quality and safety of care.¹¹⁰ Some boards and governing bodies lack professional knowledge about the delivery of aged care including

¹⁰² See, for example, Transcript, Sydney Hearing 1, Lucille O'Flaherty, 14 May 2019 at T1602.39–44; Transcript, Perth Hearing, Chris Mamarelis, 25 June 2019 at T2435.24–31; Transcript, Darwin Hearing, Catherine Maloney, 12 July 2019 at T3408.9–13.

¹⁰³ Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0001.

¹⁰⁴ Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0007.

¹⁰⁵ See, for example, Transcript, Darwin Hearing, Catherine Maloney, 12 July 2019 at T3408.9–13; Transcript, Sydney Hearing 1, Henry Brodaty, 17 May 2019 at T1892.30–37; Transcript, Sydney Hearing 1, Jennifer Lawrence, 14 May 2019 at T1602.30–37.

¹⁰⁶ See, for example, *User Rights Principles 2014* (Cth), ss 16(cad), 19AD, 23(2)(b)(v); *Records Principles 2014* (Cth), s 7(d); *Quality of Care Principles 2014* (Cth), ss 13(4), 15B(4).

¹⁰⁷ Transcript, Sydney Hearing 1, Stephen Macfarlane, 15 May 2019 at T1755.1–27.

¹⁰⁸ See, for example, Exhibit 1-62, Adelaide Hearing 1, Statement of Margaret Harker, WIT.0053.0001.0001 at 0006 [71]–0007 [79]; Exhibit 10-4, Melbourne Hearing 2, Statement of Mary Patetsos, WIT.0437.0001.0001 at 0017 [114]; Exhibit 10-2, Melbourne Hearing 2, Statement of Angelos Angeli, WIT.0511.0001.0001 at 0005 [43]–0006 [49].

¹⁰⁹ See, for example, Exhibit 6-16, Darwin Hearing, Statement of Eric Tay, WIT.0248.0001.0001 at 0006–0007 [43]; Exhibit 5-36, Perth Hearing, Statement of John Leong, WIT.0244.0001.0001 at 0009 [85]–0010 [90].

¹¹⁰ Transcript, Cairns Hearing, Petronella Neeleman, 15 July 2019 at T3584.1–20; Exhibit 6-17, Darwin Hearing, Statement of Paul Cohen, WIT.0258.0001.0001 at 0038 [208]–0044 [209]; Exhibit 13-5, Hobart Hearing, Statement of Jo-Anne Hardy, WIT.0496.0001.0001 at 0009 [36]–0010 [41].

clinical expertise.¹¹¹ There is a risk that governing bodies may focus on financial risks and performance, without a commensurate focus on the quality and safety of care.¹¹² There are not always structures in place that ensure that governing bodies are properly informed of care deficiencies and risks, and can take appropriate and timely action to address them.¹¹³ There is a lack of accountability, particularly when things go wrong.¹¹⁴

82. There is also a lack of transparency about what approved providers are doing, and how well it is being done.¹¹⁵ Good quality comparative information about aged care services is not available publicly.¹¹⁶ The quality indicators used for residential aged care facilities do not adequately capture the breadth of the concept of quality care and they are more limited than those adopted in other countries.¹¹⁷ No quality indicators currently exist for home care services. Despite the large number of reported assaults in aged care, there is no information publicly available about the number of incidents at a particular service or approved provider.
83. People receiving aged care, their families and staff may chose not to make complaints to approved providers. The reasons for this include that providers do not take complaints seriously—nothing changes following a complaint—and because people receiving aged care and their families fear negative repercussions if they do complain.¹¹⁸ Mechanisms

¹¹¹ Transcript, Darwin Hearing, Paul Cohen, 10 July 2019 at T3161.43–3162.6; T3168.32–3169.43; Transcript, Darwin Hearing, Donato Smarrelli, 10 July 2019 at T3179.21–3180.9; Transcript, Cairns Hearing, Petronella Neeleman, 15 July 2019 at T3581.42–3582.22; T3584.1–20; T3592.10–44.

¹¹² See, for example, Transcript, Hobart Hearing, Penny Webster, 15 November 2019 at T7116.25–31; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 201, 206, 207; Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 163, BPA.060.002.5503.

¹¹³ Exhibit 13-17, Hobart Hearing, Statement of Stephen Shirley, WIT.0549.0001.0001 at 0007 [32]; Submissions of Bupa Aged Care Australia Pty Ltd, Bupa South Hobart Case Study, 18 December 2019, RCD.0012.0050.0001 at 0017 [47]; 0026 [63]–0027 [66]; Exhibit 13-22, Hobart Hearing, Statement of Elizabeth Monks, WIT.0558.0001.0001 at 0011; Transcript, Hobart Hearing, Linda Hudec, 14 November 2019 at T7030.5–13.

¹¹⁴ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, p 207; Transcript, Perth Hearing, Lisa Trigg, 28 June 2019 at T2800.29; Transcript, Perth Hearing, Andrew Sudholz, 25 June 2019 at T2383.41–2384.11; T2387.1–12; Transcript, Adelaide Hearing 1, Clive Spriggs, 11 February 2019 at T43.35–38.

¹¹⁵ See John Simpson, public submission AWF.001.02459 at 0002; Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4602.38–44; Exhibit 1-60, Adelaide Hearing 1, Statement of Gerard John Hayes, WIT.0019.0001.0001 at 0013 [69(g)].

¹¹⁶ Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0003 [28].

¹¹⁷ Transcript, Henry Cutler, Adelaide Workshop 1, 11 February 2020 at T7813.11–21; Transcript, Ben Lancken, Adelaide Workshop 2, 16 March 2020 at T7983.10–13; K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, pp 93, 98 (Exhibit 1-25, Adelaide Hearing 1, RCD.9999.0011.1833 at 1938, 1943); United States Medicare, About Nursing Home Compare Data, <https://www.medicare.gov/NursingHomeCompare/Data/About.html>, viewed 20 August 2020.

¹¹⁸ See, for example, Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, WIT.0329.0001.0001 at 0007 [44]; Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0008 [51]–0009 [56]; Exhibit 12-2, Mudgee Hearing, Statement of

enabling approved providers to engage in a meaningful way with older people and their families about the services they receive and the way they are delivered are often under-developed or non-existent.¹¹⁹ Those who raise concerns are too often seen as trouble makers to be managed rather than what they really are—a valuable source of information to drive improvement in service delivery.¹²⁰ Aged care workers are not always empowered to raise concerns or provide feedback.¹²¹ Indeed, there is no explicit requirement for approved providers to ensure workers have an opportunity to express their views about the quality of care.

84. Many people from diverse backgrounds currently receive care that is not culturally safe or trauma informed. Across the system, approved providers lack understanding about what this entails, and staff training on understanding and meeting the broad additional needs of people from diverse backgrounds is lacking.¹²² A lack of cultural safety contributes to a lack of trust in the aged care system for some Aboriginal and Torres Strait Islander people. This affects the likelihood of Aboriginal and Torres Strait Islander people engaging with aged care.¹²³
85. The system itself can prevent culturally inclusive care. For example, it has been suggested that food safety regulations may prevent the provision of culturally important food.¹²⁴ Many people in aged care are not able to communicate because of inadequate support to overcome language barriers.¹²⁵
86. In major cities and inner regional areas, where most Aboriginal and Torres Strait Islander people live, most care is delivered by mainstream approved providers. There are very few providers with an Aboriginal or Torres Strait Islander focus.¹²⁶ Compared to the rest

Ruth Hamilton, WIT.0597.0001.0001 at 0003 [14]–[15]; Exhibit 13-37, Hobart Hearing, Statement of Bethia Wilson, WIT.0586.0001.0001 at 0005 [c].

¹¹⁹ Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Garth Yates, WIT.0006.0001.0001 at 0008 [31]; Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, WIT.0003.0001.0001 at 0008 [10]; Transcript, Adelaide Hearing 1, Matthew Richter, 20 February 2019 at T526.10–23; Exhibit 8-36, Brisbane Hearing, Statement of Beverley Jean Johnson, WIT.0332.0001.0001 at 0009 [51]–[52].

¹²⁰ See Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 204-205.

¹²¹ Exhibit 12-4, Mudgee Hearing, Statement of Michelle Harcourt, WIT.0524.0001.0001 at 0009–0010 [45]; Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T6019.35–37.

¹²² See, for example, Exhibit 10-3, Melbourne Hearing 2, Statement of Samantha Edmonds, WIT.0396.0001.0001 at 0025 [113]–[114]; Exhibit 10-4, Melbourne Hearing 2, Statement of Mary Patetsos, WIT.0437.0001.0001 at 0017 [115].

¹²³ Exhibit 5-28, Perth Hearing, Statement of Matthew Moore, WIT.0162.0001.0001 at 0009-0010 [37]; Transcript, Ruth Crawford, Broome Hearing, 18 June 2019 at T2096.39-44.

¹²⁴ See, for example, Exhibit 4-5, Broome Hearing, Statement of Tamra Bridges, WIT.0166.0001.0001 at 0008 [58.2]; Transcript, Broome Hearing, Tamra Bridges, 17 June 2019 at T2021.5–36.

¹²⁵ See, for example, Transcript, Broome Hearing, Yvonne Grosser, 17 June 2019 at T1997.8–18; T1997.24–35.

¹²⁶ Exhibit 4-1, Broome Hearing, General Tender Bundle, tab 18, RCD.9999.0075.0585 at 0252[2.2]–0253[2.3].

of the population, Aboriginal and Torres Strait Islander people have higher rates of disability, lower life expectancy and require aged care services at a younger age.¹²⁷ Substantial growth is projected in the number of Aboriginal and Torres Strait Islanders aged 65 years and over.¹²⁸ This population faces existing unmet health and aged care needs which will only increase with time.¹²⁹

87. Aboriginal and Torres Strait Islander organisations which deliver health or aged care services can better overcome cultural and language barriers faced by other providers.¹³⁰ Building these services takes time, and requires an approach that fosters trust and the flexibility to accommodate different needs.¹³¹ The flexible funding arrangements needed for growth in Aboriginal and Torres Strait Islander service provision have been limited to a few approved providers, predominantly in remote areas.¹³² More is needed to meet Aboriginal and Torres Strait Islander people's aged care needs wherever they live.
88. The quality of care received by people living with dementia is, at times, very poor, particularly for those with complex needs. Care staff often do not have the time or the skills to deliver the care that is needed for people's specialised needs.¹³³ While dementia care is now a core requirement within the current Certificate III aged care qualification

¹²⁷ Productivity Commission, Report on Government Services 2019, Aged Care Services, 2019; Australian Institute of Health and Welfare, Alcohol, tobacco and other drugs in Australia, web report, 2020, <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-people>, viewed 16 July 2020.

¹²⁸ Australian Bureau of Statistics, *3238.0 - Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031, Australia*, Australian Government, 2019, <https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3238.0Main%20Features402006%20to%202031?opendocument&tabname=Summary&prodno=3238.0&issue=2006%20to%202031&num=&view>, viewed 20 August 2020.

¹²⁹ See, for example, National Indigenous Australians Agency, *Closing the Gap Report 2020*, Australian Government, 2020, p 77, <https://ctgreport.niaa.gov.au/sites/default/files/pdf/closing-the-gap-report-2020.pdf>, viewed 16 June 2020; Australian Institute of Health and Welfare, *Older Australia at a glance: Aboriginal and Torres Strait Islander people*, Australian Government, 2018, <https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/diversity/aboriginal-and-torres-strait-islander-people>, viewed 16 June 2020; Exhibit 4-6, Broome Hearing, Statement of Leon Flicker, WIT.0161.0001.0001 at 0004 [15].

¹³⁰ Transcript, Darwin Hearing, Sarah Brown, 8 July 2019 at T2860.26–35; T2861.38–2862.9; Transcript, Darwin Hearing, Kim McRae, 8 July 2019 at T2866.1–12; Transcript, Darwin Hearing, Sarah Giles, 8 July 2019 at T2886.16–47; Transcript, Melbourne Hearing 2, Moreen Lyons, 11 October 2019 at T5687.39–5688.13; T5689.6–17; T5689.27–40; Exhibit 4-16, Broome Hearing, Statement of Venessa Curnow, WIT.0243.0001.0001 at 0011 [65].

¹³¹ Exhibit 20-1, Sydney Hearing 4, General tender bundle, tab 12, RCD.9999.0423.0001 at 0002 [11]; Transcript, Broome hearing, Graeme Aitken, 18 June 2019 at T2083.8–2084.8.

¹³² Transcript, Perth Hearing, Matthew Moore, 25 June 2019 at T2580.41–2581.21; T2584.9–19.

¹³³ See, for example, Transcript, Adelaide Hearing 1, Deborah Parker, 13 February 2019 at T228.29–41; Transcript, Adelaide Hearing 1, John McCallum, 11 February 2019 at T96.28–34; Transcript, Adelaide Hearing 2, Anna Hansen, 19 March 2019 at T830.20–30; Transcript, Broome Hearing, Yvonne Grosser, 17 June 2019 at T1998.1–10; Transcript, Perth Hearing, Dale Fisher, 26 June 2019 at T2561.12–15; Transcript, Darwin and Cairns Hearing, Sandy Green, 17 July 2019 at T3791.12–16; Transcript, Sydney Hearing 1, Joseph Ibrahim, 16 May 2019 at T1796.22–25.

for personal care workers, it is not for home care workers.¹³⁴ The response to approved providers' lack of capability to care for people living with dementia is often to rely on restrictive practices, which limit a person's freedom and diminish their quality of life.¹³⁵ Fewer than 50% of new aged care buildings are constructed in accordance with dementia-friendly guidelines.¹³⁶

89. Finally, there are too many younger people in residential aged care. As at 30 June 2020, there were 4,860 people under the age of 65 years living in residential aged care.¹³⁷ This included almost 900 people under the age of 55 years, 130 of whom were under 45 years of age.¹³⁸ Residential aged care is not designed to cater for the needs of younger people.¹³⁹ Younger people usually do not want to live in residential aged care, but have to do so because of a lack of suitable permanent alternative accommodation, transitional accommodation and access to health-related supports.¹⁴⁰

Causes of systemic failures

90. Systemic failures happen because of underlying causes in the way the aged care system is designed and governed, and to some extent because of the attitudes within Australian society and government which inform those decisions. The causes of systemic failure identified through the work of the Royal Commission include the following:
- a. attitudes to aged care and the delivery of services
 - b. funding and financing
 - c. inadequate governance and regulatory frameworks
 - d. failure to take opportunities for improvement

¹³⁴ See, for example, training.gov.au, *CHC33015 - Certificate III in Individual Support*, Australian Government, <https://training.gov.au/training/details/chc33015>, viewed 3 September 2020.

¹³⁵ Felicity Lathrop, Public submission, AWF.001.04977.

¹³⁶ Transcript, Sydney Hearing 1, Kate Swaffer, 17 May 2019 at T1935.25–31.

¹³⁷ Australian Department of Health's response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3541 [4].

¹³⁸ Australian Department of Health's response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3541 [4] and 3542 [6].

¹³⁹ See, for example, Exhibit 9-4, Melbourne Hearing 1, Statement of Catherine Roche, WIT.1238.0001.0001 at 0005 [33]; Exhibit 9-11, Melbourne Hearing 1, Statement of Kirby Littley, WIT.1241.0001.0001 at 0002–0003 [23]–[24].

¹⁴⁰ See, for example, Exhibit 9-3, Melbourne Hearing 1, Statement of Lisa Corcoran, WIT.1240.0001.0001 at 0001 [4]; Exhibit 9-11, Melbourne Hearing 1, Statement of Kirby Littley, WIT.1241.0001.0001 at 0004 [36]–[37]; Exhibit 9-18, Melbourne Hearing 1, Statement of James Nutt, WIT.1237.0001.0001 at 0003 [20]; Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5210.39–5211.14. Transcript, Melbourne Hearing 1, Catherine Roche, 9 September 2019 at T4833.1–34; Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019, T4956.39–41.

Attitudes to aged care and the delivery of services

91. Ageist and patronising views of older people exist in our society. While there is no doubt that elders are valued, there is some evidence that, as a society, we underestimate and devalue older Australian's contribution to the community.¹⁴¹ Ageism can be unconscious and ageist behaviours are often not intended to be harmful. In fact, they are often well-intentioned. Yet they can be seen in the aged care system, for example, a desire to keep someone safe by not allowing them to eat a soft boiled egg or go for a walk, may also undermine their dignity and sense of control over their own lives.¹⁴²
92. Ageist beliefs partly explain the poor communication and coordination within the system, particularly unkind and disrespectful communication. When government officials faced with a pandemic speak of 'decanting' elderly people living in residential care,¹⁴³ instead of assisting them to be transferred from one location to another; when they speak of 'cohorting' those same residents,¹⁴⁴ instead of separating those with the virus from those who are virus-free, it deprives those people—grandmothers, grandfathers, mothers, fathers—of their humanity. By so doing, it becomes that much easier to make decisions about whether or not to transfer those who are suffering a life threatening illness to hospital, not on the basis of their individual medical needs, not even on the basis of what is best for the other people living in that residential facility who are well, but because to do so will 'set a precedent'.¹⁴⁵
93. Maintaining the dignity and self-determination of older people are not always prominent considerations in the delivery of aged care services.¹⁴⁶ There is a widespread view that living in residential aged care will lead to an inevitable decline in control and quality of life as well as general unhappiness.¹⁴⁷ This is exacerbated by the institutional nature of aged care and the consequent lack of connection to the broader community which can

¹⁴¹ See, for example, Transcript, Perth Hearing, Kay Patterson, 26 June 2019 at T2544.23–24; Ipsos, *They look after you, you look after them: Community attitudes to ageing and aged care*, A report on focus groups for the Royal Commission into Aged Care Quality and Safety, 2019, p 20.

¹⁴² See, for example, Exhibit 5-26, Perth Hearing, Statement of Kay Patterson, WIT.0247.0001.0001 at 0007 [23]; Transcript, Adelaide Hearing 1, Patricia Sparrow, 19 February 2019 at T434.39–42.

¹⁴³ See, for example, Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 34, CTH.1039.1000.0542 at 0543–0544.

¹⁴⁴ See, for example, Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 35, CTH.1039.1000.0517 at 0518, 0521, 0522–0523.

¹⁴⁵ Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 34, CTH.1039.1000.0542 at 0544.

¹⁴⁶ See for example, Transcript, Sydney Hearing 1, Eresha Dilum Dassanayake, 6 May 2019 at T1174.17–32; Transcript, Perth Hearing, Bernard Cooney, 28 June 2019 at T2784.22–31; Transcript, Adelaide Hearing 1, Patricia Sparrow, 19 February 2019 at T434.39–42; G Macdonald and J Mears (eds.), *Dementia as Social Experience: Valuing Life and Care*, 2019, pp 118-133.

¹⁴⁷ Roy Morgan, *What Australians think of ageing and aged care*, prepared for the Royal Commission into Aged Care Quality and Safety, April 2020, p 23; Ipsos, *They look after you, you look after them: Community attitudes to ageing and aged care*, A report on focus groups for the Royal Commission into Aged Care Quality and Safety, 2019, p 63.

result in loneliness and isolation.¹⁴⁸ Too often aged care facilities are seen as places to die, rather than places to continue living.¹⁴⁹

94. There is not a shared understanding of high quality in aged care in Australia, and little consensus among approved providers, advocacy and peak bodies, academics and policymakers about what the words ‘quality’ and ‘safety’ mean in the context of aged care.¹⁵⁰ The Aged Care Quality Standards do not define high quality care, but instead mandate minimum acceptable standards to be met by approved providers. It is difficult to ensure that the standard of aged care improves over time where high quality care has not been defined.
95. For the most part, the aged care system has failed to consider the diversities of older Australians in its design and implementation. Australia is a diverse and multicultural nation made up of individuals with unique backgrounds, experiences and histories. Instead of building a system that embraces and celebrates this diversity, too often a ‘one size fits all’ approach has been adopted that makes assumptions about a person’s circumstances. For example, home care is predicated on the assumption that people own their own home and have safe housing.¹⁵¹ While the Australian Government has published the Aged Care Diversity Framework and accompanying Action Plans, these are not mandatory and approved providers are not evaluated against them.¹⁵²
96. There is a multitude of problems that are caused by the interaction of the aged care system and the health care system, which impact upon the quality of health and aged care provided to older people, including:
 - a. a lack of funding for proactive health care services provided to people at their place of residence

¹⁴⁸ Roy Morgan, *What Australians think of ageing and aged care*, prepared for the Royal Commission into Aged Care Quality and Safety, April 2020, p 3; Exhibit 3-1, Sydney Hearing, Statement of Merle Mitchell, WIT.0107.0001.0001 at 0002 [19]; 0008 [78]; 0010 [86f].

¹⁴⁹ Ipsos, *They look after you, you look after them: Community attitudes to ageing and aged care*, A report on focus groups for the Royal Commission into Aged Care Quality and Safety, 2019, p 63.

¹⁵⁰ See, for example, Exhibit 1-54, Adelaide Hearing 1, Statement of Matthew Richter, WIT.0012.0001.0001 at 0015–0016 [10]; Exhibit 1-44, Adelaide Hearing 1, Statement of Maree McCabe, WIT.0005.0001.0001 at 0014 [53]–[56]; Exhibit 1-52, Adelaide Hearing 1, Statement of Melissa Coad, WIT.0018.0001.0001 at 0010; Exhibit 1-51, Adelaide Hearing 1, Statement of Claerwen Little, WIT.0010.0001.0001 at 0006; Exhibit 1-50, Adelaide Hearing 1, Statement of Nicolas Mersiades, WIT.0011.0001.0001 at 0030; Exhibit 1-23, Adelaide Hearing 1, Statement of Glenys Beauchamp, WIT.0022.0001.0001 at 0033.

¹⁵¹ See, for example, Transcript, Melbourne Hearing 2, Fiona York, 7 October 2019 at T5337.26–45; T5342.26–33; T5348.37–44.

¹⁵² Department of Health, Aged Care Diversity Framework Action Plans, Australian Government, 2019, <https://www.health.gov.au/resources/collections/aged-care-diversity-framework-action-plans>, viewed 28 May 2020; Exhibit 10-1, Melbourne Hearing 2, General Tender Bundle, tab 11, CTH.0001.1001.2215 at 2215–2232.

- b. poor clarity about the respective roles and responsibilities of approved providers and private and public health care providers to deliver health care for people in aged care, particularly residential aged care
 - c. an unwillingness by health care providers to provide their services at a person's place of residence, even though many people in residential aged care find it difficult to travel to services
 - d. poor quality or incomplete clinical handover and communication between hospitals and approved providers, which can result in clinical decisions based on misinformation.
97. The National Disability Insurance Scheme does not provide equitable access to funding for people of all ages. A person cannot participate in that Scheme if the person first develops a disability after turning 65.¹⁵³ Nor can a person participate in the National Disability Insurance Scheme if, at the time when the Scheme came into operation in the place where the person lives, they had already turned 65.¹⁵⁴ In addition, s 29(1)(b) of the *National Disability Insurance Scheme Act 2013* (Cth) provides that a person ceases to be a participant in the Scheme if, after turning 65 years old, the person receives aged care services for the first time on a permanent basis. This has the potential to interrupt and possibly stop service continuity for that person upon any transition into the aged care system.
98. For an older person with disability, the National Disability Insurance Scheme generally offers a higher level of care and a more comprehensive schedule of available supports than the existing aged care system.¹⁵⁵ It also offers much greater provision for aids and equipment that are not particular to age-related needs, and are not currently provided for in the aged care system. These inequities may mean that an older person with a disability is unable to receive the same level of service, or the same quality of service, as a younger person with the same disability depending on the age at which they acquired the disability.

Funding and financing

99. Funding for aged care is insecure and subject to the fiscal priorities and wide-ranging responsibilities of government. Since at least 1984–85, the Australian Government's level of expenditure on aged care has not kept pace with demand. Funding does not reflect the cost of care. The Productivity Commission's 2011 recommendation for the

¹⁵³ *National Disability Insurance Scheme Act 2013* (Cth), ss 18, 21, 22 and 28.

¹⁵⁴ *National Disability Insurance Scheme Act 2013* (Cth), s 23.

¹⁵⁵ Submission of Multiple Sclerosis Australia, Public submission, AWF.001.02000.01_0001 at 0009; Submission of Spinal Cord Injuries Australia, Public submission, AWF.500.00190.0001 at 0001_0009-0001_0010; National Disability Insurance Scheme, *NDIS Quarterly Report to disability ministers*, 2020, p 87.

introduction of an independent authority to bring transparency to price setting was rejected.¹⁵⁶ Without sufficient funding, approved providers are limited in their capacity to provide high quality and safe care. Insufficient funding impacts almost every aspect of care from numbers and skill mix of the workforce, infrastructure and physical environments, access to technology and effective linkages between systems.

100. Access to Home Care Packages and residential aged care places is controlled by the Australian Government. The Australian Department of Health rations access according to the 'Aged Care Provision Ratio'.¹⁵⁷ This ratio means that care is not provided according to need or on an individualised basis. For instance, in 1984–85, the Australian Government committed to maintain a provision ratio of 100 residential aged care places for every 1,000 people aged 70 years or older within a region.¹⁵⁸ Continuing to link the provision ratio to people over 70 years obscures care needs of the majority of people in residential aged care: that is people aged 80 years or more.
101. Analysis by the Office of the Royal Commission shows that, if the ratio had been linked to the population aged over 80, rather than over 70, government expenditure on aged care in 2018-19 would have been over \$4.5 billion more than was actually spent.¹⁵⁹
102. The current aged care system, which relies on market pressures and 'consumers' actively making choices, does not work well for everyone. There is little stewardship over market structure, evolution and local conditions. In rural, regional and remote areas, and even in more populated regions where there are fewer or no trusted organisations, there can be little or no 'market' within which to make a choice about services. Specific planning to meet the needs of people in regional, rural, and remote Australia is not happening to the degree needed.¹⁶⁰ This leaves Australia's most vulnerable older people at even greater risk of being unable to access the services they need.

Inadequate governance and regulatory framework

103. The *Aged Care Act 1997* allows providers to decide what an 'adequate number of appropriately skilled staff' is to ensure the needs of people in their care are met.¹⁶¹ This is not working. As was predicted in 1997 when the Act was introduced, approved providers have been reducing their labour costs by cutting their staffing levels and

¹⁵⁶ Department of Health, *Australian Government Response to the Productivity Commission's Caring for Older Australians Report*, 2012, p 10.

¹⁵⁷ Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0008 [40].

¹⁵⁸ David Cullen, *Expenditure Constraints and Major Budget Measures*, A report for the Royal Commission into Aged Care Quality and Safety, 2020, p 4.

¹⁵⁹ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 114, RCD.9999.0522.0001 at 0008.

¹⁶⁰ Transcript, Mudgee Hearing, Graeme Barden, 6 November 2019 at T6557.14–35; Exhibit 12-25, Mudgee Hearing, Statement of Graeme Barden, WIT.0498.0001.0001 at 0009 [31] –[32]; Transcript, Mudgee Hearing, David Hallinan, 6 November 2019 at T6557.37–6561.31; Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0047 [191].

¹⁶¹ *Aged Care Act 1997* (Cth), s 54(1)(b).

replacing more expensive nurses with lower paid personal care workers.¹⁶² This has occurred as care needs, and especially clinical needs, have increased.¹⁶³

104. There are difficulties attracting enough people with the right skills to work in aged care.¹⁶⁴ This can be explained, in part, by the lack of competitive employment conditions and poor workforce planning and strategy by the Australian Government and the aged care sector.¹⁶⁵ Further, aged care workers often lack the requisite skills and training, including the ability to deliver culturally appropriate care.¹⁶⁶ This is attributable to a lack of minimum mandatory qualifications for personal care workers, and deficiencies with the training and education systems for personal care workers and health professionals.¹⁶⁷ There are also difficulties retaining workers. Approved providers could ensure better employee satisfaction and job retention through an improved work environment where employee feedback is valued and considered.¹⁶⁸
105. The current Aged Care Quality Standards are expressed in subjective language and in some respects, provide less detail than the standards they replaced. The standards lack any specific reference to meeting the needs of people living with dementia effectively, providing best practice oral health care, effective pain management, providing nutritional and culturally appropriate food and providing palliative care.¹⁶⁹

¹⁶² Productivity Commission, *Caring for Older Australians*, 28 June 2011, Vol 3, pp 204–205; National Institute of Labour Studies, *2016 National aged care workforce census and survey—the aged care workforce*, 2017 (Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 89, CTH.0001.1001.2805 at 2835).

¹⁶³ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at 0006 [28].

¹⁶⁴ See, for example, Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 89, CTH.0001.1001.2805 at 2871; 2880; 2930; 2945; Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at 0003 [13]–[15], 0004 [17], 0080 [354]–[355], 0126 [542]–[544].

¹⁶⁵ Exhibit 11-1, Melbourne Hearing 3, General tender bundle, tab 205, ACW.9999.0001.0022 at 0100; Senate Community Affairs References Committee, *Future of Australia's aged care sector workforce*, <https://engage.dss.gov.au/wp-content/uploads/2017/07/Aged-Care-workforce.pdf>, 2017, viewed 19 October 2020, p 55; Exhibit 1-35, Adelaide Hearing 1, RCD.9999.0011.0746 at [10.38].

¹⁶⁶ See, for example, Transcript, Adelaide Hearing 1, John McCallum, 11 February 2019 at T96.28–34; Transcript, Adelaide Hearing 2, Anna Hansen, 19 March 2019 at T830.20–30; Transcript, Cairns Hearing, Sandy Green, 17 July 2019 at T3791.12–16; Transcript, Sydney Hearing 1, Joseph Ibrahim, 16 May 2019 at T1796.22–36.

¹⁶⁷ See, for example, Transcript, Adelaide Hearing 1, Gerard Hayes, 21 February 2019 at T574.6–10; Exhibit 11-59, Melbourne Hearing 3, Statement of Sandra Hills, WIT.0450.0001.0001 at 0011 [62]–[63]; Transcript, Melbourne Hearing 3, Kylie Ward, 17 October 2019 at T6189.5.

¹⁶⁸ Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 1, RCD.9999.0176.0001 at 0036; Exhibit 15-1, Adelaide Hearing 3, Statement of Charlene Harrington, RCD.0011.0042.0003 at 0009; Aged Care Workforce Strategy Taskforce, *A Matter of Care – Australia's Aged Care Workforce Strategy*, 2018, p 44 (Exhibit 1-4, Adelaide Hearing 1, UVH.0001.0007.0001 at 0052).

¹⁶⁹ Exhibit 1-44, Adelaide Hearing 1, Statement of Maree McCabe, WIT.0005.0001.0001 at 0006 [28.7]–0007 [28.9]; Exhibit 3-51, Sydney Hearing 1, Statement of Peter Foltyn, WIT.0121.0001.0001 at 0006 [32]–0008 [43]; Australian Healthcare and Hospitals Association, Public Submission, AWF.001.01824.01 at 0004; Victorian Government, Public Submission,

106. Approved providers are assessed by the quality regulator, the Aged Care Quality and Safety Commission, as either ‘meeting’ or ‘not meeting’ the standards.¹⁷⁰ The overwhelming majority of providers are assessed as having met all minimum standards and outcomes. In the 2018–19 financial year, this figure was 93% of providers.¹⁷¹ This assessment does not enable meaningful comparisons of performance between approved providers, disguises the extent of poor performance, and does not reward good practice.¹⁷²
107. The quality regulator is too often reliant on approved providers to disclose information, and accepts reassurance from providers at face value.¹⁷³ There is a lack of curiosity by the regulator, and a focus on processes rather than outcomes.¹⁷⁴ There is perhaps no better example of this than the way the Aged Care Quality and Safety Commission approached the preparedness of the aged care sector for the COVID-19 pandemic. It asked approved providers to assess their own level of preparedness for a once in a century pandemic. An overwhelming majority of providers informed the regulator that their services’ preparations for the pandemic were either ‘satisfactory’ or ‘best practice’.¹⁷⁵ Subsequent events revealed this to be quite wrong in a number of cases.
108. Aged care enforcement is ‘enfeebled’.¹⁷⁶ Evidence about the performance of the Australian Department of Health when it was the primary regulator of aged care shows that it had a limited range of enforcement mechanisms and appeared to respond in a remarkably uniform way to non-compliance. Severe compliance action was rarely used.¹⁷⁷ There was a steady decrease in enforcement action from 2008, which only began to increase in the 2016–17 financial year.¹⁷⁸
109. Regulatory frameworks in key areas are deficient. Aged care provided in a person’s home is an area of high risk,¹⁷⁹ and yet the Australian Department of Health and the

AWF.001.014534.01 at 0045; Transcript, Darwin and Cairns Hearing, Sandra Iuliano, 16 July 2019 at T3670.37–47.

¹⁷⁰ K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, p 11.

¹⁷¹ Productivity Commission, *Report on Government Services 2019*, 2019, Table 14A.34.

¹⁷² Transcript, Adelaide Hearing 1, Ian Yates, 11 February 2019 at T73.20–38.

¹⁷³ Transcript, Brisbane Hearing, Gilda D’Rozario, 6 August 2019 at T4375.18–22; Transcript, Brisbane Hearing, Peter O’Brien, 7 August 2019 at T4505.22–4506.3.

¹⁷⁴ Exhibit 8-44, Brisbane Hearing, Document titled ‘Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai’, RCD.9999.0149.0001 at 0003 [3a]; Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4592.13–15.

¹⁷⁵ Exhibit 18-1, Sydney Hearing 2, General Tender Bundle, tab 10, RCD.9999.0381.0001 at 0002; Royal Commission into Aged Care Quality and Safety, *Aged care and COVID: a special report*, 2020, p 5.

¹⁷⁶ Exhibit 8-27, Brisbane Hearing, General tender bundle, tab 126, RCD.9999.0156.0001 at 0188.

¹⁷⁷ K Carnell and R Paterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, p 70; Exhibit 8-27, Brisbane Hearing, General Tender Bundle, tab 146, CTH.0001.1000.8094.

¹⁷⁸ Exhibit 8-27, Brisbane Hearing, General Tender Bundle, tab 146, CTH.0001.1000.8094.

¹⁷⁹ Transcript, Sydney Hearing 4, Robert Fitzgerald, 1 September 2020 at T8950.1–6.

Aged Care Quality and Safety Commission have acknowledged that the regulatory gaze in home care is not as strong as it needs to be.¹⁸⁰ Measures such as mandatory quality indicators and compulsory reporting of assaults, which are themselves limited as explained above, only apply to residential aged care. They are non-existent in home care.

110. Regulation of restrictive practices in aged care has been considerably lacking, and as long ago as 2014 was identified as a significant human rights issue in Australia.¹⁸¹ Recent changes to the regulation of restraints in aged care have not adequately addressed this important issue.
111. As noted earlier, the way providers respond to complaints is often inadequate. There is also often dissatisfaction with complaints handling by the regulator (and its predecessors).¹⁸² Reasons for this include that complainants feel there is a lack of transparency around the complaints process, that providers are not held to account, and that the resolution of complaints does not always translate to actual change. The views of people receiving care do not adequately inform the work of the regulator, and advocacy services for people in aged care are insufficient.¹⁸³

Failure to take opportunities for improvement

112. There has been an absence of leadership by successive governments when it comes to aged care. Even though the aged care system cares for more than 1.2 million older people, governments have treated it as a lower order priority. It has rarely merited a Minister at Cabinet level.
113. The Australian Department of Health should have access to comprehensive data to assess the performance and impact of services provided to older people. It does not.¹⁸⁴ There is a lack of data collection, poor interoperability between databases and an absence of data analysis.¹⁸⁵ As a result, no one is in a position to evaluate the

¹⁸⁰ Transcript, Adelaide Hearing 1, Janet Anderson, 18 February 2019 at T362.44–363.15; Exhibit 8-32, Statement of Amy Laffan, 8 August 2019, WIT.0282.0001.0001 at 0011 [64].

¹⁸¹ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws Report No 124*, 2014, p 243.

¹⁸² Exhibit 8-24, Brisbane Hearing, Statement of Gwenda Darling, 7 August 2019, WIT.0329.0001.0001 at 0003 [16], 0005 [31]; Exhibit 8-28, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0012 [75], 0013 [88]; Exhibit 8-39, Brisbane Hearing, Statement of Debra Barnes, WIT.0328.0001.0001 at 0007 [46]; Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August at T4705.46–4706.3.

¹⁸³ Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4597.33–36; Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4703.41–43; T4704.35–36.

¹⁸⁴ See, for example, Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0031 [125]; Submissions of the Commonwealth, Melbourne Hearing 2, 25 October 2019, RCD.0012.0035.0002 at 0016 [70]–[71]; Exhibit 9-6, Melbourne Hearing 1, Statement of Nicholas Hartland, WIT.0374.0001.0001 at 0009 [44]; 0020 [93]; 0021 [96]–[97].

¹⁸⁵ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0031 [125]; Transcript, Melbourne Hearing 2, Nicholas Hartland, 9 October 2019 at T5553.7–18;

performance of the whole of the system over the long-term against appropriately defined goals.

114. The aged care sector misses considerable opportunities in research and innovation. Reasons for this include that:

- a. funding for research on aged care quality and safety is difficult to access¹⁸⁶
- b. the aged care sector struggles to translate the results of research into practice
- c. the current funding and service models do not support providers who wish to try new practices, products, technologies and models of care¹⁸⁷
- d. the absence of quality data collected about older people and their experiences of aged care and other related services impedes the research and evaluation needed for the aged care sector to develop and safely adopt new and better care practices.¹⁸⁸

115. Approved provider peak bodies and their members have considerable input into the design and delivery of aged care.¹⁸⁹ Their voices are heard more loudly in the corridors of power than those of the people receiving care, the aged care workforce and local services.

116. Experts giving evidence to the Royal Commission voiced concerns that providers have too much influence over the aged care system and that policy reform processes are not adequately safeguarded from the risk of industry capture.¹⁹⁰ There appears to be a tendency to hear primarily from the same small group of interested parties on aged care policy, and a limited number of consumer groups are repeatedly relied upon to represent older people.¹⁹¹ The voices of aged care unions are often unheard.¹⁹²

T5558.36–5559.7; T5560.21–31; Transcript, Melbourne Hearing 2, Jaye Smith, 9 October 2019 at T5512.41–5513.3.

¹⁸⁶ Based on analysis of 'Summary of the results of the NHMRC 2019 Grant Application Round' data, <https://www.nhmrc.gov.au/funding/data-research/outcomes-funding-rounds>, viewed 23 April 2020.

¹⁸⁷ Transcript, Adelaide Hearing 1, Matthew Richter, 20 February 2019 at T528.37-41; Transcript, Sydney Hearing, Jennifer Lawrence, 14 May 2019 at T1603.30-33; Transcript, Cairns Hearing, Natasha Chadwick, 17 July 2019 at T3763.28-36.

¹⁸⁸ Transcript, Darwin Hearing, Johanna Westbrook, 11 July 2019, at T3237.5-8; K Carnell and R Paterson. 'Review of National Aged Care Quality Regulatory Processes', 2017, p 77.

¹⁸⁹ See, for example, Transcript, Adelaide Hearing 1, Paul Versteeg, 12 February 2019 at T157.1–9; Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4580.10–14.

¹⁹⁰ See, for example, Exhibit 8-44, Brisbane Hearing, Document titled 'Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai', RCD.9999.0149.0001 at 0018 [22(a)]; Exhibit 5-40, Perth Hearing, Statement of Lisa Trigg, WIT.0156.0001.0001 at 0026 [146].

¹⁹¹ Transcript, Sydney Hearing 1, Kate Swaffer, 17 May 2019 at T1937.8–10; Transcript, Sydney Hearing 1, Glenn Rees, 13 May 2019 at T1555.37–44.

¹⁹² See, for example, Transcript, Adelaide Hearing 1, Paul Versteeg, 12 February 2019 at T157.21–25; 158.1–6.

117. Finally, and perhaps most concerning of all, none of these many problems is revealed for the first time by this Royal Commission. In the last 20 years, there have been repeated reviews of aspects of the aged care system, many of which addressed recurring problems.¹⁹³ While we acknowledge that governments are not obliged to adopt all recommendations of a review, they have tended to respond with piecemeal reforms to aspects of the aged care system, which have not resolved the underlying problems. There have also been instances of significant delay in addressing or implementing important and urgent recommendations arising from reviews.¹⁹⁴
118. We submit that the above examination reveals not just the nature and extent of substandard care in the current aged care system but also its systemic causes. In so doing it enables us to lay out a series of reforms aimed at addressing those causes in a sustainable way which we will do in the remainder of these submissions. If implemented as an entire inter-connected package, those reforms should, over time, address those causes and thus improve the quality and safety of aged care in this country for the benefit of older people and ultimately the entire community.

¹⁹³ Office of the Royal Commission into Aged Care Quality and Safety, *Background Paper 8 – A History of Aged Care Reviews*, 2019; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 1, pp 67–69.

¹⁹⁴ See Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 1, pp 67–69; Exhibit 8-29, Brisbane Hearing, *Precis of evidence prepared by Ron Paterson*, RCD.9999.0143.0001 at 0004 [31].

PART 3 OUR BLUEPRINT FOR THE FUTURE

Part 3.1 Principles of the new aged care system

Background

119. The new aged care system in the home and community that is described and imagined in these submissions represents a fundamental and generational change in direction from the approach embodied in the existing legislation. In this portion of the submissions we seek to crystallise the matters of principle that should be formally recognised in the legislation that grounds the system.
120. As a matter of principle, the system is about supporting people to live well into old age, whether at home or elsewhere. It follows that the people receiving aged care services must be at the heart of the new aged care system: whether at home and alone or with a spouse, partner, family, carer or in some form of residential setting. As a matter of principle, the system must be about the people it is designed to serve.
121. The aged care system should actively encourage people receiving aged care to continue to enjoy rights of social participation available to members of society generally.
122. This should be reflected in legislation which establishes a rights-based approach, marking out certain clearly defined rights to be enjoyed by those who are applying for or receiving aged care. These rights should include the rights of carers. The approach that we have taken is to apply, with necessary contextual modification, the rights framework that has been adopted in the National Disability Insurance Scheme.
123. Applying this approach, the system should recognise people receiving aged care as individuals who have control over the planning and delivery of the care that they receive. It should recognise that people will have their own desires and goals for a meaningful life and their pursuit of happiness. It should make every attempt to support the person who needs care to live a life that is meaningful to them.
124. It follows that the care and support provided should be about enabling people, as far as possible, to continue to live their lives—regardless of poor health or any physical or cognitive impairment. It should be about reablement following illness or injury; focussed on re-establishing or maintaining living skills and restoring connection within their community. Hence, as a matter of principle, aged care should be about people being supported to live their own life in dignity, wherever they choose to do so.
125. Older people in need of care and support should have a universal right to high quality care. Care that is of high quality, safe, empowering and timely and which assists older people to live an active, dignified, self-determined and meaningful life.

126. The plan we propose is about all of us; it offers a long term blueprint for the care that we and our children will receive well into the future. In large part our efforts have been driven by a response to the very basic question: ‘How do we want to be looked after in old age?’
127. A useful starting point is to pose, rhetorically, a series of related questions to draw out the key principles that drive our submissions.

Where do we want to receive aged care?

128. We recognise that the vast majority of people that need care will want to receive it in their own home. Survey responses suggest that the older the person is, the stronger their preference to remain at home.¹⁹⁵ It is a powerful message and one that we have heard.
129. This should come as no great surprise: ageing at home can be central to a person’s sense of identity and independence.¹⁹⁶ Home is a place of familiarity, comfort and privacy, providing meaning and security in situations where major life changes need to be confronted.¹⁹⁷ At home, older people have more control over their routines with more opportunity to continue performing roles that are important to their sense of identity.¹⁹⁸ Remaining at home is also important in keeping people socially connected. The evidence is that people who are actively engaged in the community live longer, use fewer health services and have a better quality of life.¹⁹⁹
130. At the same time, there is a need to increase the availability of accessible housing throughout Australia, so that people can age and receive aged care services at home. Unsuitable housing poses greater risks of falls, injury and immobility, as well as the prospect of unanticipated or early entry into residential aged care.

How do we want to be looked after in old age?

131. Although the concept of what people want from aged care is highly subjective, there are essential principles that emerge from the evidence through the two years of this Royal Commission.
132. First, regardless of how frail, unwell or dependent a person may become, they have the right to dignity. When we talk about dignity, we are talking about the way that care should be delivered: to make the older person feel respected, giving recognition to them as a

¹⁹⁵ Roy Morgan, *What Australians Think of Ageing and Aged Care*, A survey for the Royal Commission into Aged Care Quality and Safety, 2020, p 4.

¹⁹⁶ J Wiles, A Leibing, N Guberman, J Reeve and R Allen, ‘The meaning of “aging in place” to older people’, *The Gerontologist*, 2012, Vol 52, 3, pp 357–366.

¹⁹⁷ C Bridge and H Kendig, ‘Housing and older people: environments, professionals and positive ageing’ in V Minichiello and I Coulson, *Contemporary issues in gerontology: promoting positive ageing*, 2005, p 165.

¹⁹⁸ D Stones and J Gullifer, ‘At home it’s just so much easier to be yourself: older adults’ perceptions of ageing in place’, *Ageing and Society*, 2016, Vol 36, pp 449–481.

¹⁹⁹ Transcript, Darwin and Cairns Hearing, Johanna Westbrook, 11 July 2019 at T3260.46–3261.1.

person. Dignity is about how people perceive themselves in their care setting through how they are treated and their interactions with others. Dignity in aged care requires care that is done *with* a person, not done *to* them.

133. Secondly, there must be express recognition of the control and choice that people receiving aged care must have over their own life. This means being actively involved in decisions about their life. Control and choice must always be respected. All decisions whether they involve going into residential care, deciding what to eat, when to wake up, when to wash, going outside for a walk, or even simply having the blinds open to see outside while locked down during a pandemic are important. To the extent that empowering people in aged care may involve risk, that risk should be approached by minimising harm and responsible management, not excluding it entirely. Risk is part of life. There is dignity in risk. Older people should be able to make decisions that may involve taking reasonable personal risks and their right to control and choice should prevail to the extent that it is reasonable and does not harm others.²⁰⁰
134. Many witnesses gave insights into care delivered without dignity and people having no control. The late Mr Bernard Cooney's example of the simple cup of coffee continues to resonate,²⁰¹ as does the experience of Ms Merle Mitchell who challenged the assertion that the room where she lived was her home, referring to it as an institution.²⁰²
135. Thirdly, there is the care itself. The high quality care we have just described must be defined, understood, funded, delivered and capable of being measured. High quality care is safe and insightful. It is delivered in a skilful and diligent manner through caring relationships that empower older people to achieve what they decide is important. High quality care enables the person to make decisions about change through a focus on quality of life and what is most effective for their wellbeing.
136. At the heart of the issue are relationships and interactions between people. The importance of building trusting, respectful and reciprocal relationships between everyone involved in caring for older people cannot be overstated. People and organisations who deliver aged care need to know and understand a person's history, goals, values and preferences. They need to find out what is important to those people they care for, and what those people want to be supported to do, how they react to certain scenarios, and how they live and want to live. Doing this requires investment of time, which must be recognised. The care provided to each person should be planned collaboratively with

²⁰⁰ Grattan Institute, *Rethinking aged care: emphasising the rights of older Australians*, <https://grattan.edu.au/wp-content/uploads/2020/10/Rethinking-Aged-Care-Grattan-Report.pdf>, viewed 9 October 2020, p 23.

²⁰¹ Transcript, Perth Hearing, Bernard Cooney, 28 June 2019 at T2784.19–31.

²⁰² Exhibit 3-1, Sydney Hearing 1, Statement of Merle Valma Mitchell, WIT.0107.0001.0001 at 0002 [19].

them, the people they share close relationships with and the provider. Care should be based on individual need and take into account a person's preferences and values.

137. The quality of life of people receiving care, encompassing both their social and emotional fulfilment, must also always be at the heart of aged care. Older people are entitled to receive aged care services that enable them to continue living their life, rather than creating a sense that quality of life is no longer achievable.
138. This means that the new system must do all that it can to protect people receiving aged care from mistreatment, neglect and harm from poor quality or unsafe care. People receiving care should be entitled to seek compensation for mistreatment, neglect or harm. The new system must provide the means to enable people receiving aged care to have a voice and must make provision for advocacy on their behalf. Complaint mechanisms should be focussed and effective.
139. Finally, the system must not be allowed to stagnate. There should be innovation, an embrace of technology, and be the subject of regular independent reviews.

Who do we want to deliver the care that we receive?

140. Aged care providers should be adequately funded to provide high quality care.
141. If there is one thing that is clear from the work of this Royal Commission, it is the clear connection between staffing levels and quality of care and safety in residential aged care. Going a step further, it is clear that higher nurse staffing levels contribute to better care: lower rates of pressure injuries, pain, infections, weight loss, dehydration, emergency room use, re-hospitalisations and mortality. Higher numbers of nursing staff are also linked to a lower use of antipsychotic medication.²⁰³

How should we be viewed as we age?

142. Ageist stereotypes of older people are reflected in the way older Australians are perceived and treated. Research prepared for the Royal Commission found that it was a widely held belief among those surveyed that that older Australians have value to society for reasons including their knowledge and experience and that society has an obligation to look after older people and care for them. However, older people were frequently associated with negative descriptions such as 'vulnerable', 'frail and slow', 'closed-minded', 'lonely' and 'scared'.²⁰⁴ As gerontologist Professor Erdman Palmore put it, 'ageism is so much a part of our culture that most people are not even aware of it. It

²⁰³ Exhibit 15-1, Adelaide Hearing 3, Statement of Charlene Harrington, RCD.0011.0042.0003 at 0003 [2].

²⁰⁴ IPSOS, *They look after you, you look after them: Community attitudes to ageing and aged care*, 2019, prepared for the Royal Commission into Aged Care Quality and Safety, pp 7, 19.

is like the air we breathe'.²⁰⁵ We submit that negative attitudes about the aged care workforce and working in aged care as a career are by-products of these sorts of attitudes.

143. Ageism may lead to older people being seen as incompetent when they are not, resulting in an 'overly protective response towards older people in aged care'.²⁰⁶ While this can sometimes be well-meaning, for example, by trying to keep people safe, it undermines a person's dignity and sense of control over their own lives.²⁰⁷ This can influence what people expect for themselves when they get older and stop them from reaching their true capabilities.²⁰⁸

144. We submit that one does not have to look far to see a culture in which older people are valued, respected and seen as valuable resource within the community. The approach of Aboriginal and Torres Strait Islander communities to their Elders is instructive for all of us. As observed in the Interim Report, Aboriginal and Torres Strait Islander people see Elders as central to the future of culture, deserving of respect and entitled to be looked after with dignity.²⁰⁹ We echo what Ms Venessa Curnow said at the Broome Hearing:

the old people are the ones that teach you how to go out on Country. They teach you all the songs, they teach you languages. So you have an innate respect for them and their place in community...we...wouldn't be here without the older people...looking after our older people is part of who we are...It's like our connection to their mother, and their mother before, and that's how we pass down our knowledge through the generations.²¹⁰

145. We submit that the final report should set a new bar for aged care in Australia.

146. Looking after older people should be a part of who we are. We should have an innate respect for them and elevate their place in our community. All of Australia should value and develop our connection with them.

147. The new standard of aged care should emphasise the need to develop and actually deliver a culture of excellence in aged care, reflecting the standard of personal and

²⁰⁵ E Palmore, 'Ageism comes of Age', *Journals of Gerontology: Social Sciences*, 2015, Vol 70, 6, pp 873–875 at 874.

²⁰⁶ Exhibit 5-26, Perth Hearing, Statement of Kay Patterson, WIT.0247.0001.0001 at 0007 [23]; Exhibit 5-5, Perth Hearing, Statement of Joanne Toohey, WIT.0168.0001.0001 at 0006.

²⁰⁷ Exhibit 5-26, Perth Hearing, Statement of Kay Patterson, WIT.0247.0001.0001 at 0007 [23].

²⁰⁸ T Gergov and I Asenova, 'Ageism and negative mental tendencies in the Third Age', *Psychological Thought*, 2012, Vol 5, 1, pp 69–74; V Minichiello, J Browne and H Kendig, 'Perceptions and consequences of ageism: views of older people', *Ageing and Society*, 2000, Vol 20, pp 243–278 at 255.

²⁰⁹ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol. 2, pp 177–178. Transcript, Broome Hearing, Faye Dean, 17 June 2019 at T1974.22–26; Transcript, Broome Hearing, Graham Aitken, 18 June 2019 at T2065.17–21.

²¹⁰ Transcript, Venessa Curnow, Broome Hearing, 19 June 2019 at T2186.16–26.

clinical care and support that older people should expect and receive as a matter of course.

148. With this background in mind, the key matters of principle that are developed in these submissions through recommendations seek to:
 - a. Recognise and give effect to the preference of older Australians to live in their own home as they age and provide them with the necessary support to enable them to do so.
 - b. Give older people a universal entitlement to high quality aged care based on assessed need; giving all Australians, of all ages, the expectation that high quality aged care will be available if needed.
 - c. Define the concept of 'high quality aged care', and using that concept for the purposes of, among other things, calibrating the necessary funding.
 - d. Elevate the role of informal carers.
149. New legislation is required to repeal the *Aged Care Act 1997* (Cth) and replace it with legislation that establishes the rights of the older Australian at the heart of the system. A range of international human rights instruments contain important provisions relevant to older people.²¹¹
150. The 1991 United Nations Principles for Older Persons adopted by the UN General Assembly reflects non-binding or soft law that is expressed in aspirational terms and is focussed on five key themes: independence, participation, care, self-fulfilment and dignity. Article 15 states that 'older persons should be able to pursue opportunities for the full development of their potential'.²¹² The aged care system that we propose is directed to these outcomes. These Older Persons Principles also state that older people have 'the right to make decisions about their care and the quality of their lives'. While a number of the 18 Articles go well beyond the terms of reference of this Royal Commission, the following Principles assist in marking out rights that should be recognised in the context of aged care in Australia:

²¹¹ The Constitution of the World Health Organization; the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the International Covenant on the Elimination of All Forms of Racial Discrimination (ICERD) and the Convention on the Rights of Persons with Disabilities (CRPD).

²¹² United Nations Human Rights Office of the High Commissioner, *United Nations Principles for Older Persons*, <https://www.ohchr.org/en/professionalinterest/pages/olderpersons.aspx#:~:text=Older%20persons%20should%20be%20able%20to%20live%20in%20dignity%20and,physical%20or%20mental%20abuse.&text=Older%20persons%20should%20be%20treated,independently%20of%20their%20economic%20contribution>, viewed 15 October 2020, article 15.

Independence

...

5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

Participation

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.

...

Care

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfilment

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.²¹³

151. The new Act must expressly protect and enhance the human rights of older people.
152. The current approach is insufficient in recognising older people's rights. The Aged Care Act is substantially a funding instrument where the rights of older people are picked up as an afterthought in a subordinate instrument. Set out in Schedule 1 to the *User Rights*

²¹³ United Nations Human Rights Office of the High Commissioner, *United Nations Principles for Older Persons*, <https://www.ohchr.org/en/professionalinterest/pages/olderpersons.aspx#:~:text=Older%20persons%20should%20be%20able%20to%20live%20in%20dignity%20and,and%20physical%20or%20mental%20abuse.&text=Older%20persons%20should%20be%20treated,independently%20of%20their%20economic%20contribution,viewed%2015%20October%202020>.

Principles 2014 (Cth) is the Charter of Aged Care Rights. The Charter is couched as consumer rights made under s 96-1 of the *Aged Care Act*, and does not sufficiently protect the rights of older Australians.

153. Although expressed as a charter of rights, the text does not establish any rights that are capable of enforcement, either by the individual or by the regulator on their behalf. Any rights-based approach must guarantee universal access to the supports and services that an older person is assessed as needing.²¹⁴
154. The rights in the Charter are largely aspirational; the older person's only recourse is via a complaint to the Aged Care Quality and Safety Commissioner. Further the rights in the Charter are not contained in the legislation itself, but in subordinate legislation that can be changed at any time.
155. The rights in the Charter also only apply once someone has obtained a place in the system and has signed an agreement to take up a place. Critically, they do not extend to those who are waiting for a place on the various waiting lists which have been referred to. This falls well short of providing an adequate rights-based approach.
156. We agree with the Grattan Institute's criticism of the current approach in a recently published paper concerning the deficiencies in the existing system.²¹⁵ Our approach is a rights-based approach to aged care; with guiding principles that set out for everyone (that is, people who are receiving or who will receive aged care, policy makers, approved providers, and the broader community) the broad aims of the aged care system.
157. The guiding principles set out below should be embedded in every part of the system, from overarching aged care policy development through to on-the-ground aged care service delivery. These principles should inform the drafting and interpretation of the legislation establishing the new aged care system.
158. It is the basis of the first recommendation that we submit should be made.

Recommendation 1: A new Act

1.1. The *Aged Care Act 1997* (Cth) should be replaced with a new Act to come into force by no later than 1 July 2023. The objects of the new Act should be to:

²¹⁴ This approach parallels that of the National Disability Insurance Scheme. See *National Disability Insurance Scheme Act 2013* (Cth), s 4(3); Council on Federal Financial Relations, *Addendum to National Health Reform Agreement 2020-2025*, https://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf, viewed 15 October 2020, p 8 [8].

²¹⁵ Grattan Institute, *Rethinking aged care: emphasising the rights of older Australians*, <https://grattan.edu.au/wp-content/uploads/2020/10/Rethinking-Aged-Care-Grattan-Report.pdf>, viewed 9 October 2020, p 20.

- a. provide a system of aged care based on a universal right to high quality, safe and timely support and care to:
 - i. assist older people to live an active, self-determined and meaningful life, and
 - ii. ensure older people receive high quality care in a safe and caring environment for dignified living in old age
 - b. protect and advance the rights of older people receiving aged care to be free from mistreatment and neglect, and
 - c. harm from poor quality or unsafe care, and to continue to enjoy rights of social participation accessible to members of society generally
 - d. enable people entitled to aged care to exercise choice and control in the planning and delivery of their care
 - e. ensure equity of access to aged care
 - f. provide advocacy and complaint mechanisms for people receiving aged care
 - g. provide for regular and independent review of the aged care system
 - h. promote innovation in aged care based on research
 - i. promote positive community attitudes to enhance social and economic participation by people receiving aged care.
- 1.2. The new Act should state that the above objects are to be achieved by establishing:
- a. the Australian Aged Care Commission
 - b. the Australian Aged Care Pricing Authority
 - c. the office of the Inspector-General of Aged Care
- and by the other provisions of the Act.
- 1.3. The new Act should:
- a. define aged care as:
 - i. support and care for people to maintain their independence as they age, including support and care to ameliorate age-related deterioration in their social, mental and physical capacities to function independently

- ii. supports including respite for informal carers of people who need aged care
- b. provide that the paramount consideration in the administration of the Act should be ensuring the safety, health and wellbeing of people receiving aged care
- c. specify the following principles that should also guide the administration of the Act:
 - i. Older people should have certainty that they will receive timely high quality support and care in accordance with assessed need
 - ii. Informal carers of older people should have certainty that they will receive timely and high quality supports in accordance with assessed need
 - iii. Older people should be supported to exercise choice about their own lives and make decisions to the fullest extent possible, including being able to take risks and be involved in the planning and delivery of their care
 - iv. Older people should be treated as individuals and be provided with support and care in a way that promotes their dignity and respects them as equal citizens
 - v. Older people are entitled to pursue (and to be supported in pursuing) physical, social, emotional and intellectual development and to be active and engaged members of the community, regardless of their age or level of physical or cognitive capability
 - vi. The relationships that older people have with significant people in their lives should be acknowledged, respected and fostered
 - vii. To the fullest extent possible, older people should receive support and care in the location they choose or, where that is not possible, in the setting most appropriate to their circumstances and preferences
 - viii. Older people are entitled to receive support and care that acknowledges the aged care setting is their home and enables them to live in security, safety and comfort with their privacy respected

- ix. Older people should have equal access to support and care irrespective of their location or personal circumstances or preferences
- x. Care should be provided in a healthy environment which protects older people from risks to their health
- xi. Care and supports should, as far as possible, emphasise restoration and rehabilitation, with the aim of maintaining or improving older people's physical and cognitive capabilities and supporting their self-determination
- xii. Aboriginal and Torres Strait Islander people are entitled to received support and care that is culturally safe and recognises the importance of their personal connection to community and Country
- xiii. The system should support the availability and accessibility of aged care for all older Australians, including special or vulnerable groups
- xiv. The aged care system should be transparent and provide public access to meaningful and readily understandable information about aged care
- xv. Innovation, continuous improvement and contemporary best practice in aged care are to be promoted
- xvi. Older people should be supported to give feedback and make complaints free from reprisal or adverse impacts
- xvii. People receiving aged care should respect the rights and needs of other people living and working within their environment, and respect the general interests of the community in which they live; the rights and freedoms of people receiving aged care should be only limited by the need to respect the rights of other members of their community.

1.4. The new Act should specify a list of rights of people seeking and receiving aged care, and should declare that the purposes of the Act include the purpose of securing those rights and that the rights may be taken into account in interpreting the Act and any instrument made under the Act. The list of such rights should be:

- a. for people seeking aged care:
 - i. the right to equitable access to care services

- ii. the right to exercise choice between available services
 - b. for people receiving aged care
 - i. the right to freedom from degrading or inhumane treatment, or any form of abuse
 - ii. the right to liberty, freedom of movement, and freedom from restraint
 - iii. the right of autonomy, the right to the presumption of legal capacity, and in particular the right to make decisions about their care and the quality of their lives and the right to social participation
 - iv. the right to fair, equitable and non-discriminatory treatment in receiving care
 - c. for people receiving end-of-life care, the right to fair, equitable and non-discriminatory access to palliative and end-of-life care.
- 1.5. Unless indicated otherwise, the new Act should incorporate provisions giving effect to amendments to the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth) (as well as to delegated legislation made under those Acts) the subject of other recommendations.

159. The new Act should provide that the objects of the Act are to be achieved through the establishment of the following independent statutory bodies:

- a. the Australian Aged Care Commission to assume responsibility from the Australian Department of Health as the overall system governor with the general administration of the new Act
- b. the Aged Care Pricing Authority to assume the role of ensuring that prices for aged care services are determined independently on the basis of benchmarking and cost data
- c. the office of the Inspector-General of Aged Care who will have primary responsibility for oversight of the Commission's performance of its various functions.

160. We return to these independent statutory bodies later in these submissions.

Recommendation 2: Integrated long-term support and care for older people

- 2.1. The Australian Government should coordinate the development of an integrated system for the long-term support and care of older people providing for their needs for welfare support, community services directed at enhancing social participation, affordable and appropriate housing, high quality health care, and aged care, through a new National Cabinet Reform Committee on Ageing and Older Australians, to be established between the Australian and State and Territory Governments, and composed of the highest-ranking ministers whose primary responsibility is the care, health and wellbeing of older people.
- 2.2. Work on a strategy to develop the integrated system for the long-term support and care of older people should begin immediately. That work should involve consultation with older people. The strategy should be agreed between the Australian and State and Territory Governments by 31 December 2022. The strategy should include measurable goals, regular reporting on progress to the National Federation Reform Council, and two-yearly public progress reports.
- 2.3. The strategy should provide for implementation of an integrated system for the long-term support and care of older people within a 10-year period.

161. There is a clear need for a deeper engagement between community and health services and older Australians. Aged care is only one piece in the system of supports that older people need.
162. In the 20 years since the 2001 *National Strategy for an Ageing Australia*, there have been efforts to improve health, wellbeing and social participation of older people across all levels of government; however there has been limited concerted national effort to bring this work together.
163. Although public policy is often framed in terms of an ageing crisis and the associated burdens on both the economy and the population overall of such a crisis, there needs to be recognition that increased life expectancy provides opportunities that should be embraced and developed.²¹⁶ Longer lifespans are a valuable resource for society. Older people contribute to society in a number of ways, including as mentors, entrepreneurs, consumers, caregivers, volunteers and friends.

²¹⁶ As to the economic challenges associated with an ageing population, see Department of Treasury, *Australian to 2050: future challenges*, https://treasury.gov.au/sites/default/files/2019-03/IGR_2010.pdf, viewed 15 October 2020.

164. Cross-generational engagement and programs have been and should continue to be established to link older people to their communities.
165. There should be an integrated system for the long-term support and care of older people and their ongoing engagement with the rest of the community. This requires the involvement of all levels of government and establishing linkages between aged care and other relevant domains, such as:
 - a. the broader health sector and welfare and community services
 - b. affordable and age appropriate housing
 - c. the education sector.
166. Such a system should be the focus of a National Cabinet Reform Committee on Ageing and Older Australians. The placement of the issue on the National Cabinet agenda is about elevating the rights of older people.
167. The Australian Government's role is clear; however, the State and Territory Governments also have a critical role to play. Their service coverage is critical. All States and Territories other than the Northern Territory and a number of local governments have developed some form of ageing-related strategy. Therefore, they should be actively engaged in the process.
168. The strategy proposed should include measurable goals, regular reporting on progress to the newly established National Federation Reform Council; recognising that national leadership is required and that each level of government has a role to play in helping people age well throughout their life.
169. The strategy should initially cover a 10-year period after which time it should be comprehensively reviewed to inform development of the next strategy. The strategy should be about:
 - a. supporting people to reach their full capacity so that people are able to enjoy more healthy and meaningful years of life
 - b. providing supportive and inclusive environments that promote dignity, independence and fulfilment despite any significant physical or cognitive incapacity
 - c. establishing and enhancing mechanisms within the community that foster inclusion
 - d. taking a proactive approach to preparing for older age – including engaging in healthy behaviours to promote health and function across the lifespan and adequately planning for future care needs.
170. A key element of the strategy should be about encouraging older Australians (and those who are soon to be older Australians) to take active steps to preserve and maintain their

own health and wellbeing in later life, with the governments supporting people to take the first step. Focus areas for the strategy should be identified and led by older people.

Part 3.2 Design of the new aged care system

171. The Terms of Reference require the Commissioners to inquire into what ‘the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe’.²¹⁷

The nature and key elements of the aged care system

172. The term ‘the aged care system’ has been heard frequently in the Royal Commission’s work. But what is actually meant by it? It is necessary to understand it before making submissions on the design of its governance arrangements. The Office of the Royal Commission conducted a consultation process about governance of the aged care system in the period June to October 2020, in the course of which many interested parties made submissions, and selected experts made witness statements, which were ultimately tendered into evidence at a hearing in September.²¹⁸ After analysis of this material and the evidence received over the course of the inquiry, we offer the following observations.

173. The ‘aged care system’ is a composite description of all the entities, structures, people and processes contributing to how aged care is provided, regulated and funded, and the policies that shape the content of aged care.

²¹⁷ Letters Patent, 6 December 2018, as amended on 13 September 2019 and 25 June 2020, paragraph (d).

²¹⁸ Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle. Submissions received in relation to system governance are available on the Royal Commission’s website at: <https://agedcare.royalcommission.gov.au/submissions/read-published-submissions/system-governance-submissions>.

174. Aged care²¹⁹ is a wide array of services defined and subsidised by government, and delivered by more approximately 3,000 approved providers conducting thousands of ‘services’ or outlets throughout the country.²²⁰
175. The core components of the aged care system in Australia are:
- a. those who need and receive aged care services and their families and friends
 - b. those who deliver aged care – the aged care workforce and informal carers and volunteers²²¹
 - c. the approved providers of aged care services.
176. The structure and functioning of the aged care system cannot be understood or improved without taking into account the way it interacts with:
- a. the health care system
 - b. the wider community
 - c. the Australian Government and other tiers of government.
177. In his evidence, Mr Michael Lye, Deputy Secretary for Ageing and Aged Care, Department of Health, described the aged care system as a ‘distributed system’ which

²¹⁹ The Royal Commission’s Terms of Reference define ‘aged care services’ as services provided by four categories of service provider (Letters Patent, 6 December 2018, p 5 ‘aged care services’). The first is approved providers under the *Aged Care Quality and Safety Commission Act 2018* (Cth): providers of home care, residential care and flexible care (flexible care comprises Transition Care, Short-Term Restorative Care, Multi-Purpose Services, and Innovative Care: *Aged Care Act 1997* (Cth), ss 49-3, 50-2; *Subsidy Principles 2014* (Cth), ss 103-106A; Department of Health, 2018-2019 Report on the Operation of the Aged Care Act 1997, 2019, p 54). The second is entities to which grants are payable under Chapter 5 of the *Aged Care Act 1997*, which includes capital grants, advocacy grants and community visitor grants (*Aged Care Act 1997* (Cth), ch 5). The third is entities to which funding is payable under a program relating to aged care specified in Schedule 1AA or 1AB to the *Financial Framework (Supplementary Powers) Regulations 1997*, which includes (*Financial Framework (Supplementary Powers) Regulations 1997* (Cth), schs 1AB, 1AA, pt 4) aged care programs for access and information, home support (such as the Commonwealth Home Support Programme), residential and flexible care (such as the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme), workforce and quality and ageing and service improvement (such as the Dementia Support Australia) (*Financial Framework (Supplementary Powers) Regulations 1997* (Cth), sch 1AA, pt 4, items 415.016-020). The fourth is entities that receive funding for the purposes of the Veterans’ Home Care Program established under the *Veterans’ Entitlements Act 1986* (Cth).

²²⁰ Australian Department of Health, 2018-2019 Report on the Operation of the Aged Care Act 1997, 2019, pp x-xi. Chapter 1, Vol 1, of the Interim Report, provided a detailed overview of the scope of the services encompassed, the historical development of the sector and the iterations of subsidy programs that have supported it, and its current programs, funding and regulation.

²²¹ The workforce includes personal care workers in home and residential care, registered nurses, general practitioners, medical specialists, allied health professionals, cooks and cleaners. Counsel Assisting made specific workforce submissions in February 2020, some of which will be repeated or expanded upon in these submissions (Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001). It is important to recognise the workforce as a core component of the aged care system. The aged care workforce should be sufficiently trained and qualified to be capable of providing high quality and safe aged care.

is 'not a government service' due to the way it is funded. He described it as 'in large part [a] not-for-profit and for-profit service delivery system'. He stated that:

residential aged care facilities have primary responsibility for the management of their – their service. And so they need to exercise judgment within their own legal responsibilities. And so as a distributed service, we – we can't assume that responsibility from them.²²²

178. There are wide variations in local conditions and resources that affect the delivery of aged care. The composition of approved providers is also varied. A large majority are autonomous, privately owned entities, many of which are constituted as not-for-profit entities and others as for-profit entities.
179. Drawing on the work of American economists Vincent and Elinor Ostrom, the statements received from both Professor Gary Sturgess, NSW Premier's Australian and New Zealand School of Government Chair in Public Service Delivery, and Associate Professor Gemma Carey, Research Director at the Centre for Social Impact, provide insights in to the special challenges of designing and managing systems that are not private markets but that depend heavily on government funding and commissioning. Such markets are called 'quasi-markets' or 'mixed economies', and the design of these systems must be constantly refined in the course of management, meaning that it may be arbitrary to draw distinctions between management and design.²²³
180. For more than two decades the Australian Government has had significant policy and administrative responsibilities for aged care. Since reforms set out in the 2012 National Health Reform Agreement, the Australian Government's responsibilities for aged care have been exclusive of the States and Territories. Responsibility for understanding and if possible pre-empting problems in the system, has lain with the Australian Government, and in particular with its responsible Ministers and Departments of State, principally the Australian Department of Health.
181. The Minister for Aged Care and Senior Australians and the Australian Department of Health have had tools available to achieve effective leadership of the aged care system. The Department has been the dominant funder of aged care services, it has been in a position to create mechanisms for measuring performance of the aged care system and identifying areas for improvement, and it has been responsible for design of the method for regulation of the quality and safety of aged care services. Only quite recently have all the Department's responsibilities for quality and safety regulation been divested to an

²²² Transcript, Sydney Hearing 2, Michael Lye, 12 August 2020 at T8647.42–8648.2.

²²³ Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 1, RCD.9999.0352.0001, especially at 0002 [8] and 0007 [22.2]–[22.4]; Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 5, RCD.9999.0417.0008 at 0014 [37] and 0017 [56].

independent body, the Aged Care Quality and Safety Commission (on 1 January 2020).²²⁴

182. The Department of Health has also, for many years, been responsible for funding approved providers either by direct grant agreements made between the Department and providers, or mechanisms that mimic the operation of a market, whereby subsidies for services to be provided to particular individuals are channelled to the providers engaged by those individuals. Implicit in being the dominant funder, the Australian Government is the head of the 'supply chain' in the aged care system.²²⁵
183. The trajectory of policy development has been to encourage competition between providers of aged care services in the expectation that competitive market forces would tend to lead to innovation and to improvements in quality and outcomes for people who need care. The legislative and regulatory framework of and under the *Aged Care Act 1997* (Cth) has encouraged this approach, and has used language reflective of it, such as by describing people who need aged care as 'consumers' and emphasising the protection of consumer rights.²²⁶
184. Consistently with this market-based perspective, the Department has tended not to take a proactive active system governance role. Instead, it has tended to react to adverse developments, often belatedly. In short, there has been a vacuum in the area of system leadership and an unspoken assumption that market forces should generally be left to themselves, subject to quality regulation of the providers.
185. However, it is unsafe to rely on market forces putting downward pressure on prices or upward pressure on quality or otherwise to protect the interests of the people who need and receive aged care services. At least, no general assumptions can be made about this. Although there may be some geographic areas of workably competitive markets for the supply of aged care services, it is unclear how far these extend and how effective they are. It is also unclear whether the supply of aged care services appropriately tailored to meeting diverse needs can be achieved in all geographic areas, particularly those in regional and remote areas, and whether it can be described as workably competitive.²²⁷

System governance challenges

186. Effective leadership of a distributed system such as the aged care system is no simple matter. Mr Lye is correct in his observation that approved providers are each responsible for providing high quality and safe aged care, and the autonomy of the various providers

²²⁴ *Aged Care Legislation Amendment (New Commissioner Functions) Act 2019* (Cth).

²²⁵ Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0001.0001 at 0003 [47].

²²⁶ See for example: *User Rights Principles 2014* (Cth), section 5(1)(a), (b), (ca), (d) and (e).

²²⁷ Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020, T9443.17-20; Transcript, Mudgee Hearing, David Hallinan, 6 November 2019 at T6562.16–20.

presents special challenges to the way in which leadership should be exercised. However, this is not a reason for abdication of system governance responsibility by the Australian Government. Rather, for reasons which we will now outline, it calls for a particular form of governance that reflects the Australian aged care system. The hallmark of effective governance of a system of this kind is that it should adopt a proactive, adaptive approach of steering the system toward strategic objectives, rather than a direct command and control approach.

- a. The characteristics of the system identified above inject complexity into the arrangements needed to define, commission, fund, deliver and regulate aged care, and the way the elements all interact. Academic literature on the nature of 'complexity' in systems yields an important insight: in a 'complex' system attempts to deal separately with particular causes, or to control outcomes are unlikely to succeed.²²⁸
- b. Not only is aged care in Australia complex, it is what systems theory calls a 'complex *adaptive* system', that is, 'a system often involving human activities and dynamics that make it continuously emergent and with only limited predictability'.²²⁹ It is 'adaptive' because the participants in the system, including the service providers, have sufficient autonomy to adapt their behaviours in response to changes, such as government interventions, new policies and environmental or health emergencies. Most participants will see the system from only their perspective. Corporate service providers will seek to pursue their own interests, and for-profit companies will seek to maximise margins and returns to the extent they consider it prudent to do so. All will adopt behaviours in response to interventions, and the behaviours of other participants, with a degree of autonomy and self-interest.
- c. Confronted by such challenges, it is difficult, and probably inadvisable, to 'draw hard boundaries around what government should do'.²³⁰ Effective governance of

²²⁸ R Poli, 'A Note on the Difference Between Complicated and Complex Social Systems', *Cadmus*, 2013, Vol 2, 1, pp 142-147. In a complex system, there are: 'multiple interacting causes that cannot be individually distinguished; must be addressed as entire systems, that is they cannot be addressed in a piecemeal way; they are such that small inputs may result in disproportionate effects; the problems they present cannot be solved once and for ever, but require to be systematically managed and typically any intervention merges into new problems as a result of the interventions dealing with them; and the relevant systems cannot be controlled – the best one can do is to influence them, learn to "dance with them" ...'. The expression 'dance' with systems was coined by Donella Meadows: See D Meadows, *Thinking in Systems – a primer*, 2009, pp 166-185.

²²⁹ The Organisation for Economic Cooperation and Development (OECD) definition of a complex adaptive system. OECD, *Systems Approaches to Public Sector Challenges: Working with Change*, 2017, p 131.

²³⁰ See J O'Flynn and GL Sturgess, *2030 and beyond: getting the work of government done*, Australia & New Zealand School of Government, 2019, p 15.

such systems must be dynamic and purposeful.²³¹ System governance must cater for potential unintended consequences and varied participant motivations. The legislative framework should provide tools for a system ‘steward’ to set goals and evaluate the performance of each critical level of the system, and to correct and refine performance over time. We prefer to use the expression ‘governance’ rather than ‘stewardship’ to emphasise that the role should be exercised proactively. The goals should be fixed but the ways of attaining them should be flexible. Regular review of performance should involve an iterative process of communication between the participants who deliver services, the institution that commissions them, and policy makers. Delivery methods should be refined and improved in light of practical experience, funding constraints and other realities. Processes of this kind have been described by experts in government studies as critical to effective government commissioning of services.²³²

187. In addition, effective governance of a system of this kind requires keen attention to be given to key features of the context with which the aged care system operates, as mentioned above.
- a. The health care system must remain readily accessible and effective for people receiving aged care, impediments to access to the various tiers and forms of health care that are available to the general community must be removed or at least ameliorated, and responsibilities for securing access to health care must be clarified.
 - b. The responsibility of the wider community for a respectful, supportive approach to ageing, the personhood and human rights of older people, and their social inclusion and social and economic participation.
 - c. Across the various portfolio responsibilities of the Australian Government, and across the different tiers of government in Australia, there is much to be gained from a more coherent and co-operative approach to advancing the interests of older people across areas such as health, housing, welfare, industry innovation, workforce, education and training, community services and recreation.

Shortfalls in the governance of the aged care system

188. The aged care system serves us all. We all have someone that we know—a family member, a mum or dad, a partner, a friend—who at a point in their older years has needed aged care services. For some, this has meant receiving assistance around the home

²³¹ See S J O’Flynn and GL Sturgess, *2030 and beyond: getting the work of government done*, Australia & New Zealand School of Government, 2019, pp 12–13.

²³² See for example Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 5, RCD.9999.0417.0008 at 0024–0025 [106]–[107].

and for others, a move out of home into a residential aged care facility. Many of those who reach old age will require aged care services in some form or another. Adapting the words of Commissioner Tracey we have already mentioned, the measure of how well the system of aged care system functions and treats older people is a reflection on all of us.

189. Many of the witnesses before the Royal Commission spoke of their experiences as people who have received, or whose family members have received aged care services, or of their experience working in the aged care system. Some of these accounts are summarised in Part 1, of these submissions, above. The body of evidence comprising these accounts demonstrates that the needs of older people are not being met by the current aged care system to the extent that they deserve and the community expects.
190. Community sentiment about the aged care system is self-evident – Australians expect more from their aged care system than what they are currently getting. Research commissioned from a team based at Flinders University demonstrates a willingness to make a greater financial contribution to secure this.²³³
191. In October 2019, Commissioners Tracey and Briggs described the system of aged care in Australia as one in crisis.²³⁴ A key and tragic impact of the COVID-19 pandemic has been to highlight the existing weaknesses and shortcomings in the aged care system. This includes inadequate staffing levels by approved providers, a scarcity of clinically skilled frontline staff, the lack of planning and the reactive nature of governance of the system. Put simply, the aged care system has been under prolonged stress in its current form for many years and it had reached crisis point. This has only been exacerbated under pandemic conditions.
192. What then, do Australians expect of their aged care system? The community expects that older people who experience deterioration or impending deterioration in their ability to function independently in their daily lives, will be assisted to maintain their independence, health and wellbeing, and that they will receive high quality and safe aged care services to help them achieve this. Further, that where taxpayer funds are being provided to approved providers of aged care services, Australians expect accountability in the expenditure of those funds to deliver high quality and safe aged care services.
193. In Part 2 of our submissions we have identified certain systemic shortcomings which have contributed to poor quality or unsafe aged care. Noteworthy and prolonged

²³³ Flinders University, *Australia's aged care system: Assessing the views and preferences of the general public for quality of care and future funding*, A research paper for the Royal Commission Research into Aged Care Quality and Safety, 2020, p 48.

²³⁴ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 1, p 70.

systemic failures, or reactive and belated responses, have occurred in at least three key areas, home care, funding and restrictive practices.

Shortfalls in the area of home care

194. Wait times for the assignment of Home Care Packages have been unacceptably lengthy for several years. By 2018, the wait time was up to 22 months for higher level packages.²³⁵ Government announcements in relation to additional Home Care Packages have not kept pace with the demand reflected in the national waiting list.²³⁶
195. The Australian Government assumed responsibility for all forms of in-home aged care with the transition of the State-administered Home and Community Care Program to the current Commonwealth Home Support Programme from 2012, but the Australian Government has not established organisational arrangements for local system management to replace the role previously played by states and local government. This has led to gaps in planning, development and management of services.²³⁷
196. Regulation of the quality and safety of home care services is weak. Threshold requirements for the approval of providers are not rigorous, and months can pass before a quality review is performed upon a newly established home care service. Even then, regulatory visibility of in-home care is limited. The Aged Care Quality and Safety Commissioner has acknowledged the need for improvement of home care quality and safety regulation.²³⁸

Shortfalls in the area of funding

197. It is surprising that the aged care system does not yet have a mechanism for independent review of the cost of providing high quality aged care, to inform the setting of subsidies and (where appropriate) prices at levels that will enable the provision of high quality care.
198. The Productivity Commission recommended this in its 2011 report, as one of the functions of a recommended independent commission.²³⁹ However, the Australian

²³⁵ Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, WIT.0058.0001.0001 at 0021 [63].

²³⁶ Transcript, Adelaide Hearing 2, Paul Sadler, 18 March 2019 at T731.29–36.

²³⁷ Exhibit 2-86, Adelaide Hearing 2, Statement of Professor Swerissen, 15 March 2019, WIT.0085.0001.0001 at 0005 [25]–[26].

²³⁸ Transcript, Adelaide Hearing 1, Janet Anderson, 18 February 2019 at T362. 44–T363.15; Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9039,20–24. See also Exhibit 8-32, Statement of Amy Laffan, 8 August 2019, WIT.0282.0001.0001 at 0011 [64].

²³⁹ Productivity Commission, Inquiry Report no. 53, *Caring for Older Australians*, 28 June 2011, Vol 1, p XLVI, and Recommendation 15.1, p LXXII–LXXVII. That report recommended an independent commission whose functions would include the '*monitoring, reporting and assessing costs and transparently recommending a scheduled set of prices, subsidies and a rate of indexation for approved aged care services*'. Other functions of the independent commission included regulatory functions covering the quality of community and residential care, prudential requirements and supported resident ratios, assisting and educating providers, providing information, collecting and disseminating data, determining and referring complaints, and handling reviews.

Government did not accept that recommendation stating that the benefits of an independent agency are 'unlikely to outweigh the substantial start-up costs of establishing such an agency'.²⁴⁰ However the Department of Health now appears to support the introduction of independent pricing.²⁴¹ The government's inaction on this topic is difficult to understand. It has been evident in the years since the Productivity Commission report that it is sorely needed.

199. As we outline in more detail in Part 3.15 Proposed Funding Arrangements, in his evidence, the former Chair of the Aged Care Financing Authority, Mr Michael Callaghan AM PSM, described a lack of trust between Australian Government and approved providers over funding. Mr Callaghan also said that 'many of the key attributes of sound governance arrangements were missing'.²⁴² Mr Callaghan proposed that an independent pricing mechanism, operating within well defined-functions under limited objectives, would assist to dispel that mistrust.²⁴³
200. The mistrust to which Mr Callaghan referred was stoked by Australian Government claims about the practices of approved providers in making claims for funding under the Aged Care Funding Instrument (**ACFI**), government concerns about its fiscal position and about exceeding the forecasted aged care expenditures, and decisions by government to change the indexation approach and funding criteria for residential aged care under ACFI.²⁴⁴
201. It is unsurprising that these events occurred and that this mistrust developed. In our submission, they were generated by structural aspects of the aged care system and its governance arrangements, and in particular the exposure of system governance to decision-making based directly on the Australian Government's fiscal position. The focus of system governance should be on the continuity and quality of aged care, and should not be distracted by direct consideration of the Government's fiscal policies. Yet the scope for fiscal policy to exert a direct effect on aged care system governance was

²⁴⁰ Department of Health and Ageing, 2013, Australian Government response to Productivity Commission's Caring for Older Australians Report, response to recommendation 15.1.

²⁴¹ In his evidence before the Royal Commission, the Secretary of the Department, expressed support for independent pricing (Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020, T9434.39–43): 'But I think all of us, all parties agree that the way out of this is to get a proper independent transparent pricing system and a new case mix funding model. And so we are at one on that approach going forward, the sector and the Department, so rather than continually re-prosecute the past on ACFI and what has or has not happened, we would prefer to look forward and move to something that is trusted and transparent and agreed by all as the way forward.'

²⁴² Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 6, WIT.1364.0001.0001 at 0005 [26].

²⁴³ Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020, T9323.5–9324.33.

²⁴⁴ See Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 6, WIT.1364.0001.0001 at 0005 [26]–[28]; see also Transcript, Sydney Hearing 5, Michael Callaghan, 17 September 2020, T9318.14–9319.21.

present from the inception of the new residential aged program launched under the *Aged Care Act 1997* (Cth). This is clear from advice to government by the Department of Health and Family Services and the Department of Finance at the time. A Cabinet Memorandum from those Departments received by the Cabinet Office on 27 March 1997, relating to the integration of two previously separate programs for residential care (in either hostels or nursing homes), is now publicly available from the National Archives.²⁴⁵ The memorandum identifies the ‘billions’ in savings that had been achieved to that time by ‘capping service provision’, the ‘risks’ to the government’s fiscal position presented by the new program over the long term, and various mechanisms available to the government to control the costs of the system ‘over the forward years’.²⁴⁶

Government has total control over all of its parameters – the number of care classifications, the number of residents in each of them and the amount of funding that attaches to each classification – and so total control of its theoretical cost.

202. The memorandum presented ‘Options’ including:²⁴⁷

Options that would be available, should Ministers decide at some point to consider further risk reduction measures, include enhancing the management controls on the number of high care or low care (nursing home or hostel) places, applying quotas to numbers of people at various care levels, an efficiency dividend or other adjustment to funding structures, various offsetting savings measures or changes to service provision benchmarks.

203. The reference to an ‘efficiency dividend’ can be related to the method for calculation of annual indexation of funding levels adopted by the Australian Government in the years since 1997, which we address in detail in Part 3.15, below. However all of the options identified in this passage of the memorandum are of concern. The suggestion that there might be changes to ‘service provision benchmarks’ is particularly disturbing, as this goes beyond rationing and implies the possibility of reductions in quality levels to justify limitations in funding.

204. As we outline in more detail in Part 3.15, the Royal Commissioners received evidence about the indexation pauses applied by the Department to residential care funding in 2012 and 2016, and their effect on approved providers.²⁴⁸ The financial year 2017-18

²⁴⁵ Departments of Health and Family Services and Finance, Cabinet Memorandum, Residential Aged Care – Long Term Outlays and Issues for Funding Structures, National Archives of Australia, part of NAA: A14370, JH1997/158, RCD.9999.0539.0001 at 0004-0013.

²⁴⁶ Departments of Health and Family Services and Finance, Cabinet Memorandum, Residential Aged Care – Long Term Outlays and Issues for Funding Structures, National Archives of Australia, part of NAA: A14370, JH1997/158, RCD.9999.0539.0001 at 0006 [4], 0007 [9], 0008 [11].

²⁴⁷ Departments of Health and Family Services and Finance, Cabinet Memorandum, Residential Aged Care – Long Term Outlays and Issues for Funding Structures, National Archives of Australia, part of NAA: A14370, JH1997/158, RCD.9999.0539.0001 at 0011 [33].

²⁴⁸ See for example Exhibit 1-46, Adelaide Hearing 1, Statement of Sean Rooney WIT.0013.0001.0001 at 0008 [68]–0009 [74], and 0015 [126]; Transcript, Sydney Hearing 5, Nicholas Mersiades, 21 September 2020 at T9521.44–9522.12; Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9181.1–6.

marked a significant deterioration in the financial performance of approved providers. The Aged Care Financing Authority reported on this deterioration in its Seventh Report on the Funding and Financing of the Aged Care Industry, July 2019, saying:

ACFI has not provided a stable and effective care funding tool for both the Government and providers. The Government has been concerned that the growth in ACFI payments has exceeded the underlying growth in the acuity of the Australian population and subsequent changes it has made to ACFI arrangements have had a significant impact on the financial performance of residential aged care providers. A sizeable proportion of residential care providers are currently making a loss and a number of smaller providers are seeking to leave the sector while many are concerned about their ongoing viability if current financial trends are maintained. Overall, under the ACFI funding tool, there have been cycles of high growth followed by low or no growth causing uncertainty for providers, investors and Governments.²⁴⁹

Slow and reactive regulatory reform to address the use of restraints

205. The misuse of restraints in residential aged care has been a focus of the Australian Department of Health for some time prior to regulatory amendments in 2019.²⁵⁰ In early 2019, the Minister for Senior Australians and Aged Care announced better regulation of restrictive practices in response to media reports of restrictive practices in residential aged care.²⁵¹ That announcement was made in the absence of a formal recommendation from the Department of Health about how the strengthening of regulation might be achieved.²⁵² It led to amendments to the *Quality of Care Principles 2014* developed through a consultative process with a clinical advisory committee and with industry. As Commissioners Tracey and Briggs observed in the Interim Report, experts at Sydney Hearing 1 did not express confidence that the amendments would be effective in reducing the use of psychotropic medications.²⁵³ After Sydney Hearing 1, the Parliamentary Joint Committee on Human Rights conducted an inquiry in the amendments, which commenced on 29 July 2019. In the Australian Government's response to that inquiry, it reported that it had made further amendments to tighten the regulation of the use of restraints.²⁵⁴
206. Why has there been such delay and reactivity instead of proactive and effective governance of the system? The answer cannot not lie in division of responsibilities across the States and Territories and the Australian Government, because governance

²⁴⁹ Aged Care Financing Authority, *Seventh Report on the Funding and Financing of the Aged Care Industry*, July 2019, p 119.

²⁵⁰ Exhibit 3-78, Sydney Hearing 1, Statement of Amy Laffan, WIT.0105.0001.0001 at 0006 [26].

²⁵¹ Exhibit 1-28, Adelaide Hearing 1, The Hon. Ken Wyatt MP, Media Release, 17 January 2019, RCD.9999.0011.2033.

²⁵² Transcript, Sydney Hearing 1, Amy Laffan, 16 May 2019 at T1848.40–43.

²⁵³ Royal Commission, *Interim Report: Neglect*, 2019, Vol 1, p 209.

²⁵⁴ The *Quality of Care Amendment (Reviewing Restraints Principles) Principles 2019* commenced on 29 November 2019. See 'Australian Government response to the Parliamentary Joint Committee on Human Rights report on the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*', March 2020, p 4.

of the aged care system has been the exclusive responsibility of the Australian Government since the National Health Reform Agreement in 2012.²⁵⁵

207. The weight of evidence examined is that the current arrangements fail to meet community expectations for a reliable, well governed aged care system. The extent of the problems that emerged in evidence, public submissions and community forums dictates that any changes the Commissioners recommend to the way in which the aged care system is structured and governed, must bring about a fundamental change in approach, and must restore and instil trust.
208. The Department of Health has been an ineffective system governor. Our recommendation for an independent Australian Aged Care Commission is in response to the shortcomings of the current aged care system.
209. In some ways, the aged care system resembles a vast series of interconnected supply chains, requiring constant attention and proportionate interventions. There is a risk that those interventions could be disjointed if made by separate bodies each with their own mandate. Quality outcomes, financial risk and program administration all require coherent monitoring and responses. The management of all these matters, and governance responsibility, should be placed in the hands of a statutory body with dedicated purposes and clear responsibilities confined ensuring high quality aged care reaches those who need it. That body should be independent from the short-term distractions that beset the government of the day.

Reform of governance arrangements

210. It is necessary to restructure the governance arrangements for the aged care system in a manner that gives due recognition to the principle of ministerial responsibility which underlies our Westminster system of government. Restructure must also engender confidence on the part of the sector that funding will be determined and provided, and other program arrangements will be formulated and implemented in a manner that is free from the influence of the fiscal imperatives and political strategies of the executive government of the day.
211. Broadly, there are two options that are reasonably available to consider in a redesigned aged care system:

- a. ***Departmental model***

Improve and clarify the system governance, system management and administrative responsibilities of the Australian Department of Health and Minister, introduce an independent pricing body, and otherwise retain the essential

²⁵⁵ Council of Australian Governments, National Health Reform Agreement, Schedule F, cl F5–F9.

characteristics of the current institutional arrangements (including the Aged Care Quality and Safety Commission), or

b. ***Independent Commission model***

Introduce an independent statutory body (an integrated aged care commission) to exercise regulatory, system governance, system management and administrative responsibilities pursuant to a clear statement of functions and objectives, together with an independent pricing body, with the Minister, supported by his or her Department, retaining a supervisory role and responsibility for future refinement of the system by law reform. The responsibility for dispensing public funds to providers in return for services could reasonably be located in either the integrated commission, or in the pricing authority, or indeed it could be retained by the Australian Department of Health. Our recommendation is that the integrated commission should be best placed to dispense funding to providers.

212. For both a departmental model and an independent commission model, an indispensable element of the reformed system is that there be independent determination of the subsidies to be paid to providers and of prices they may charge for services (where such prices are not subject to competitive market forces).
213. We submit that a redesigned aged care system should follow the independent commission model. The best way of achieving a reliable and sustainable governance structure for aged care is to confer clear system governance and management roles on independent statutory bodies which operate on their own budgets, free from Ministerial direction, and for the responsible Minister and their Department to retain an overarching supervisory and policy role. The name of this body should be the 'Australian Aged Care Commission', a name first suggested by the Productivity Commission in 2011.²⁵⁶ The governance structure should also include a new officeholder who exercises systemic review functions; the 'Inspector-General of Aged Care'.
214. Our recommendation is similar in many respects to the model recommended by Professor Hjalmar Swerissen, Fellow at the Grattan Institute, for what he called the 'national system governor', which he proposed should govern the system alongside a number of independent regional agencies.²⁵⁷

²⁵⁶ Productivity Commission, Inquiry Report no. 53, *Caring for Older Australians*, 28 June 2011, Vol 1, p XLVII.

²⁵⁷ Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 3, RCD.9999.0383.0001 at 0010 [65]: 'A national system governor should be established as an independent statutory agency with a governing board directly responsible to the relevant Minister. The Aged Care Financing Authority and the Aged Care Quality and Safety Commission should be incorporated into an overarching governing agency. The national agency should have responsibility for implementation, performance and governance of the aged care system.' He

215. Professor Kathleen Eagar likewise submitted that independent regional agencies or authorities should be established, under an umbrella organisation she called the National Aged Care Authority.²⁵⁸
216. Rather than establishing separately constituted regional bodies, the system governor should have a network of regional offices, and a highly locally devolved operating model. The network of regional offices and devolved operating model should help to support the care finder and assessment networks. This was identified by other experts as a key measure needed to improve system stewardship. Associate Professor Gemma Carey made this point in her statement, saying that the role of 'local actors' (such as local area coordinators) in the National Disability Insurance Scheme is critical.²⁵⁹ Mr Robert Bonner, Director of Operations and Strategy of the Australian Nursing and Midwifery Federation (SA Branch) proposed a body (which he referred to as a standing Commission) as system governor, stating that regulatory and system management functions should be concentrated in its hands. He too emphasised the importance of implementation of the system management role at the regional level.²⁶⁰
217. The formal establishment of the Australian Aged Care Commission under a new Act will take some time, probably about 2 years. In the meantime, the implementation of the relevant recommendations to be made by the Royal Commissioners should proceed under temporary administrative arrangements. In the period prior to the formal establishment of the Australian Aged Care Commission as an independent statutory body under the new Act, there should be an administrative unit to implement and direct implementation of the recommendations (see section 4.18, Transition and

added: 'The Department should continue to have the stewardship role: monitoring the performance of the aged care system and providing policy advice to government.'

²⁵⁸ Submission of Kathleen Eagar, Public Submission, August 2020, AWF.670.00037.0001_0001. Professor Eagar submitted at _0002: 'The NACA [National Aged Care Authority] would be a Commonwealth corporate entity that takes over the current functions of both the Commonwealth Department of Health and (with one exception) the existing Aged Care Quality and Safety Commission. As a Commonwealth corporate entity, it would report directly to the Minister and the Parliament, have statutory independence and receive an annual appropriation direct from Treasury. Roles include: Aged care policy, National aged care planning across the five domains of aged care: health, function, social, residential and palliative, Distribution of funds to a national network of regional aged care planning and commissioning agencies which, in turn, plan and commission aged care services for the local region ..., Distribution of funds to states and territories for regional Aged Care Assessment and Referral Services ..., In partnership with the Australian Commission on Safety and Quality in Health Care (ACSQHC), determination of aged care standards, Aged care inspections against standards, Funding system design and monitoring of funding system performance, Workforce planning and development, Performance monitoring and reporting, including public reporting via a 5 star public reporting system, Research, evaluation and service development'. Professor Eagar emphasised the importance of a separate complaints avenue as a check and balance (see _0002–0003).

²⁵⁹ Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 1, RCD.9999.0352.0001 at 0007 [21.5]–[21.6], and 0007–0008 [22.4]–[22.7].

²⁶⁰ Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 2, RCD.9999.0376.0001 at 0007 [31]–[35].

Implementation, below). Once the new Act is passed, its work will pass to the Australian Aged Care Commissioners.

218. It should be possible to appoint the Inspector-General of Aged Care under temporary administrative arrangements in the near future, well before the commencement of the new Act. As outlined below, one of the key tasks of the Inspector-General is that they should monitor and report on the system governor's and others' progress in implementation of the recommendations of the Royal Commission.

The Australian Aged Care Commission

Recommendation 3: Australian Aged Care Commission

- 3.1. By 1 July 2023, the Australian Aged Care Commission should be established under the new Act as a corporate Commonwealth entity within the meaning of the *Public Governance, Performance and Accountability Act 2013* (Cth), with its own legal personality, and able to sue and be sued. The Commission should be independent of Ministerial direction, and there should be a requirement that any expectations or advice provided by the responsible Minister to the Commission should be made public. The Commission should have:
- a. a governing board appointed by the Governor-General, in which the authority and functions of the Commission should be vested under the new Act, comprising:
 - i. at least three non-executive members, who are to constitute the majority of the board and one of whom is to be appointed as chair of the board, and who are to be chosen for their integrity, eminence and public standing, each of whom must be independent of any current involvement in the aged care sector, and who together are representative of the community and should have a range of backgrounds and skills including experience and proven capacity in: aged care, clinical services, human services, legal services, and corporate governance; and in one or more of the financial, accounting or general business areas
 - ii. the Secretary of the Department administered by the responsible Minister, who shall be an *ex officio* member of the board
 - iii. the presiding commissioner of the Commission, who shall be the chief executive officer of the Commission and may participate in the deliberations of the board of the Commission except where the

presiding commissioner has a material personal interest in the subject matter under deliberation

- b. no fewer than five assistant commissioners to be appointed by the board on the basis of their integrity, standing, skills, and expertise, one of whom must be a person of Aboriginal or Torres Strait Islander background, one of whom will be responsible for complaints, and another of whom will have workforce development and training as a dedicated portfolio
- c. staff employed or engaged by the Commission (whether under the provisions of the *Public Service Act 1999* (Cth) or otherwise), who should be subject to the direction and supervision of the commissioners
- d. a distributed network of offices including regional offices to deliver or manage the delivery of assessment and care finding services, administer the aged care program, and provide general assistance to the public, and a head office outside Canberra
- e. system management functions, including support and funding of local assessment and care finding teams and personnel, provision of information on services and providers (including through My Aged Care), system data management, ensuring the coverage of service availability for all aged care services to which people are assessed as eligible, commissioning and funding of providers to provide sufficient aged care services in all locations, providing assistance to providers to build capacity where appropriate, and managing the orderly exit of consistently poor-performing providers
- f. the following functions:
 - i. approval of service providers as providers eligible to receive subsidies for providing aged care
 - ii. financial risk monitoring of providers, and prudential regulation of providers
 - iii. approval of the scope of subsidised services approved providers may provide, and accreditation of the outlets ('services') through which they provide them
 - iv. payment of subsidies to approved providers of aged care
 - v. quality and safety regulation of approved providers and their services

- vi. ensuring that appropriate aged care services are widely available for Aboriginal and Torres Strait Islander people
 - vii. workforce planning and development, including setting and refining requirements for minimum staffing levels and minimum qualifications for staff providing care, and (through a workforce planning division within or operated by the Commission) ongoing development of workforce capacity through requirements for training and professional development
 - viii. consulting with the Australian Commission on Safety and Quality in Health and Aged Care (which is to be responsible under the new Act for review and setting of quality and safety standards and quality indicators) on reviews and revisions of the standards and indicators for the provision of safe and high quality aged care
 - ix. management of complaints about providers, staff, assessors and care finders
- g. the primary responsibility for system governance, including the responsibility of continuously monitoring the performance of the system, formulating new policy and reform proposals for improvement of the performance of the system, limited authority to make legislative instruments about the details of arrangements for the administration of funding and service delivery, and the responsibility for recommending other amendments of legislation and delegated legislation to the responsible Minister
- h. an obligation to report regularly to the Inspector-General of Aged Care and to the responsible Minister on the performance of its functions
- i. an obligation to lay before the Parliament and to publish an annual report on all important aspects of the operation of the new Act, including:
- i. the extent of unmet demand for aged care, including unmet demand for particular services or in particular places
 - ii. the adequacy of the Commonwealth subsidies provided to meet the care needs of people needing or receiving aged care
 - iii. the extent to which providers are complying with their responsibilities under the Act

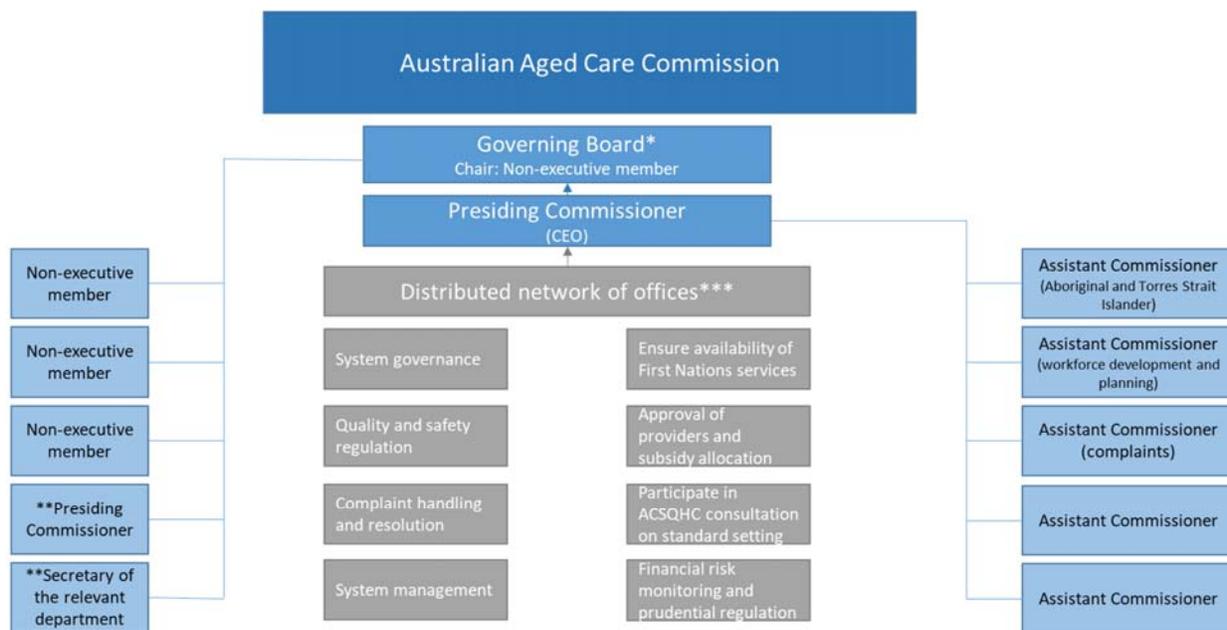
- iv. the amounts paid by people receiving residential care in connection with their care, including amounts paid for accommodation and daily living needs
- v. the amounts paid for accommodation in the form of lump sum deposits and in the form of daily payments
- vi. the duration of waiting periods for assessment, and between assessment and commencement of provision of particular services, including respite and residential care
- vii. the extent of building, upgrading and refurbishment of aged care facilities, and
- viii. such other aspects of the operation of the Act as the Commission considers relevant to ensure an accurate understanding of the operation of the Act.

219. In the above recommendation, we propose that a specialist body independent of day-to-day executive government (the Australian Aged Care Commission), should exercise as many of the functions needed for the smooth management and governance of the aged care system as possible.

220. The Australian Aged Care Commission should consist of: its board, a number of commissioners including one of whom (the presiding commissioner) is its chief executive, and its staff. The other commissioners (the assistant commissioners) should be assigned responsibilities by the presiding commissioner under the governance of the board. The presiding commissioner must ensure that the functions of the Commission are each made the particular responsibility of at least one commissioner (that is, the presiding commissioner or an assistant commissioner). The presiding commissioner should take responsibility for the system governance function. The presiding commissioner should allocate responsibility for ensuring that appropriate aged care services are widely available for Aboriginal and Torres Strait Islander people (to an assistant commissioner of Aboriginal and Torres Strait Islander background. The presiding commissioner should also allocate responsibility for the workforce, including its development and training, to an assistant commissioner who holds responsibility primarily for workforce matters.

221. As noted in Part 3.15, below, ideally the new Act should contain a special appropriation and specify that subsidies for aged care services will be paid in accordance with prices determined by the Aged Care Pricing Authority. One important question is whether subsidies are to be paid to approved providers through the Australian Aged Care

Commission or in some other manner. Our recommendation is that the Australian Aged Care Commission would be a corporate Commonwealth entity. This may have implications for the manner in which funding is to be channelled to approved providers. Ideally, however, funding administration should be in the hands of the Australian Aged Care Commission, along its other functions relating to day-to-day management of the system and the aged care program.



*To be appointed by the Governor-General
**Ex officio member

***Head office to be outside Canberra

Advisory Council

222. The responsible Minister should appoint an advisory council to advise the Commission and the Minister on policy matters concerning the performance of the aged care system and policy matters of importance from the perspectives of older people who need and use aged care services, the workforce, providers, educators, and professionals involved in the provision of aged care.

Recommendation 4: Aged Care Advisory Council

4.1. By 1 December 2021, the responsible Minister should appoint an Aged Care Advisory Council, to be constituted by such people of eminence, expertise and knowledge of aged care services as the Minister sees fit, drawn from all relevant aspects of the aged care system, including people receiving aged care, representatives of the aged care workforce, approved providers, health

and allied health professionals, specialists in training and education, and independent experts.

4.2. The Advisory Council should be established with its own secretariat, funded by the Australian Government, for the purpose of providing advice on aged care policy, service arrangements and any aspect of the performance of the aged care system, to the Australian Aged Care Commission and the Minister. It should convene itself regularly, and should have authority to provide advice to the Commission and the Minister on its own initiative. In addition, the Commission and the Minister should have authority to convene it on reasonable notice, and may refer particular issues to it for advice.

223. One of the challenges encountered in the past has been that there have been disconnects between the body exercising regulatory functions and the body exercising system management and governance functions. The Earle Haven case study examined at the Brisbane Hearing is an example in point.²⁶¹ System management and quality regulation should be directed to the same goals, namely, the protection and advancement of the interests, health and wellbeing of people who need and receive aged care. The same is true of oversight of financial risk, prudential regulation, the approval of providers, and complaints handling. Making fine distinctions and attempting to divide these functions into a 'system management' and 'regulatory' category is somewhat arbitrary and, as the Earle Haven case study reveals, can be counter-productive. After the reforms of the last two years relating to the functions of the Aged Care Quality and Safety Commission, the issue of whether the Australian Department of Health or that Aged Care Quality and Safety Commission (or both) should be responsible for the monitoring of providers' financial performance and risk profiling appears to remain a matter of debate between them.²⁶² That is understandable, because the administration of the funding programs remains with the Department, while regulatory responsibility rests on the Commission and exercise of those functions rightly must remain independent of the Australian Government. The problem is generated by the institutional structures that have been adopted. The best solution is to consolidate those functions in the hands of a body that is independent of the government of the day.
224. There are great advantages in consolidating these functions in the hands of one organisation, because many of them are interrelated and should benefit from coordinated attention. Consolidation would limit the risks of delay in identifying emerging problems or

²⁶¹ Submissions of Counsel Assisting the Royal Commission, Brisbane Hearing, Earle Haven case study, 26 August 2019, RCD.0012.0026.0001 at 0065 [228].

²⁶² See for example, Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9469.9–18.

inaction in addressing them. In particular, there are advantages in the consolidation of quality and safety monitoring and compliance, financial risk monitoring and prudential compliance, together with general system management functions. The latter include: approval and commissioning of providers; receiving and acting on feedback from providers about service delivery challenges and program improvements; funding administration; provider capacity building; service coverage and market evaluation; special interventions in 'thin' markets such as commissioning providers of last resort to ensure coverage; and managing orderly exits of poorly-performing providers.

225. For these reasons, we submit that a model based on consolidation of functions in an Australian Aged Care Commission should be adopted.
226. The most obvious alternative is a continuation of the status quo, together with independent pricing and with clarification and strengthening of responsibilities. This model would be based on a Department subject to Ministerial direction retaining core system management responsibilities, and regulatory functions remaining in the hands of the Aged Care Quality and Safety Commission, exercised separately from the influence of the executive government. If the Departmental model is retained, the separate regulator should be too. Conferral of far-reaching regulatory functions over privately owned entities to an agency under executive government direction would not be appropriate.²⁶³
227. If the Australian Aged Care Commission model is adopted, there is no impediment to consolidation of quality regulation along with its other functions. Provided the body exercising regulatory functions is independent of executive government, any tension between the exercise of regulatory functions and the exercise of system management and funding functions under the same roof would be manageable, and the benefits of consolidation outweigh the burden of managing any such tensions that may arise.
228. However, we do not propose that the function of determining the amounts of subsidies and prices for aged care services should be performed by the Australian Aged Care Commission. That function calls for highly specialised capabilities, and it might in any event be imprudent for the same body that regulates the approved providers, administers funding to them, and manages the performance of the system, also to be responsible for determining how much money should be available to approved providers. The body responsible for the long term performance of the system should not be able to 'write its own cheque'. The pricing function would be in tension with those other roles, and so the pricing function would be better conferred on a separate body.

²⁶³ Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 5, RCD.9999.0417.0008 at 0009 [9]–[13]; 0011 [20]–[22].

229. The Australian Aged Care Commission's operating budget should be directly appropriated from the Consolidated Revenue Fund. While this would not necessarily insulate it from annual budget pressures, it would create a clearly identified stream of funding, and variations to the funding would be highly visible.
230. The provision of funding to approved providers in the sector is a more difficult matter. As already mentioned, on balance we submit that the better solution is that the Australian Aged Care Commission should administer funding to providers.
231. For the reasons we outlined above, the Australian Aged Care Commission should have a strong regional presence. To give impetus to decentralisation of its operations, we recommend that its headquarters should not be in Canberra. This regional presence will enable allocation and integration of resources according to the identified needs of the local population. The Australian Aged Care Commission should support community and provider engagement and relationship building between all involved in the aged care system. The Australian Aged Care Commission should have a network of offices throughout Australia. These offices will support a regional network of aged care assessors and care finders. Care finders should be employees of the Australian Aged Care Commission or of State or Territory or local government authorities commissioned to perform the role, ideally with capabilities in human services, health, aged care and local knowledge. Employees of the Australian Aged Care Commission should be under the direction and control of the Commission and assistant commissioners, and should not be employees under the *Public Service Act 1999 (Cth)*. They should, however, be subject to the rigorous integrity requirements, like public servants. If the Australian Aged Care Commission requires additional services in regions to be provided through contractors, there must be local level input into managing the commissioning process for the services concerned. We make more detailed submissions on the role of care finders later in these submissions. Care finders will form a large, regionally distributed workforce that will require management at a local level. These regional networks should work hand in hand with assessment teams, which will likewise be distributed throughout the country.
232. At the heart of its duties, the Australian Aged Care Commission should be responsible to vulnerable people who can have increasing needs for support as they age. This requires a system that is reliable and robust. The Australian Aged Care Commission ought to be independent and established as a corporate entity. Parliament ought to define its objectives in the new Act and hold the Australian Aged Care Commission accountable for its performance in meeting those objectives.
233. To ensure independence from the sector, current employees of approved providers, advisors to the sector or representatives of peak bodies should not be eligible for appointment to the board of the Australian Aged Care Commission. The board should

be given responsibility for the strategic direction of the Australian Aged Care Commission and for actively managing the functions of the Commission, and its performance, whilst having a singular focus - ensuring that the aged care system is working well.

234. The Australian Aged Care Commission should be prepared actively to intervene in the aged care 'quasi-market'. The Commission should use its powers (including its powers for approval of providers, commissioning of providers, and funding of providers) to manage the aged care system actively, to ensure:
- a. an adequate coverage of services to meet the population needs for urban, rural, regional and remote Australia
 - b. an adequately diverse mix and adequate number of providers to enable older people seeking services to exercise an informed choice, where possible, between available providers
 - c. the building of capacity and capability of new and existing providers to foster best practice and innovation
 - d. that existing approved providers are supported to address their business and service delivery issues (to enable sustainability)
 - e. continuity of service for older people in the event that approved providers who are unable to deliver high quality services or who no longer wish to provide aged care services are supported in transitioning out of the aged care system.
235. Our recommendation for an Australian Aged Care Commission aims to strike a balance between independence, ministerial responsibility and accountability. We submit that is appropriate for the dedicated, stable and transparent governance of such a vital national service as the aged care system.

The Australian Aged Care Pricing Authority

Recommendation 5: Australian Aged Care Pricing Authority

5.1. The Australian Government should establish an Aged Care Pricing Authority and confer on it all necessary functions for determining prices (inclusive of subsidies and user contributions) for specified aged care services so as to meet the reasonable and efficient costs of delivering those services. Its functions should include the function of identifying and recommending to the Australian Aged Care Commission the aged care services for which price cap determinations or other forms of economic regulation may be appropriate.

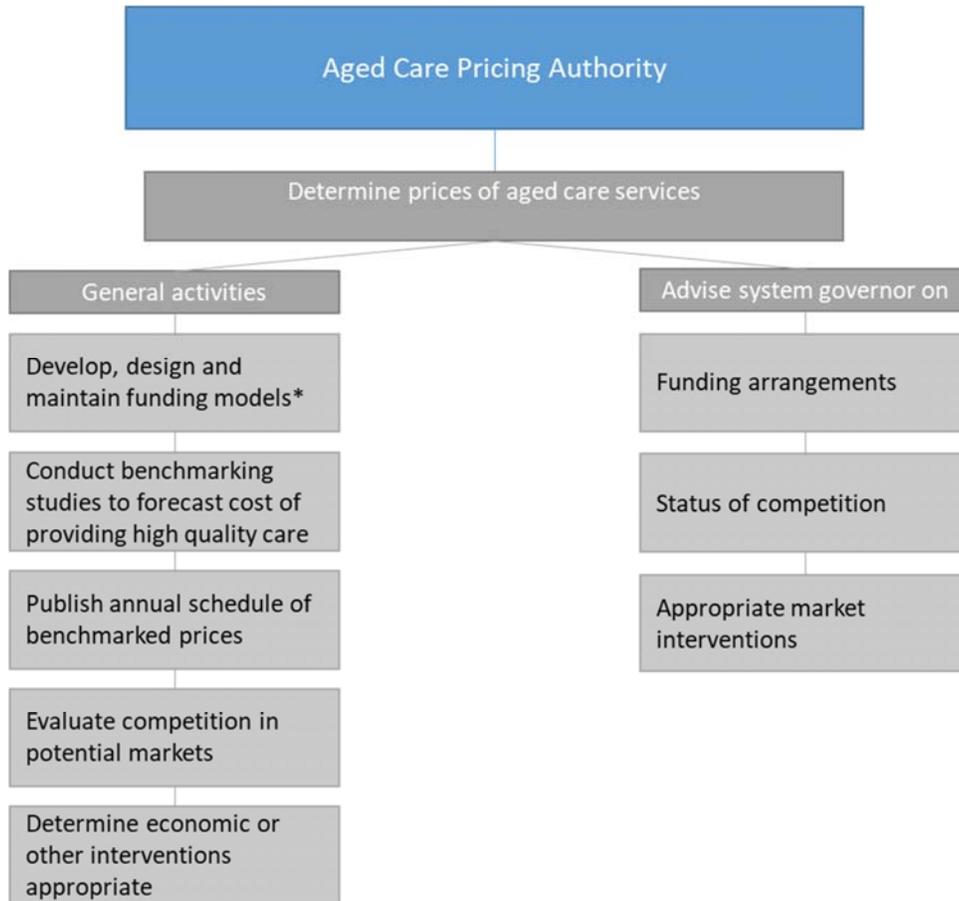
236. For the reasons previously outlined, the introduction of independent pricing into the system is critical to restore or instil confidence and trust between the sector and government, and thus to instil confidence in the sustainability of the system in the wider community. There is already an existing independent statutory body with proven capabilities on which aged care pricing functions could be conferred – the Independent Hospitals Pricing Authority (**IHPA**). One option would be to confer aged care pricing functions on IHPA, Alternatively, a new entity with a separate statutory existence could be established. We recommend the latter.
237. The role of the pricing authority should be broader than the role of IHPA, and should not be limited to conducting cost studies and determining subsidy and price levels. The pricing authority should assume the monitoring and decision-making functions of the current Aged Care Pricing Commissioner, the advisory roles until now exercised by the Aged Care Financing Authority. It should assume a broader role of evaluating the effectiveness of competition in various market segments and locations, and proposing appropriate interventions, including economic regulatory interventions such as price caps. All this will call for a specialised focus on aged care, and might distract IHPA from its core task of hospital pricing under the National Health Reform Agreement framework.
238. In the short to medium term, until the new body is established under statute and develops its own independent capabilities, it may be appropriate for IHPA to provide capacity-building services under temporary administrative arrangements. That should be a matter for the system governor to decide when implementing the Royal Commission’s recommendations.
239. In the balance of these submissions, we will use the expression ‘Aged Care Pricing Authority’ to refer to the new aged care pricing body we propose, including any temporary administrative unit commencing on the task of building aged care cost study and price

determination capacities pending the formal establishment of the new body under statute.

240. The functions and purposes of the Aged Care Pricing Authority are outlined in greater detail in Part 3.15 Proposed Funding Arrangements. They should include:

- a. providing expert advice to the Australian Aged Care Commission on optimal forms for funding arrangements for particular types of aged care services and in particular market circumstances
- b. reviewing data and conducting studies relating to the costs of providing aged care services
- c. determining prices for particular aged care services based on estimates of the amounts (whether constituted by government subsidies or user payments or both) appropriate to the provision of high quality and safe aged care services
- d. evaluating, or assisting the Australian Aged Care Commission to evaluate, the extent of competition in particular areas and markets
- e. advice on appropriate forms of economic regulation, and implementation of such regulation, where necessary.

241. The Australian Government should take steps to develop the capabilities and resources necessary to perform the above functions pending statutory establishment of the Aged Care Pricing Authority. Further details about the role of the Aged Care Pricing Authority appear in Part 3.15 Proposed Funding Arrangements.



*Including funding classification and case mix schemes, as well as associated data standards to support implementation and operation

The Inspector-General of Aged Care

242. An Inspector-General is required to ensure that the governance of the aged care system is subject to ongoing scrutiny, and ensure that the Australian Aged Care Commission and the Aged Care Pricing Authority in particular are accountable for their performance. The Inspector-General should be separate from the proposed Australian Aged Care Commission, the Department and other agencies with aged care responsibilities.

Recommendation 6: Inspector-General of Aged Care

- 6.1. The Australian Government should establish an independent office of the Inspector-General of Aged Care to monitor and report on the administration and governance of the aged care system, including:
- a. the implementation of the reforms recommended by the Royal Commission
 - b. the performance by the Australian Aged Care Commission and the Australian Aged Care Pricing Commission of their functions
 - c. the extent to which the aged care system attains the objects of the new Act.
- 6.2. An Inspector-General should be appointed forthwith under interim administrative arrangements, and should in due course be established formally under the new Act.

243. There have been numerous major inquiries and reviews into the Australian aged care sector over the last two decades since major reforms were introduced through the *Aged Care Act 1997* (Cth).²⁶⁴ These inquiries and reviews have addressed recurring issues within the aged care system.²⁶⁵
244. At the same time, the implementation of the Royal Commissioners' recommendations is likely to result in significant change in a system that has already experienced ongoing change since the Royal Commission started. Over time, there are likely to be other changes that impact upon the aged care system, including demographic and fiscal changes, and changes in community expectations and preferences.
245. The Inspector-General would perform a critical role in monitoring and reporting on progress in implementing the recommendations of the Royal Commissioners.
246. Before the 2012 aged care reforms, the former Aged Care Commissioner had a limited ability to conduct own-motion reviews of certain regulatory processes.²⁶⁶ The scope of these functions, however, was more limited than what is now required.
247. The inquiry of this Royal Commission into certain issues arising from the responses to COVID-19, and other reviews conducted into outbreaks of COVID-19 in aged care,

²⁶⁴ See Royal Commission into Aged Care Quality and Safety, 'A history of aged care reviews', Background Paper 8, October 2019, p 1.

²⁶⁵ See Royal Commission into Aged Care Quality and Safety, 'A history of aged care reviews', Background Paper 8, October 2019, p 1.

²⁶⁶ Former s 95A-1 of the *Aged Care Act 1997* (Cth). Amended by the *Aged Care Amendment (Independent Complaints Arrangements) Act 2015* (Cth).

demonstrate the importance of independent review in the context of unforeseen or unusual events. That inquiry and other reviews extended beyond an examination of the actions of individual providers, and identified a lack of clarity in the roles of the Department of Health, the aged care regulator, state government officials and the approved provider in the response to the outbreak at Newmarch House.²⁶⁷

248. This suggests the need for a body with ongoing oversight of the aged care system, one which can receive complaints and feedback about aged care governance and which can conduct reviews and make recommendations on its own initiative.
249. The model we propose is similar to the Inspector-General of Taxation and Taxation Ombudsman, which is an independent statutory office, whose functions include improving taxation administration.²⁶⁸ However, there are important differences that reflect the differences between the system for the administration of taxation, and the aged care system.
250. The primary functions of the proposed Aged Care Inspector-General should be to identify and investigate systemic issues in the provision or regulation of aged care, to make and publish reports of its findings, and to make recommendations to the Australian Aged Care Commission, the Department and the Minister. The Inspector-General should have a broad scope to review all aspects of the aged care system, including the functions and processes of the Department, the Australian Aged Care Commission, and systemic issues relating to the performance of providers and treatment of people who need care.
251. The Inspector-General should have the power to conduct an investigation on his or her own initiative, or at the request or direction of the relevant Minister. Other sources through which the Inspector-General may identify potential topics for review include:
 - a. feedback and/or complaints from people receiving aged care or others
 - b. consultation with external organisations and individuals
 - c. media reports
 - d. requests from the Parliament and Australian Aged Care Commissioner.²⁶⁹
252. It is important that the systemic review function is informed by complaints. Complaints are a key source of information about systemic problems; they provide a practical sense of issues facing people receiving aged care and their families. If a systemic oversight

²⁶⁷ Royal Commission into Aged Care Quality and Safety, *Aged care and COVID-19: a special report* (2020), p 13–15; Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 121, CTH.1000.0005.8876 at 8879.

²⁶⁸ *Inspector-General of Taxation Act 2003* (Cth), see in particular ss 3 and 7.

²⁶⁹ See for example, the IGTO-ATO Review Operational Guidelines (available at: <https://www.igt.gov.au/news-and-publications/other-publications/igto-ato-review-operational-guidelines>) at para 1.30; *Inspector-General of Taxation Act 2003* (Cth), s 8.

role is conferred without any responsibilities for complaint handling, there is a risk that the oversight body will never develop the understanding it needs to identify systemic issues. Likewise if a complaints function is conferred without a systemic oversight function, there is a risk that attention will only ever be given to individual problems, without ever leading to systemic changes.²⁷⁰ However, the Inspector-General should maintain a focus on systemic issues. That means it would be inappropriate for the Inspector-General to be given primary responsibility for administering the scheme for handling aged care complaints. The appropriate balance is, we submit, that the Australian Aged Care Commission should conduct the complaints scheme, and that any person who is dissatisfied with the way their complaint has been handled by the Commission, or considers the complaint otherwise warrants the attention of the Inspector-General, may refer the matter to the Inspector-General.

253. The Inspector-General should have unfettered power to address complaints and respond to feedback about the aged care system. There should be no restrictions imposed on the source of information which may be received by the Inspector-General. For example, feedback and complaints may come from the advisory council, health professionals, the community, those providing or receiving aged care services, the friends and family of those receiving aged care services and support, and members of the aged care workforce or their representatives.
254. The Inspector-General should have powers to obtain documents and information, examine witnesses and enter premises.²⁷¹
255. The functions of the Inspector-General should include the following:
 - a. monitor and report annually to Parliament and the Australian people on the progress of implementation of the recommendations of the Royal Commissioners
 - b. receive, investigate and act upon complaints on any aspect of the aged care system it considers appropriate, and in particular any such complaints raising systemic issues
 - c. conduct systemic inquiries or reviews on any aspect of the aged care system and its performance, including (if the Inspector-General deems fit) independent reviews of the performance or conduct of the Australian Aged Care Commission or the Aged Care Pricing Authority

²⁷⁰ On the synergies between complaint handling and review, see Australian Government Inspector-General of Taxation, *Valedictory Speech*, Melbourne, 4 October 2018.

²⁷¹ See *Ombudsman Act 1976* (Cth), ss 9, 13 and 14; *Inspector-General of Taxation Act 2003* (Cth), s 15.

- d. make recommendations to the Australian Aged Care Commission and the Aged Care Pricing Authority and the responsible Minister arising from systemic reviews
 - e. receive and address complaints about any aspect of the aged care system and its performance
 - f. at the Inspector-General's discretion, refer complaints about providers, members of the workforce, care finders and assessors to be handled by the Australian Aged Care Commission
 - g. report as the occasion requires to the Minister on the administration and performance of the aged care system and its governance, and the extent to which the system is attaining the objects in the new Act
 - h. report annually to the Commonwealth Parliament and the public on the administration and performance of the aged care system and its governance, and the extent to which the system is attaining the objects in the new Act.
256. Upon commencement of the new Act the Inspector-General should be provided with annual budget allocations in the amount required to enable the Inspector-General to engage the staff and other resources reasonably necessary for the performance of those functions.
257. As outlined in more detail in Part 3.18 Transition and implementation, below, the Inspector-General should be responsible for monitoring the implementation of the recommendations of the Royal Commissioners. It should ensure that governments and the community have access to transparent and independently verified information on the response to the recommendations. In this way, it will play a role in holding governments and providers accountable for their response to the work of this Royal Commission.²⁷²

Responsible Minister, Department, and new National Cabinet Health Reform Committee

258. The responsible Minister remains an important feature of these governance arrangements. We choose not to make submissions about precisely what Ministerial portfolio arrangements should apply now or in the future. It is, however, necessary that the administrative arrangements adopted by the government of the day should allocate portfolio responsibility for aged care to a particular Minister, and that the Minister should continue to be supported by an Australian Government department.
259. While the Australian Aged Care Commission would be responsible for aged care programs and delivery, the Minister would continue to be responsible to Parliament for the Commonwealth's aged care policies. The Minister would present to Cabinet any aged

²⁷² See exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, tab 4, RCD.9999.0417.0001 at 0006-0007.

care policy proposals, recommend appointments to the Board of the Commission, appointments to the Advisory Board, and related matters. The department responsible for supporting the Minister would be expected to work closely with the Commission in the development of aged care policy proposals. The Minister and the department would also have primary responsibility for the provision of support and policy advice to the proposed National Cabinet Reform Committee in connection with the development of an integrated long-term care strategy for older people addressing needs across housing, welfare, health and community services (in addition to aged care), and would have a particular focus on achieving more smoothly functioning interactions between the health systems and the aged care system via that Committee and also the Health National Cabinet Reform Committee.

260. As Professor John Pollaers emphasised in his evidence, there must be far greater focus on improving the way the aged care system is to be co-ordinated with other services of potential benefit to older people, across all tiers of government.²⁷³ Links to the National Cabinet Reform Committees should be used to achieve this.

Advocacy

Recommendation 7: Enhanced individual advocacy

7.1. By 1 July 2022, the Australian Government should, through the implementation unit referred to in Recommendation 123, complete a consultation with the contracted provider of services under the National Aged Care Advocacy program in order to determine the extent of unmet demand for prompt advocacy services by people seeking or receiving aged care services. In light of the conclusions reached by the implementation unit after that consultation, the Australian Government should increase the funding of the National Aged Care Advocacy program to a level that provides for increased coverage of the program so as to meet currently unmet demand for prompt advocacy services.

261. Advocacy has an important role to play in the aged care system, whether it be the person receiving care advocating for themselves, or being supported by a friend or family member, care professional or formal advocate. Many older people are able to articulate and negotiate for their own needs, but others require support to do so. Advocacy provides a voice for people who struggle to have their voice heard. It supports family

²⁷³ OSA reference please Tab 04 - RCD.9999.0417.0001 - Statement of Professor John Pollaers, Tab 05 - RCD.9999.0417.0002, 5

members who are exhausted, exasperated or confused. Although not everyone will need it, access to formal advocacy should be a right for people receiving aged care services.

262. Advocacy services should be a fundamental part of the new aged care system. It is a much needed conduit that can achieve improvements in care for individuals. It can act as a mechanism by which people are empowered to question, challenge and exercise choice. In conjunction with the other safeguarding measures, an expanded formal advocacy program should be a vehicle for service improvement and self-determination for older people.
263. Advocacy should be recognised as an efficient mechanism for quality assurance and improvement. Service providers cannot improve if they do not know about someone's preferences or are unaware of their own deficiencies. But they must be willing to listen and have in place systems and processes to respond.
264. Systems advocacy is also important. Professor John McCallum from National Seniors Australia described the impact of their work as a consumer lobby for all older Australians.²⁷⁴ Mr Paul Versteegen explained the important work the Combined Pensioners and Superannuants Association does in providing targeted systems advocacy for low income retirees.²⁷⁵ We acknowledge the important work of consumer lobby and peak body organisations like these, but in this section focus on advocacy at the individual level.
265. Individual advocacy can be informal, such as by a family member or friend, or it can be by a health professional or social worker as part of their role. It can be formal, undertaken by a consumer group or an advocacy organisation which has been approached by the older person or concerned others.
266. Increasing physical frailty or cognitive changes, poverty or isolation can make it difficult for some older people to make their needs and preferences known. In addition, older people can also be vulnerable at significant transition points in their life, such as when making decisions about entry to residential care, where other voices may dominate and their preferences are not fully considered or explored. Older people from culturally diverse backgrounds can be vulnerable due to language barriers; and those with diverse needs can experience stereotypes or prejudice. Older people experiencing abuse may be isolated and fearful of speaking up.
267. For these reasons, we see an integral role for advocates – both formal and informal – in the aged care system that we propose. The advocacy role is performed mainly by three

²⁷⁴ Transcript, Adelaide Hearing 1, John McCallum, 11 February 2019 at T91.45-92.6.

²⁷⁵ Transcript, Adelaide Hearing 1, Paul Versteegen, 12 February 2019, at T155.28-33.

groups: family and friends; aged care and health professionals; and professionals from formal advocacy programs.

268. In this section, we confine our submissions to the formal advocacy and the enhancement of support structures for its provision.

Formal and independent advocacy

269. Several submissions indicated that where a person did not have family, or if family feared retribution for advocating, that an independent advocate was essential. Suggestions about the role of formal advocates included:

There should be an advocate for residents in every ward. Have same person come into room and ... treat them appropriately as humans. Who listens to the people with dementia? If the facilities don't even listen to the family members?Many family members won't say anything – don't want to speak up because don't want retribution or appear not to appreciate what staff are doing and understand it's a difficult job for the staff. So the residents continue to be treated badly.²⁷⁶

... an independent advocate who can support the resident if they have concerns and provide an independent and alternative voice for the resident. Many families are reluctant to speak up about the concerns they have for a resident because of fear of retribution to the resident.²⁷⁷

270. The idea of an independent person to support families with advocacy due to the imbalance of power was supported by several submissions. One older person in residential aged care suggested that a qualified social worker with specialised knowledge who would attend the home regularly, to give appropriate support and advocacy was required.²⁷⁸ Another noted the importance of clinical and systems knowledge for advocates:

to have someone of authority with the appropriate clinical knowledge (particularly in the gerontology/mental health/dementia area) to act on behalf of those in care and needing care would go a long way to addressing situations as was experienced by our family.²⁷⁹

271. We recognise that advocacy requires skills and knowledge that not everyone possesses. In implementing our recommendation for an expanded formal advocacy program, we consider additional training and education for advocates and information for service providers regarding the role of formal advocates as critical to the success of the program.

National Aged Care Advocacy Program

272. Older people currently receiving, or applying for subsidised aged care, are eligible to receive assistance from a formal advocacy service under the National Aged Care

²⁷⁶ Name withheld, Public submission, AWF.250.01433.

²⁷⁷ Name withheld, Public submission, AWF.001.01640.

²⁷⁸ Exhibit 5-07, Perth Hearing, General tender bundle, tab 67, AWF.001.00519.

²⁷⁹ Kathryn Tucharke, Public Submission, AWF.001.01880.

Advocacy Program.²⁸⁰ In addition to advocacy assistance, this program also provides help to understand and access the aged care system, and informing people of their aged care rights.

The National Aged Care Advocacy Program seeks to empower older people to protect their rights in the aged care sector, including by encouraging informed choice and decision making relating to care services, better informing them of their aged care rights, and supporting the resolution of complaints with care providers.²⁸¹

273. These goals are to be achieved through the following activities:
- a. independent and individually focused advocacy support, for older people and their families and representatives
 - b. the provision of independent information
 - c. the delivery of education sessions for older people and approved providers, promoting aged care consumer rights and approved provider responsibilities.²⁸²
274. This National Aged Care Advocacy Program is guided by the National Aged Care Advocacy Framework which outlines the objectives, guiding principles, program activities, target groups and mechanisms required by the National Aged Care Advocacy Program provider.²⁸³ The key objective is for those receiving aged care services to be empowered regarding their choices, to improve transitions between aged care services including avoiding premature admission to aged care facilities, to know and exercise their rights, and able to resolve complaints and issues about care received. The National Aged Care Advocacy Framework identifies that the program is guided by but not limited to: The United Nations Charter of Human Rights and the United Nations Principles for Older Persons (1991); The Charter of Care Recipients' Rights and Responsibilities; and Australian Consumer Law.
275. The guiding principles of the program have a focus on building capacity of the older person, their family or representatives in their interactions with aged care services. The principles strengthen the independence and consumer focus of the program.
276. In particular, the program has a focus on people living with dementia, a mental health condition, a disability, cognitive decline and those who identify as being from special

²⁸⁰ Department of Health, *National Aged Care Advocacy Program*, <https://www.health.gov.au/initiatives-and-programs/national-aged-care-advocacy-program-nacap> viewed 9 July 2020.

²⁸¹ Department of Health, *National Aged Care Advocacy Program Guidelines*, 2017, p4.

²⁸² Department of Health, *National Aged Care Advocacy Framework*, 2018, p3. <https://www.health.gov.au/sites/default/files/documents/2019/12/national-aged-care-advocacy-framework.pdf> viewed 14 October 2020.

²⁸³ Department of Health, *National Aged Care Advocacy Framework* 2018, <https://www.health.gov.au/sites/default/files/documents/2019/12/national-aged-care-advocacy-framework.pdf> viewed 14 October 2020.

needs groups. Providers of the program are required to provide services that are nationally consistent and accommodate geographic and cultural needs, and to build networks and linkages with key agencies to maximise the reach of the service and referral pathways. In the new system, links between the National Aged Care Advocacy Program and the Inspector-General will be critical to the program's success.

277. We support the notion of a nationally consistent program for formal advocacy, noting there is scope for improvement. In his evidence, Professor Ron Paterson reflected on the strength of New Zealand's publicly funded advocacy program, considered a 'jewel in the crown' of the aged care system in that country.²⁸⁴ By contrast, he saw weakness in Australia's formal advocacy system, describing it as 'loose' and in need of strengthening.²⁸⁵ We agree with this observation, particularly in light of the relatively thin coverage that the current National Aged Care Advocacy Program is able to deliver. In our view, more people receiving aged care services should have access to formal advocacy, delivered by trained and professional advocates.
278. The budget for the National Aged Care Advocacy Program has increased in recent years and stood \$10.6 million for 2019-20.²⁸⁶ Since 2017, the National Aged Care Advocacy Program is provided by the Older Person's Advocacy Network (known as OPAN), a network comprised of nine service delivery organisations across Australia. Mr Craig Gear, Chief Executive Officer of OPAN stated that in the year ending June 2018, the network assisted some 11,474 older people and visited almost 1,500 aged care homes.²⁸⁷ This equates to less than 1% of people receiving aged care services. The OPAN Annual Report for 2018-19 reported a 67% increase in demand for information and advocacy support over the preceding two years.²⁸⁸ The majority of complaints were about residential aged care, despite the report noting that 75% of aged care users are in home care. The Annual Report noted that despite supporting close to 15,000 people in aged care services, this is still only 1% of the number receiving formal aged care.
279. Mr Geoff Rowe spoke about the advocacy role of Aged and Disability Advocates Australia, one of the OPAN members. He estimated that his organisation supports less than 1% of the aged care population in Queensland, and said that recent substantial increases in advocacy demand had not met with a commensurate increase in funding.²⁸⁹ Mr Rowe estimated that the Aged and Disability Advocates Australia waiting list for

²⁸⁴ Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4596.16-18.

²⁸⁵ Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4596.33-36.

²⁸⁶ Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 6, Department of Health's Response to Notice to Give Information in Writing NTG-0280, CTH.001.1000.7892 at .7896.

²⁸⁷ Exhibit 1-08, Adelaide Hearing 1, Statement of Craig Gear WIT.0007.0001.0001 at 0002 [17].

²⁸⁸ Older Persons Advocacy Network, *Annual Report 2018-2019*, 2019, p.4

²⁸⁹ Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4704.27-29.

advocacy was around six weeks.²⁹⁰ Such a wait is too long, as people will generally seek formal advocacy support for a 'here and now' issue, which they may have already spent some time trying to address themselves. These figures indicate to us the need for a significant increase in the availability of formal advocacy support.

280. We understand that formal advocacy may also come from organisations and services outside of the National Aged Care Advocacy Program. Other local consumer and disability support agencies offer individualised advocacy. Community organisations for diverse cultural groups also provide support for people in navigating complicated systems, liaising with service providers and making complaints. In other cases, someone may receive advocacy support from a government agency or statutory authority, such as a public advocate or guardian. We support the continuation of this support for people who are eligible to receive it.

281. In expanding the coverage of formal advocacy, we see great potential for a range of organisations to access funding to improve coverage across the country. Further, we see expanding the National Aged Care Advocacy Program as an opportunity to develop a broad network of advocacy organisations with a capacity to respond in a timely manner, and in person, when people seek formal advocacy support. This network should also have members with specialist knowledge and capacity to advocate on behalf of people from diverse backgrounds and special need groups. This includes Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, the LGBTI community, care leavers, veterans and those with disability. Some members of these communities highlighted the importance of advocates with an understanding of their needs, for example:

Not being able to speak up for myself would be my biggest fear. That's why access to advocacy is crucial – vulnerable people, minority groups and CALD [culturally and linguistically diverse] communities need someone on their side to fight for them. People need to be heard and understood.²⁹¹

282. At Melbourne hearing 2, Dr David Panter, Chief Executive Officer of ECH, spoke of developing a service to assist those in the LGBTI community to navigate services, following consultation on unmet needs:

And so when we did our co-design work with older members of the LGBTI community this issue of navigation and finding your way through the system came up as a really big issue. And so we worked with the community to come up with a service response which is our LGBTI Connect service. And so, essentially, what that means is that we now employ on a part-time basis, currently two older lesbians, two older gay men and an older transwoman, and they act as those ambassadors, those navigators. They're the face of ECH out in the LGBTI community that people can approach to help find their way through the system.²⁹²

²⁹⁰ Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4704.31–36.

²⁹¹ V Samuela, Public Submission, AWF.001.01485.

²⁹² Transcript, Melbourne Hearing 2, David Panter, 10 October 2019 at T5658.4–11.

Advocacy and complaints

283. Ideally, advocating on someone's behalf will lead to an older person gaining access to a service or experiencing an improvement in the quality of care they receive. Most often, this will not require a formal complaint to be made, although sometimes an advocate will need to escalate a concern if it cannot be addressed by the service provider.
284. There should be a two-way relationship between formal advocates and each of the Australian Aged Care Commission (which will have primary responsibility for the conduct of the complaints scheme for all aspects of aged care), and also the Inspector-General. Each of these institutions and the advocacy networks should have the capacity to refer matters to each other. The Commission might refer matters directly received from people receiving aged care or informal advocates to the formal advocacy program, with a view to a mediated and prompt resolution. Formal advocates could refer matters to the Commission when they have failed to resolve a matter, or when a service provider is unwilling to address the issue at hand. We propose that these processes are developed with a timely resolution being the main goal.
285. As the Australian Aged Care Commission develops and articulates a complaints handling process, the role of formal advocates should be built into that role. In this way, the role of a formal advocate will be enhanced and recognised across the system.

Other institutional arrangements

286. In addition, as outlined elsewhere in these submissions, the Australian Government should:
- a. confer on the Australian Commission on Quality and Safety in Health Care responsibility for setting safety and quality standards for aged care, and reviewing them at least every five years
 - b. confer on the Australian Aged Care Commission and the Australian Institute of Health and Welfare responsibilities responsibility for collecting and maintaining aged care data, and for analysing and reporting on aged care data and related datasets, such as health care system data
 - c. seek agreement from the Australian Health Workforce Ministerial Council to confer on the Australian Health Practitioner Regulation Agency responsibility to manage new system governance arrangements.
287. To sum up, we submit that governance of aged care should be independent, specialised and accountable to the Australian public through a single dedicated statutory agency. We submit that the best way to achieve systemic coherence and stability, coupled with agility and the capacity to respond to future need, is to entrust governance to an

independent Australian Aged Care Commission. In this way, aged care should be removed from the uncertainties of politics, lobbying and annual debate about budgetary allocations. The security and predictability of care are foundational to the wellbeing of older people. Other key elements in the governance arrangements include the Aged Care Pricing Authority, the supervisory role of the Inspector-General and the supervisory and policy roles of the Minister and Department.



288. This is a fundamental redesign. It recognises the shortcomings of the existing aged care system, and is a response that addresses them, based on a thorough understanding of the complexity of the system and the need for active and nuanced stewardship by a specialist system governor.

Part 3.3 Program design

Guiding principles for proposed new services, administrative arrangements and funding arrangements

289. In the preceding section of these submissions (Design of the new aged care system), we identified system governance challenges arising out of the nature of the aged care system. We also outlined proposed new institutional arrangements, including: a new approach to system governance, a new body to govern and manage the system (the Australian Aged Care Commission), and the introduction of independent pricing of funding for aged care services (the Aged Care Pricing Authority). In this section we build on the conclusions we reached on these matters, and outline principles that should guide the design of the aged care program. In doing so, we are mindful that the complexity of the system, and the need to accord the Australian Aged Care Commission flexibility in addressing unforeseen challenges, means that it is desirable to avoid detailed prescription.
290. From early December 2019, the Royal Commission conducted consultations on 'program redesign'. By program redesign, we mean design of the administrative arrangements for assisting people to gain access to aged care assessment and services, assessment of eligibility for aged care services, and differences in approaches to allocation of subsidies for the provision of different categories of services and delivering those services.
291. Those consultative processes involved written submissions from interested parties, a hearing in the form of a workshop in February 2020, and the presentation of oral and written submissions by Counsel Assisting on 4 March 2020. The outcomes of those processes contributed to aspects of Sydney Hearing 4 (on home care) from 31 August to 2 September 2020, and aspects of Sydney hearing 5 (on funding and finance) from 14 to 22 September 2020.
292. The key elements of our proposals on program design remain as they were in our submissions on 4 March 2020.²⁹³ The new program should:
- a. transition as quickly as practicable to a point where the availability of subsidies is no longer subject to population-based rationing, and where all older people who are assessed as needing aged care receive it, funded (through independent pricing) to the level required to provide high quality and safe care as assessed
 - b. be reoriented toward wellbeing and independence
 - c. provide information and face-to-face services to enable people to obtain the aged care they need

²⁹³ Submissions of Counsel Assisting, Adelaide Hearing 4, 4 March 2020, RCD.0012.0062.0001.

- d. facilitate innovative accommodation options
 - e. be supported by data collection and analytics
 - f. be supported by strategies to improve coverage and equity of access formed or influenced at the regional and local levels wherever possible
 - g. continue to be provided by a mix of private for-profit businesses, private not-for-profit entities, social and charitable enterprises, religious bodies and governments
 - h. continue under the requirement that subsidies will only be paid to providers who are officially approved or commissioned
 - i. be accessible through a single avenue of assessment for each person who seeks aged care
 - j. continue to be provided through residential aged care facilities on the one hand, and in the home and community on the other, although there might be proportionately fewer people in residential aged care facilities over time
 - k. provide residential aged care services that continue to be bundled (i.e. they will include a mix of health-related, personal care, accommodation and other services)
 - l. provide aged care in the home and community through an integrated set of service arrangements, involving the unification of the CHSP and HCP program.
293. The redesign must strike an appropriate balance between the object of empowering people seeking aged care with greater autonomy and direction of the services they receive and the object of minimising administrative burden on them and on the system more generally. This is particularly acute in the context of home and community care. Some witnesses and submissions before the Royal Commission suggested that assessment and funding leading to the assignment of consumer directed packages are more conducive to empowerment of individual autonomy.²⁹⁴ Others considered the cost-benefit analysis less clear or contended that grant-funded service arrangements are less administratively burdensome, and that they have other advantages.²⁹⁵ It was suggested that grant-funded service arrangements engender more confidence about expected funding, encouraging establishment and retention of services in areas that might

²⁹⁴ Post-hearing submission of COTA Australia, Sydney Hearing 4, 11 September 2020, RCD.0012.0071.0001 at 0002-0003; Transcript, Sydney Hearing 4, Carmel Laragy, 2 September 2020 at T9014.18-19; Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 40, RCD.9999.0461.0001 at 0004-0005.

²⁹⁵ Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 48, RCD.9999.0468.0001 at 0001; Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 44, RCD.9999.0462.0001 at 0005; Transcript, Sydney Hearing 4, Fiona Macdonald, 1 September 2020 at T8978.27-8979.23.

otherwise be undesirable to approved providers, and that they allow the approved provider a flexibility which enables services to be scaled up or down to particular individuals as the occasion arises, because there is no need for every dollar allocated to a particular individual to be spent on that individual.²⁹⁶ At least one witness has emphasised that consumer direction of expenditure is not the only form of choice; for example, choice can be built into ‘coordinated case management’.²⁹⁷

Challenges of transition and implementation

294. It is clear that the existing disparate programs, each with their particular eligibility criteria, assessment processes and budget allocations, should be consolidated and simplified. It is also clear that information about each of those elements needs to be more accessible to the Australian community in all its rich diversity, and better assistance is required to enable people who need services to obtain them.
295. The key challenge to a successful consolidation of services lies in the careful transition of present arrangements for aged care in the community and the home. The Commonwealth Home Support Programme (**CHSP**) is a grant-funded program for particular service categories of time-limited supports accessible through a short form of assessment. The Home Care Package program involves comprehensive assessment of the individual by a different assessment body, and the classification of the individual to one of four levels of funding, and the assignment of that package to the individual to be expended on care in accordance with a plan and individualised budget decided in partnership with an approved provider of the individual’s choice. As can be seen from this brief description, the administration of the CHSP is a far simpler matter than the administration of the Home Care Package program. However, this strength is also a weakness. The CHSP does not have mechanisms designed to cater for individual choice to the extent the HCP program does. The CHSP does not even provide funding for care management, a service to which we give particular attention later in this section. How should these programs best be integrated?
296. In 2018–19, of the 662,552 people who received CHSP services, 401,105 people received care at home funded through CHSP.²⁹⁸ These figures illustrate the magnitude of the task of integrating the CHSP and Home Care Package programs into a single suite of service arrangements. If it is proposed that all people who need care at home should

²⁹⁶ For example, Transcript, Adelaide Hearing 2, Claire Hargreaves, 19 March 2019, T790.28–791.42; Transcript, Broome hearing, Ruth Crawford, 18 June 2019, T2110.28-2111.2; Transcript, Perth Hearing, Mike Moore, 26 June 2019, T2577.8–17; Transcript, Darwin and Cairns hearing, 8 July 2019, Michelle McKay T2916.19–24.

²⁹⁷ Transcript, Adelaide Workshop 1, Professor Deborah Parker, 11 February 2020 at T7786.5-8.

²⁹⁸ These figures are based on analysis undertaken by staff of the Office of the Royal Commission of the Australian Institute of Health and Welfare 2018-2019 Commonwealth Home Support Program data.

receive a comprehensive assessment of need and a package of entitlements to meet those needs, this will involve migrating a large number of people to arrangements for assessment, funding and service delivery that are likely to be administratively more complex than the current arrangements that apply under the CHSP.

297. Before the removal of population-based caps on the availability of subsidies in particular regions, it will be necessary to ensure that a sufficient supply of well trained and skilled nurses and personal care workers are available to provide the care that will be required, and it will be necessary to ensure that the capabilities are in place to ensure that high standards of quality and safety will be met. As we submit in more detail in the final section of these submissions (Part 3.18 Transition and implementation), these considerations necessitate a cautious, phased and flexible approach to implementation by an administrative unit which should commence implementation of the recommendations, and then (upon its establishment) by the Australian Aged Care Commission, closely monitored by the Inspector-General of Aged Care.
298. A number of formal recommendations appear in the remainder of this section, and each of them is accompanied by a proposal about the timing of its implementation. For the purposes of assisting the implementation unit and then the Australian Aged Care Commission in the implementation task ahead, these reforms are also presented in chronological sequence in Transition and Implementation below, alongside the other recommendations we propose.
299. At the conclusion of the steps up to 1 July 2024, by that date the Australian Aged Care Commission should be capable of implementing a new aged care program that should meet the goals, and have the key characteristics, set in the following recommendation.

Recommendation 8: A new aged care program

- 8.1. By 1 July 2024, the Australian Government should implement a new aged care program that combines the existing Commonwealth Home Support Programme, Home Care Packages Program, and the Residential Aged Care Program, including Respite Care and Short-Term Restorative Care. The new program should aim to retain the benefits of each of the component programs, while delivering a more comprehensive continuum of care for older people. The core features of the program should be:
 - a. a common set of eligibility criteria, identifying a need (whether of a social, psychological or physical character) to prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects

of such deterioration, and to enhance the person's ability to function independently as well as possible, for as long as possible

- b. an entitlement to all forms of support and care which the individual is assessed as needing
- c. a single assessment process, using the same assessment framework and arrangements for assessors
- d. certainty of funding based on assessed need
- e. genuine choice accorded to each individual over how their aged care needs are to be met (including choice of provider and level of engagement in managing care, and appropriate and adapted supports to enable people from diverse backgrounds and experiences to exercise choice)
- f. access to one or multiple categories of the aged care program simultaneously, based on need, and
- g. portability of entitlement between providers and across State or Territory borders

Interim measures to improve home care access

300. Recently the Australian Government announced the release of additional home care packages: \$1.6 billion over four years from 2020-21 for the release of an additional 23,000 home care packages across all package levels.²⁹⁹ From November 2020, this provides for 5,000 level 1, 8,000 level 2, 8,000 level 3, and 2,000 level 4 home care packages.³⁰⁰
301. In the Interim Report, Commissioners Tracey and Briggs described at length the effect on people of the lengthy waiting list for home care packages.³⁰¹ The Interim Report provided an estimate of waiting times for people entering the home care package program by package level.³⁰² We update this analysis as follows, which shows that by 30 June 2020, the estimated waiting time for people entering the Home Care Package program by package level have not improved at all over the 12 month period since 30 June 2019, despite some initial movement in February 2020 in waiting times for level 4

²⁹⁹ Budget 2020-21, Budget Measures Budget Paper No 2 2020–21, p 90.

³⁰⁰ Australian Department of Health, Portfolio Budget Statement, p 122–3.

³⁰¹ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, p 145-164.

³⁰² Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, p 153.

packages. We accept that the information available on this is limited to bands of 3 months, which is a large band. This limits the analysis.

Table 1: Estimated wait time for people entering the home care package program by package level (*My Aged Care*)

29 February 2020			
Package Level	Interim package assigned	Time to interim package	Time to approved package
Level 1	Level 1	3-6 months	3-6 months
Level 2	Level 1	3-6 months	12+ months
Level 3	Level 1	3-6 months	12+ months
Level 4	Level 2	6-9 months	12+ months

30 June 2020			
Package Level	Interim package assigned	Time to interim package	Time to approved package
Level 1	Level 1	3-6 months	3-6 months
Level 2	Level 1	3-6 months	12+ months
Level 3	Level 1	3-6 months	12+ months
Level 4	Level 2	12+ months	12+ months

Source: Department of Health, Home Care Package Program Quarterly Data Report

302. The urgent reforms we propose must address the ongoing problem with interim packages - many people continue to wait for a package at their approved level, especially those waiting for a level 4 package.

303. We have also updated Figure 6.1 of the Interim Report as follows.³⁰³

³⁰³ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, p 156.

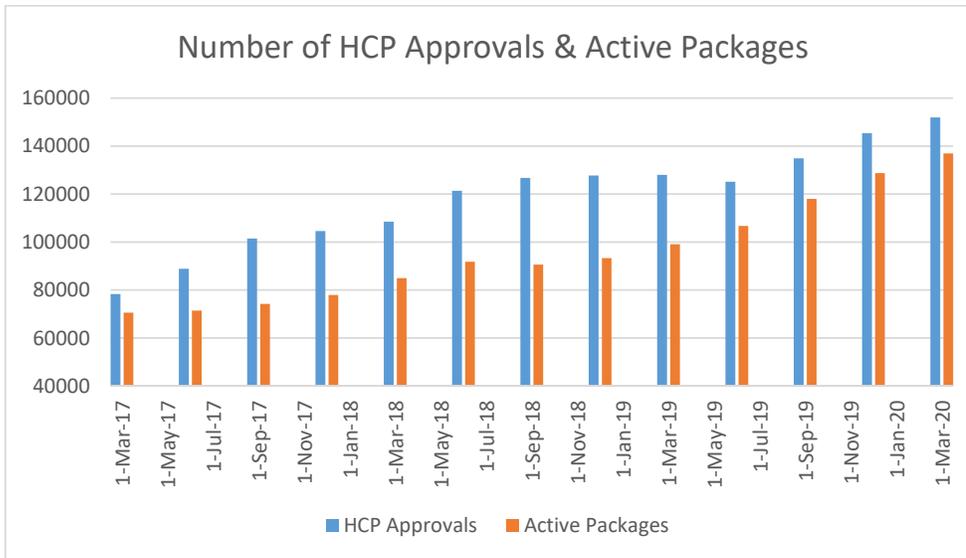


Figure: Number of Home Care Package approvals and active Packages: March 2017 to March 2020

304. The figure above indicates that there has been some narrowing of the gap between the number of home care package approvals and the number of active home care packages between 31 December 2018 and 31 March 2020. Accordingly, while those that were waiting in 31 December 2018 are more likely to have received a package, those that were approved since 31 December 2018 are just as likely to wait. Further, they are likely to wait for the same amount of time for a package at their assessed level as people in the past.

Recommendation 9: Meeting preferences to age in place

9.1. The Australian Government should clear the home care package waiting list, otherwise known as the National Prioritisation System, by:

- a. immediately increasing the home care packages available and allocating a package to all people on the waiting list that do not have a package or do not have a package at the level they have been approved for (as set out in their letter from the Aged Care Assessment Team/Service). The package allocated should be at the level the person was approved for (Level 1, 2, 3 or 4). This must be completed by 31 December 2021
- b. keeping the waiting list clear by allocating a home care package at the approved level to any new entrants to the waiting list within one month of the date of their assessment. This must occur between 1 January 2022 and 1 July 2024, and

- c. publicly reporting, each quarter, the status of the waiting list, showing progress in clearing the waiting list as set out in paragraphs a. and b. above, at a national, State or Territory, and regional level. This report should include reasons for delay in clearing the waiting list and actions being taken to address the delay. This must occur every quarter from 31 March 2021 to 1 July 2024.

305. The effect of the lengthy wait is profound. Commissioners Tracey and Briggs have stated all the reasons why it is unacceptable. This must be addressed urgently.
306. In tandem with these measures, the Australian Government should make available certain services from categories of services that are currently grant-funded, and which would continue to be grant-funded under certain proposals we outline below. In particular, the Australian Government should allow access to the Commonwealth Home Support Programme for people using a home care package for social support services (group and individual), centre-based respite services, transport services and meals.

Local assistance to gain access to services

307. As submitted in detail in Counsel Assisting's written submissions on program redesign dated 4 March 2020, a person seeking care may wish to have the assistance of a 'care finder' to help them to engage with the local assessment team, and with local approved providers who might suit them.³⁰⁴ If the person wishes, there should be scope for consultation between the approved providers and assessment team about the person's preferences and available services before the assessment is finalised. Prompt re-assessment should be available whenever the person's needs change in any material way, and reassessment and contact with new approved providers may be facilitated by the care finder, if the individual wishes this.

Recommendation 10: Care finders to support navigation of aged care

- 10.1. From 1 July 2023, the Australian Aged Care Commission should engage, support and fund 'care finders' to provide assistance on a local, face-to-face basis, to people seeking or receiving aged care services. The care finders should be Commonwealth, State or Territory or local government employees who have suitable skills and experience in meeting the needs of people for aged care, health care, social work or other human services, or otherwise

³⁰⁴ Submissions of Counsel Assisting, Adelaide Hearing 4, 4 March 2020, RCD.0012.0062.0001 at 0024-0035.

demonstrate aptitude for a highly trusted role in assisting older people who have such needs.

10.2. Pending establishment of the Commission, the implementation unit referred to in Recommendation 123 should commence engagement of care finders.

308. A care finder should commence assisting a person on receipt of a request (either directly or indirectly through an office of the Australian Aged Care Commission or otherwise) for assistance, from an older person seeking aged care, or from any person making a request on an older person's behalf such as a carer, family member, legally appointed representative or a health professional or social worker.
309. The degree of involvement by the care finder will vary depending on the complexity of the person's needs and their assessed vulnerability.
310. Care finders must be subject to strict conditions of integrity in their employment, including a duty to provide care finding services in assisting people seeking or receiving aged care and to avoid conflicts of interest in assisting them.
311. The functions of care finders are to assist people seeking aged care services, and their informal carers, family or legally appointed representatives, with information about the aged care system and case management services, and in particular:
 - a. providing face-to-face assistance to help older people and their informal carers understand the processes involved in obtaining aged care
 - b. understanding the expressed needs and goals of the older person and helping the person to make a plan for the services they wish to receive
 - c. assisting the older person to understand, gain access to and participate in assessments and reassessments of needs and eligibility for aged care, and working closely with the local assessment team to facilitate the assessment process
 - d. ascertaining the best options for services in the local area and linking the person to these options, either through providing information or making referrals on behalf of the person. This may also involve linking the person to support outside the aged care system (for example, housing or mental health)
 - e. following up to make sure that the referrals have been accepted and the support and care identified in the assessment is in place
 - f. conducting regular check-ins with the person receiving aged care services to ensure that the services are meeting their needs

- g. where changes in the older person's needs occur, or services are not meeting the older person's needs, taking any necessary steps in consultation with the person receiving aged care services, including arranging re-assessments or referrals to other services.

More accessible and usable information on aged care

312. It is of crucial importance that there be a comprehensive national information service for aged care, to provide a trustworthy and official source of information of assistance to people seeking aged care services, or deciding whether to switch from one approved provider to another. The official government information service for the aged care system is the My Aged Care website and call centre. My Aged Care also acts as a repository of administrative data about aged care assessments and services. In the Interim Report, Commissioners Tracey and Briggs were critical of many aspects of My Aged Care.³⁰⁵ However, there have been four sets of changes to My Aged Care since this Royal Commission commenced, three of which post-date the Interim Report: in June 2019, January 2020, March 2020 and June 2020.³⁰⁶
313. The Australian Aged Care Commission should keep My Aged Care under regular review, and future decisions to improve or replace it, change its branding, or reallocate any of its data management functions, should be left to the judgement of the Commission based on up-to-date information about the performance of My Aged Care and user satisfaction with its functionality. In making future improvements, it is clear that the Commission should improve the information available on My Aged Care (or any future national information system) about relative approved provider performance, and should require more detailed information about service availability in particular locations. For example:
- a. The approved provider search and comparison function on My Aged Care should be further refined to include:
 - i. more detailed information on the kinds of services the approved provider delivers and any limitations in the types of services provided in particular localities
 - ii. information on performance indicators and star ratings (when those systems are established)
 - iii. information on staffing, including staff turnover

³⁰⁵ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, p 123–140.
³⁰⁶ Australian Government, Department of Health, Updates to My Aged Care, <https://www.health.gov.au/initiatives-and-programs/my-aged-care/updates-to-my-aged-care#recent-updates>, viewed 19 October 2020.

- iv. the number, nature and disposition of complaints made to the Australian Aged Care Commission
 - v. the number of reports made to the Australian Aged Care Commission under the serious incident response scheme
 - vi. up-to-date consumer experience reports arising from interviews by the Australian Aged Care Commission of the people receiving care from the approved provider
- b. All information at (i) to (vi) should be presented in a standardised manner and should be verified to the satisfaction of the Australian Aged Care Commission.
314. As submitted in our program redesign submissions dated 4 March 2020, there are many other ways in which accessibility of information about aged care should be improved, and people should be encouraged to make timely plans for their later years, including plans about aged care.³⁰⁷

Recommendation 11: Improved public awareness of aged care

11.1. By 1 July 2022, the Australian Government in cooperation with other levels of government, and working with health professionals, aged care providers and Primary Health Networks, should fund and support education and information strategies to:

- a. improve public awareness of resources to assist people to plan for ageing and potential aged care needs
- b. improve knowledge about aged care among those responsible professionals with whom older people have frequent contact
- c. encourage discussion about and consideration of aged care needs.

11.2. These strategies should be implemented by 1 July 2022 and should:

- a. support a continuum of planning for ageing, including consideration of health care preferences, finances, housing and social engagement
- b. bring older people's general practitioners to the centre of their planning for ageing and aged care
- c. be evaluated and revised annually by the Australian Aged Care Commission.

³⁰⁷ Submissions of Counsel Assisting, Adelaide Hearing 4, 4 March 2020, RCD.0012.0062.0001 at 0021-0023.

A single avenue of assessment

315. As also submitted in our submissions dated 4 March 2020 and supplemented above, each person seeking aged care of any kind should receive timely access to a scalable assessment through a single assessment process.³⁰⁸ A person receiving aged care of any kind should receive timely re-assessment upon any material change in conditions or needs.

Recommendation 12: A single comprehensive assessment process

12.1. By 1 July 2023, the Australian Government should replace the Aged Care Assessment Program and the Regional Assessment Services with a single assessment process. That assessment process should:

- a. be independent from approved providers, so that a person's level of funding should be determined independently of the approved provider, but that determination may involve consultation with providers or prospective providers, provided final assessment decisions affecting eligibility for funding are made by independent assessors
- b. occur, wherever possible, before funded services commence, although funded services may be offered on an interim basis pending assessment where this is necessary in the opinion of a care finder
- c. be efficient and scalable according to the complexity of needs and vulnerability of the older person
- d. be forward-looking and promote older people's autonomy and self-determination
- e. include assessment of the need for care management and the intensity and complexity of that need
- f. include an assessment of any informal carer's needs, and
- g. use multidisciplinary teams for more complex needs

12.2. People should be provided with details of their assessed need and funding level at the conclusion of the assessment process, and

12.3. Reasonable requests for reassessment of need can be made by a person receiving care (or their informal carer, close family or other representative), their care finder, or their approved provider

³⁰⁸ Submissions of Counsel Assisting, Adelaide Hearing 4, 4 March 2020, RCD.0012.0062.0001 at 0044-0049.

316. Features to incentivise an enabling approach to residential care should be incorporated in the rules, principles and guidelines for assessment. These features are outlined in Part 3.15, below.

Informal carer needs and respite care

317. In these submissions, we address the importance of informal carers to the sustainability of the aged care program and system, and we outline our recommendations directed to supporting informal carers. We now address how the general administrative arrangements we recommend for the new aged care program should provide additional support for informal carers. This starts with care finding and assessment of need and eligibility to receive subsidised services. As we submitted in detail in our program redesign submissions on 4 March 2020, assessment should explicitly focus on the needs of the informal carer, as well as on the primary person receiving aged care.³⁰⁹ Comprehensive assessment for eligibility for aged care should give attention to the needs of informal carers of older Australians in their own right, leading to specific assessed entitlements for informal carers to receive support services, such as counselling, training, and respite. The guidelines for assessment should not confine the availability of respite to circumstances where the caring relationship is already under strain. It should be available on a preventative basis and be used as a potential opportunity for enablement so that the older person is assisted to restore their capacity or manage it themselves.
318. Respite care³¹⁰ requires urgent attention and expansion in scope, variety and scale. Current respite offerings are difficult to navigate, not financially viable for providers and insufficient to address the needs of older people and their carers.³¹¹ The services are currently under-delivered but in high demand. People and providers do not understand respite and it does not support carers.³¹² Service coverage is of particular concern in outer regional areas and beyond. New grant-funded respite services should commence

³⁰⁹ Submissions of Counsel Assisting, Adelaide Hearing 4, 4 March 2020, RCD.0012.0062.0001 at 0036.

³¹⁰ Currently defined as short term care that is provided with the primary purpose of giving a carer or care recipient a break from their usual care arrangement by *Aged Care Act 1997*, schedule 1.

³¹¹ Transcript, Adelaide Workshop 1, Sue Elderton, 11 February 2020 at T7754.42-7755.2 and T7775.38; Exhibit 7-4, Mildura Hearing, Statement of Rosemary Cameron, WIT.0309.0001.0001 at 0008 [50]-[52]; Transcript, Mildura Hearing, Dr Meredith Gresham, 30 July 2019 at T4019.23-4020.3 and T4037.32-37; Transcript, Mildura Hearing, Dr Lyn Phillipson, 30 July 2019 at T4020.33-4021.8; Transcript, Mildura Hearing, Shontia Saluja-Honeysett, 29 July 2019, T3932.1-9; Transcript, Mildura Hearing, Darren Midgley, 31 July 2019 at T4100.36-42 and T4087.26-31.

³¹² Transcript, Mildura Hearing, Darren Midgley, 31 July 2019 at T4097.3-10; Exhibit 7-3, Statement of Dorothy Holt, WIT.0336.0001.0001 at 0003 [21]-[22]; Transcript, Mildura Hearing, Rosemary Cameron, 29 July 2019 at T3882.26-38; 'Draft Counsel Assisting's outline of proposed new service arrangements for aged care in the community and home' (2020) (Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 59, RCD.9999.0474.0004 at 0008).

as soon as is practicable, with a view to replacing the current residential respite arrangements when sufficient scale has been attained.

Recommendation 13: Respite supports category

13.1. From 1 July 2022, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should implement a respite supports category within the aged care program that:

- a. supports the carers of older people earlier and more often to maintain their wellbeing and supports the caring relationship
- b. provides a greater range of high quality respite support in people's homes, in cottages and in purpose-built facilities
- c. provides people with up to 63 days of respite per calendar year
- d. is grant funded with a capital component.

13.2. The respite supports category should continue within the new aged care program from 1 July 2024.

319. People assessed as being in need of respite should be entitled receive up to 63 days per year of respite care, in line with the annual cap imposed under the present arrangements. However, conditions of the grant agreements under which respite is provided should ensure that a person's quota of respite may be used in the blocks of time they choose, whether that be as one weekend a fortnight or more sporadically, and that providers are not to impose any requirements about minimum blocks of time. Respite should be accompanied by access to meaningful activities for the person receiving care, and should have a strong enabling and restorative focus. Respite has a dual purpose - it provides relief for the carer as well as improved outcomes for the person receiving care. New requirements for respite can most readily be imposed through conditions in direct grant agreements. Direct grant agreements will also have the advantage of removing pricing distortions and arbitrage opportunities that currently apply, and which appear to have led to the residential respite program being used for purposes other than the purpose for which it was designed.³¹³

320. New respite services should be built in consultation with carers and the Carer Gateway to determine what will best meet their needs. This co-design approach will provide access to different models of respite, including cottage based overnight and short-term

³¹³ Australian Government, Aged Care Financing Authority, Report on respite for aged care recipients, 2018, p 3 (Exhibit 7-1, Mildura Hearing, General Tender Bundle, tab 26, RCD.9999.0124.0102 at 0104).

multiday respite services, in-home day and overnight care, and respite in a nursing home. Respite should be commissioned through the regional offices of the Australian Aged Care Commission so that, as far as possible, local needs are understood and met through the commissioning process, and to create better opportunities to co-ordinate respite with other local aged care and carer support services.

321. Respite should be provided in addition to any care at home entitlement conferred by the home care package. This will ensure that the provision of respite should not diminish the money available for the provision of ongoing supports and care for the person receiving care.
322. As outlined in our submissions at Part 3.7 Informal carers, the Department of Social Service's Carer's Gateway should be linked to the systems by which respite is made available so that informal carers are not confronted by separate system and the task of attempting to co- ordinate disparate services in order to obtain help.

Aged care in the home and community

323. The current Home Care Package program will have to continue for some time pending the integration of Commonwealth Home Support Programme and the Home Care Package program. Under the Home Care Package program, where an older person is assigned a home care package, they must select an approved provider of home care to administer the package and manage the care provided with funds provided via the package (a '**lead provider**'). The following arrangements should be adopted by the Australian Aged Care Commission for the duration of the Home Care Package program, and should continue under the integrated service arrangements for aged care in the community and home, and to the extent that the new arrangements continue to include any form of subsidisation in the form of an assessed package of entitlements to home care.
324. A package-holder's lead provider may arrange for or permit third parties to provide direct care services, but in doing so the lead provider will remain at all times responsible for ensuring that high quality and safe care is provided, and (if it is not provided) liable for non-compliance with the quality standards and potential contravention of the general duty to ensure safe and high quality care. This responsibility and potential exposure to liability should ensure that the lead provider discharges its 'care management' role with due care and skill. It should also provide a strong incentive for the lead provider to give weight to the advantages of directly employing its care workforce, so as to ensure its ability to supervise and direct the way in which services are delivered.
325. 'Care management' is an integral element of aged care, and is especially important for people who have complex needs or needs which require multiple or intensive responses.

It goes without saying that care management is a critical element of residential care, but in the home and community aged care context its role is liable to be misunderstood or undervalued, because of the wide spectrum of individual needs and circumstances presented in that setting. A care manager must consult closely with the person seeking care and any informal carers, and must understand their preferences for what care they wish to receive, when and how, and all this must be documented in a care plan. An individual may choose to be more or less involved in the week-to-week direction and management of their care. There should be flexibility in what the role entails and how it is performed, particularly in the context of home and community aged care. For example:

- a. A person may wish to have minimal direction and oversight in the management of their care, with their chosen home care provider organising and delivering services in accordance with the assessment process and the care plan established at the start of their relationship. This would not remove the requirement for a relationship-centred approach to the delivery of care.
 - b. A person may wish to exercise a higher degree of choice over who delivers care and when. For example, they may want a specific staff member to shower them each day. They may want their home care provider to engage a specific person or another provider to deliver an element of their care plan. For example, they may wish to continue to see a particular allied health professional who is not employed by their home care provider.
326. It is conceivable that some people may be assessed as being eligible for some basic form of care in the home, and as not requiring care management. However, in every other case the lead provider must give due consideration to the scope and nature of the care management role that will best suit the individual. The lead provider may be liable for a contravention of the new general duty to ensure high quality care if they fail to do so and if the risk of harm or harm results.

Recommendation 14: Approved provider’s responsibility for care management

- 14.1. From 1 July 2022, unless an assessment team has assessed the person as eligible for home care (or, from 1 July 2024, care at home) without the need for any care management, the person’s approved provider must assign a care manager to the person.
- 14.2. In the case of home care (or, from 1 July 2024, care at home), if the person has more than one approved provider, the person’s lead provider must assign a care manager to the person.

14.3. Care management should be scaled to match the complexity of the older person's needs and should be provided in a manner that respects any wishes of the person to be involved in the management of their care.

14.4. The care manager should:

- a. have relevant qualifications and experience as a registered nurse or allied health professional
- b. consult with the person and, if applicable, their carer, to develop a comprehensive support and care plan, including activities to promote various aspects of health and wellbeing and to enhance their ability to live or participate in the community and address their strengths, capability, aspirations and goals
- c. implement, monitor and review the support and care plan, and adjust as appropriate
- d. for home care (or, from 1 July 2024, care at home), meet the requirements for care management set out in the care recipient's care plan and (if applicable) personalised budget
- e. for residential care:
 - i. identify when the older person accessing aged care services requires additional care beyond the usual services provided by the approved provider
 - ii. take reasonable steps to ensure that the older person in aged care accesses appropriate health care at an appropriate time
 - iii. take reasonable steps to ensure that any health care plan is implemented on an ongoing basis and updated as required
 - iv. liaise with general practitioners, other primary health care providers, including allied health care providers, specialists and multidisciplinary outreach services; and take reasonable steps to ensure that staff of the provider are available to support visiting health practitioners
 - v. liaise with the person's family and staff of the aged care provider.

327. For people who are assessed as needing support and care outside a residential setting, a range of different options for design of the service arrangements have been tested during consultations and in hearings of the Royal Commission.

328. In addition to respite care, during the hearings of the Royal Commission in September 2020, we tested propositions for two other grant-funded categories of services available to support people in their homes and in the community – Social supports and Assistive technology/home modifications. Some services from these categories of services may also be available to people receiving residential care, for example assistive technology equipment to aid mobility, or transport to activities to enhance a person’s social participation. These proposals received general support³¹⁴ and we recommend that the following service arrangements should be adopted.

Social supports category

329. Social supports’ are supports that improve social inclusion and community participation among older people, and represent the social support, delivered meals and transport service types from the Commonwealth Home Support Programme. These supports are also provided to people with home care packages. In future, they should be linked wherever possible with services and activities provided by local government, community organisations and business designed to enhance the wellbeing of older people.

Recommendation 15: Social supports category

15.1. From 1 July 2022, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should implement a social supports category within the aged care program that:

- a. provides supports that reduce and prevent social isolation and loneliness among older people
- b. can be co-ordinated to the greatest practicable extent in each location with services and activities provided by local government, community organisations and business designed to enhance the wellbeing of older people
- c. includes the social support, delivered meals and transport service types from the Commonwealth Home Support Programme, and
- d. is grant funded.

³¹⁴ Transcript, Sydney Hearing 4, Fonda Voukelatos, 31 August 2020 at T8851.34-44; Transcript, Sydney Hearing 4, Carmel Laragy, 2 September 2020 at T9020.39-9021.5; Transcript, Sydney Hearing 4, Michael Lye, 2 September 2020 at T9054.17-20; Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 87, RCD.9999.0492.0003 at 0003; Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 83, ANM.0024.0001.0001 at 0003; Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 71, RCD.9999.0464.0003 at 0007-0008; Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 70, RCD.9999.0480.0001 at 0002.

15.2. The social supports category should continue within the new aged care program from 1 July 2024.

Assistive technology and home modifications

330. Ageing brings changes in functioning that can impact on a person's capacity to live independently.
331. Currently, aged care services provide limited opportunity to access support to regain, maintain or learn to live with new functioning. Under the new program, there will be a greater focus on the provision of support through assistive technology and home modifications together with awareness of changes to function. There is also a need for a focus on providing goods and services that help older people to manage changes in functioning. This category focuses on maximising older people's independence to perform tasks or activities and minimise any risk to their safety.
332. Improved access to assistive technology and home modifications will also assist older people with hearing and vision impairments that cannot otherwise receive support under the National Disability Insurance Scheme due to age.

Recommendation 16: Assistive technology and home modifications category

- 16.1. From 1 July 2022, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should implement an assistive technology and home modifications category within the aged care program that:
- a. provides goods (including aids and appliances) and services that promote a level of independence in daily living tasks and reduces risks to living safely at home
 - b. includes the assistive technology, home modifications and hoarding and squalor service types from the Commonwealth Home Support Programme, and
 - c. is grant funded.
- 16.2. The assistive technology and home modifications category should continue within the new aged care program from 1 July 2024.

Care at home

333. In addition to the three grant-funded categories of services recommended above, during the home care and funding hearings in September 2020, we proposed a ‘care at home’ category of services, to be provided upon assessment and assignment of either a personalised budget reflecting the individual’s assessed needs, or else a standard amount based on a particular casemix classification.
334. Professor Eagar considered that this would have the effect of moving many services into individualised funding bundles, which would adversely affect the delivery of services currently funded through the Commonwealth Home Support Programme.³¹⁵ Professor Eagar’s preferred model of aged care services involved the creation of four streams, two of which could deliver care at home:
- a. primary aged care services, being ‘those that can be accessed directly and without a formal comprehensive assessment’ including domestic and social support, funded on a price and volume basis, and³¹⁶
 - b. secondary aged care services, being those required by people ‘living at home with higher level needs’, to be funded on a casemix basis, with some episodic services funded on a price and volume basis³¹⁷
335. In her oral evidence, Professor Eagar also discussed a potential compromise between her proposed model and the propositions we advanced, which would give an older person a choice between managing a package of funds themselves and choosing to have their services provided to them by a single provider who would receive a block grant from the Australian Government.³¹⁸
336. As explained by Dr Hartland, the Department of Health has been conducting design work on a new integrated program for aged care in the community and home using a consultant, HealthConsult. HealthConsult’s preliminary proposals involve a mixed model based on a ‘triage’ of people who receive assessment. HealthConsult proposes a fee-for-service approach to funding and allocating services needed by people who have relatively simple needs, and a ‘classification’ approach for people who have more complex needs for ongoing care or short term reabling care, and for informal carers. The classification approach would involve classifying the person to one of several different levels of funding, corresponding to the estimated costs of meeting needs of the kind the

³¹⁵ Transcript, Sydney Hearing 5, Professor Kathleen Eagar, 17 September at T9355.43-9356.7.

³¹⁶ Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0009 [49]-[50].

³¹⁷ Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0011 [64].

³¹⁸ Transcript, Sydney Hearing 5, Professor Kathleen Eagar, 17 September at T9356.37-9357.5.

person is assessed to have.³¹⁹ Dr Hartland said that there were similarities between HealthConsult's report and Professor Eagar's initially proposed model.³²⁰ Dr Hartland preferred Professor Eagar's initial proposal to her compromise model.³²¹

337. Before settling the details of the administrative and funding arrangements for the 'care at home' category, or finalising the scope of this category, the Australian Aged Care Commission should complete its work on the optimal design for the integration of the Commonwealth Home Support Programme and Home Care Package program. This should include a study to ascertain the need characteristics, service usage patterns and resource requirements of people who access care at home. This study should be used to develop a classification system with distinct classes of need within categories based on clinically meaningful differences in service usage patterns and resource requirements. Classes of need would identify particular entitlements across care management; personal care and meal preparation; clinical, enabling and therapeutic care (including nursing care, allied health care and short-term enabling plans); respite; and palliative and end-of-life care. The study should address whether individualised budgets, casemix funding levels, or some other mechanism for funding, such as direct grants, are appropriate. It should identify whether different funding mechanisms should be used for certain service types or different needs classifications, including, if any direct grant arrangements are to be used, whether price and volume funding, or block funding should apply, and to what services or in what circumstances,.

HealthConsult's most recent available report [Ex 21-1, tab 106, HealthConsult - ACF Model Options Final Report (26 May 2020) CTH.1000.0004.8045] indicates that they recommend development and examination of a particular model of scalable or 'proportionate' assessment, with classification and funding dependent on a triage or 'screening' process during assessment (see in particular at CTH.1000.0004.8053). For people screened during assessment as having a relatively simple need to access a particular service, they would 'classified and funded using only service events'. Classification and funding using service level events is described (especially at CTH.1000.0004.8052) as being analogous to Medicare Benefits Schedule classification and funding, and each such service would be classified to a class for which there would be a pre-specified payment, set with reference to a standardised price schedule. For people assessed as having one of three categories of (what HealthConsult calls) 'episode level' needs, a more complex assessment would result in classification of the person to a particular level of funding entitlement. HealthConsult explain (especially at CTH.1000.0004.8052-3) that this is similar to many aspects of the AN-ACC classification and funding system – in other words, it is a casemix-adjusted classification and funding concept. HealthConsult explain that this process of assessment, classification and funding would be provided to people with an 'ongoing care episode' of need, or a 'short term (including reablement) episode' of need, and also to assess, classify and fund services to meet the needs of informal carers (especially at CTH.1000.0004.8052-3 and 8084). The same person might experience all three episode types in parallel (at CTH.1000.0004.8084).

³²⁰ Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9444.26-30.

³²¹ Transcript, Sydney Hearing 5, Nicholas Hartland, 18 September 2020 at T9436.47-9437.1.

338. In conducting this work, the Australian Aged Care Commission should consult with the sector and older people who use the relevant services, and should conduct any trials it deems necessary. In doing so, the Commission should consider the following proposals:
339. The Australian Government and Australian Aged Care Commission should be in a position to commence payment of subsidies for service provision within a new 'care at home' category by 1 July 2024. This category should be developed and iteratively refined in consultation with the aged care sector and older people. The starting point for this consultation, development and refinement process should be that this category:
- a. supports older people living at home to preserve and restore capacity for independent and dignified living to the greatest extent and prevents inappropriate admission to long-term residential care
 - b. offers episodic or ongoing care from low needs (for example, one hour of domestic assistance per week) to high needs (for example, multiple hours of personal care and nursing care)
 - c. provides a form of entitlement (such as, for example, a budget) based on assessed needs which allows for a coordinated and integrated range of care and supports across the following domains:
 - i. Care management
 - ii. Living supports - cleaning, laundry, preparation of meals, shopping for groceries, gardening and home maintenance
 - iii. Personal, clinical, enabling and therapeutic care - including nursing care, allied health care and restorative care interventions, and
 - iv. Palliative and end-of-life care
 - d. requires a lead provider to be nominated by the older person. The lead provider will:
 - v. be responsible for ensuring that services are delivered to address the assessed needs
 - vi. monitor the status of people receiving care and adjust the nature and intensity of the care to meet the person's needs, and
 - vii. seek a reassessment if an increased need persists beyond 3 months
340. Many people receiving aged care services do not have sufficient access to allied health services and are missing out on the many benefits that those services can provide.³²²

³²² See, for example, Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0003; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi,

Multiple witnesses described the importance of maintaining mobility and functionality and the crucial role of allied health in achieving this.³²³ Maintenance of a person's functionality sustains their independence and quality of life.³²⁴ The new program must focus on wellness, reablement and rehabilitation, and extend beyond physical health to a multidimensional view of wellbeing.³²⁵

341. A key theme that emerged from the evidence was the need for the aged care system to support the delivery of allied health care in a way that is person-centred and focuses on the goals of the individual.³²⁶ This is ultimately 'about ensuring that individuals who want to continue to be engaged in things that are meaningful for them and have purpose in their life need to have capacity to do so'.³²⁷ An allied health service provider's ultimate goal is arguably to facilitate wellbeing.³²⁸
342. While much of the evidence related to people living in residential aged care, witnesses described similar considerations affecting people receiving aged care services at home. The level of use of home care packages to fund allied health care remains low and is affected by a lack of understanding of the availability and benefits of allied health.³²⁹
343. Many witnesses emphasised the importance of comprehensive initial assessments and ongoing assessment in the delivery of allied health care.³³⁰

RCD.9999.0344.0001 at 0005, 0007, 0010; Exhibit 17-20, Melbourne Hearing 4, Statement of Esther May, RCD.9999.0358.0001 at 0003 [15]; Transcript, Melbourne Hearing 4, Jennifer Hewitt, 16 July 2020 at T8237.14–16; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8256.25–27; Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8281.29-44.

³²³ Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8256.17–22; Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0003; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0005 [28].

³²⁴ Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.999.0345.0001 at 0004 [9a]; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0005–0006; Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8286.1–5.

³²⁵ Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD. 9999.0345.0001.0001 at 0003 [8a], 0011 [15b]; Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0007 [7]; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0006 [30a]-[30b]; Exhibit 17-21, Melbourne Hearing 4, Life Care – Response to draft propositions, RCD.9999.0334.0001 at 0003; Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8279.4–10; Transcript, Melbourne Hearing 4, Claire Hewat, 17 July 2020 at T8287.30–32.

³²⁶ Transcript, Melbourne Hearing 4, Angeline Violi, 16 July 2020 at T8257.16–18; Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8279.7–10; Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8300.23–25; Transcript, Melbourne Hearing 4, Christopher McGowan, 17 July 2020 at T8323.23–28.

³²⁷ Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8256.30–33.

³²⁸ Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8261.25–28.

³²⁹ Exhibit 17-1, Melbourne Hearing 4, General Tender Bundle, tab 22, CTH.1000.0004.1012 at 1015; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.999.0345.0001 at 0005 [9d]; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0009.

³³⁰ Exhibit 17-15, Melbourne Hearing 4, Statement of Stephanie Ward, RCD.9999.0356.0001 at 0005; Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt,

344. Witnesses spoke about the importance of allied mental health professionals, including psychologists and social workers, and the need to integrate mental health responses with other allied health services.³³¹
345. To ensure care at home includes a level of allied health care appropriate to each person's needs, in the course of developing and refining the arrangements for the care at home service category, the Australian Aged Care Commission should consider the following proposals:
- a. the assessment process for eligibility for care at home should identify any allied health care that an older person needs to restore their physical and mental health to the highest level possible (and maintain it at that level for as long as possible) to maximise their independence and autonomy
 - b. the funding assigned to the older person following the assessment should include an amount to meet any identified need for allied health care, episodic or ongoing. This allocation must be spent on allied health care and be consistent with practice guidelines developed by the Australian Aged Care Commission
 - c. the older person's lead home care provider should be required to:
 - i. be responsible for ensuring that these services are delivered
 - ii. monitor the status of people receiving care and adjust the nature and intensity of the care provided to meet the person's needs
 - iii. seek a new aged care assessment if an increased need persists beyond 4 months
 - d. the aged care program should reimburse the provider for the cost of any additional allied health care needed by the older person through an adjusted home care package, without the need for a new aged care assessment, for a period of up to 4 months, and undertake a new aged care assessment if the need for additional services persists beyond 4 months.
346. The Australian Aged Care Commission should continue with the work of identifying and testing the details of the assessment, classification and funding arrangements best adapted for care at home, using the above proposals as a starting point. In tandem with this process, the aged care program should adopt direct funding arrangements (based

³³¹ RCD.9999.0315.0001.0001 at 0009; Transcript, Melbourne Hearing 4, Stephanie Ward, 16 July 2020 at T8244.15–18; Transcript, Melbourne Hearing 4, Esther May, 17 July 2020 at T8282.35–38; Transcript, Melbourne Hearing 4, Nigel Lyons, 17 July 2020 at T8322.40–47. Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0004; Exhibit 17-19, Melbourne Hearing 4, Allied Health Professions Australia – Response to draft propositions, RCD.9999.0325.0001 at 0010-0011; Transcript, Melbourne Hearing 4, Stephanie Ward, 16 July 2020 at T8235.22–23.

on block and activity-based funding agreements) for providers of social supports, home modifications and assistive technology and respite, as we have outlined above.

347. The Australian Aged Care Commission should consider developing and adopting a casemix-based classification and funding mechanism to meet relatively more complex and intense needs for care at home.
348. Throughout these steps, it will be critical to ensure that
 - a. no interruption occurs to the continuity of services provided by providers directly contracted to provide services under Commonwealth Home Support Programme
 - b. a smooth transition occurs from the currently separate Commonwealth Home Support Programme and Home Care Package program to the new service arrangements, and
 - c. people seeking support and care in the community are met with a 'seamless' process of assessment, assignment of entitlement and service delivery, supported (if they choose) by a 'care finder'.
349. Irrespective of the precise arrangements chosen for classification and funding, people assessed as needing to receive care at home will have to be put in contact (with the assistance of a 'care finder', if they choose) with a home care service provider who will have responsibility for care management and co-ordination of services.
350. There should be flexibility in how care management is provided, subject to reasonable limits. For this reason, rather than encouraging 'self-management' by a person of their own home care, the program should enable 'shared management', ensuring the lead provider always retains responsibility for ensuring the person's needs are being met and that quality and safe care is provided in accordance with the person's plan or package.
351. Perhaps the most important element of the new approach to care in the home and community will be regular review and flexibility in the implementation and refinement of service delivery elements. The Australian Aged Care Commission (and any interim implementation unit or body) should perform regular monitoring and respond with improvements in the detail of access and service arrangements. Where the data or complaints information show that there are systemic problems developing, those problems should be addressed promptly by refinement of the arrangement.

Residential care

Recommendation 17: Residential care category

17.1. From 1 July 2024, the Australian Government and the Australian Aged Care Commission should implement a category within the new aged care program for residential care that:

- a. provides older people with:
 - i. goods and services to meet daily living needs
 - ii. accommodation
 - iii. care and support to preserve and, where possible, restore capacity for meaningful and dignified living in a safe and caring environment
- b. ensures care is available for people who can no longer live at home due to their frailty, vulnerability or behavioural and psychological symptoms of dementia, or other similar reasons
- c. provides integrated and high quality and safe care based on assessed needs, which allows for personalised care, regular engagement, and a coordinated and integrated range of supports across the following domains:
 - i. Care management
 - ii. Social supports, including support for psychological, cultural and (if applicable) spiritual wellbeing
 - iii. Personal, clinical, enabling, therapeutic care and support – including nursing care and allied health care
 - iv. Palliative and end-of-life care.

352. The most appropriate model for funding of residential care is casemix-adjusted activity based funding. Casemix-adjusted funding is appropriate where a single provider will be responsible for providing or coordinating all the aged care services the person needs to receive.

353. Under these circumstances, consumer choice is limited to selecting a single provider, as there is no scope for funding to be split between providers for different services and activities. The one provider is responsible for delivery of the entire bundle of supports and care the person will receive. The bundled approach is the most appropriate model of care, because there are significant overlaps between the daily living and care needs

of residents, and between the built environment in which care and daily living supports are delivered. The bundled approach ensures that the one provider is responsible and may ensure that holistic support and care is provided for the person covering their nutritional needs, personal care needs, nursing, healthcare, allied healthcare needs, as well as support that enhances their quality of life and wellbeing.

354. It follows that casemix-adjusted activity based funding is the most appropriate model. The Department is well advanced in trials of the particular casemix funding model for Australian residential aged care, the Australian National Aged Care Classification (AN-ACC) model.
355. These trials should be continued and completed by the interim implementation unit and by the Australian Aged Care Commission. In due course, AN-ACC should be revised with a view to inclusion of incentive mechanisms for providers to enhance the quality of life and wellbeing of residents. Subject to these and any other modifications that may be necessary after trials and iterative testing of that model, we submit that AN-ACC or something closely resembling it should be implemented in the future system.

Care at a residential aged care home to include allied health care

356. We have made submissions regarding allied health with particular application to care in the home or community. While those broad submissions apply to residential care, there are particular and additional concerns that arise in this setting.
357. The prescriptive nature of the Aged Care Funding Instrument means that allied health practitioners are not funded to deliver interventions that are most appropriate and evidence-based.³³² A particular complaint about the operation of the Aged Care Funding Instrument was that it is reactive and does not incentivise or support a preventative care approach.³³³ Many witnesses referred to the vital role of allied health care in preventing physical and cognitive decline, in addition to providing restorative short term care in response to acute events.³³⁴
358. Allied health care in residential aged care is insufficient. Item 3.11 of Schedule 1 of the Quality of Care Principles 2014 requires approved providers to make available ‘therapy

³³² Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0315.0001 at 0002; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0012, 0014; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8258.33–39.

³³³ Exhibit 17-22, Melbourne Hearing 4, Southern Cross Care (SA, NT, Vic) - Response to propositions, RCD.9999.0357.0020 at 0021; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0011.

³³⁴ Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0004; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0007 [32b], 0009 [40b]; Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0003 [6]; Transcript, Melbourne Hearing 4, Nicholas Young, 16 July 2020 at T8255.29–30; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8256.24–32; Transcript, Melbourne Hearing 4, Nigel Lyons, 17 July 2020 at T8322.22–25.

services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services' to all who need them, as long as the services are not 'long-term rehabilitation services required following, for example, serious illness or injury, surgery or trauma'.

359. If a person is not assessed as 'high' under one of the three Aged Care Funding Instrument domains, or 'medium' under two domains, they may be charged for the allied health services provided under Item 3.11 of Schedule 1 of the Quality of Care Principles 2014. It is perverse that people are charged for services that may avoid or delay deterioration in their health, but services are provided for free once they have deteriorated.
360. People in aged care may fund their own allied health services, but many people cannot afford to do this. If they have a chronic disease, they may qualify for five Medicare subsidised allied health services annually under the Chronic Disease Management program.³³⁵ This level of service provision is starkly inadequate.³³⁶
361. If a person is receiving 'complex pain management and practice undertaken by an allied health professional or registered nurse', they are categorised as needing 'complex health care' under the Aged Care Funding Instrument and the provider receives additional funding. The complex pain management is defined as including massage therapy or a limited range of pain management services.³³⁷ These pain management services are not evidence-based.³³⁸ A number of physiotherapists told us of their frustration at not being able to provide the allied health care they knew their client needed because they were required, by the approved provider, to provide a limited range of non-evidence

³³⁵ Australian Department of Health, *Chronic Disease Management – Provider Information Fact Sheet*, Australian Government, 2016, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-factsheet-chronicdisease.htm>, viewed 3 July 2020.

³³⁶ Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0018 [6] – 0019 [2]; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0011 [a]; Exhibit 17-1, Melbourne Hearing 4, General Tender Bundle, tab 7, AWF.001.04299.01 at 0007; Exhibit 17-1, Melbourne Hearing 4, General Tender Bundle, tab 20, RCD.9999.0324.0001 at 0005-0006 [61].

³³⁷ Australian Department of Health, *Aged Care Funding Instrument*, Australian Government 2016, <https://www.health.gov.au/sites/default/files/documents/2020/01/aged-care-funding-instrument-acfi-user-guide-acfi-user-guide-2017.pdf>, viewed 25 February 2020.

³³⁸ Transcript, Darwin Hearing, Catherine Maloney, 12 July 2019 at T3402.6-7, T3410.1-4, and T3407.32-39; Transcript, Adelaide Hearing 1, Gerard Hayes, 21 February 2019 at T573.9-11; Transcript, Sydney Hearing, Constance Pond, 14 May 2019 at T1638.32-39; Transcript, Perth Hearing, Gaye Whitford, 26 June 2019 at T2518.11-15; Exhibit 17-16, Melbourne Hearing 4, Statement of Jennifer Hewitt, RCD.9999.0327.0001 at 0002 [v.]; Transcript, Melbourne Hearing 4, Nicholas Young, 16 July 2020 at T8259.29-37.

based pain management services to ensure retention of funding under the Aged Care Funding Instrument.³³⁹

362. The Australian Aged Care Commission must provide for allied health delivery in the residential care setting.

Recommendation 18: Residential aged care to include allied health care

18.1. To ensure residential aged care includes a level of allied health care appropriate to each person's needs, the Australian Government and the Australian Aged Care Commission should, by no later than 1 July 2024:

- a. require approved providers to engage at least one of each of the following allied health professionals: an oral health practitioner; a mental health practitioner; a podiatrist; a physiotherapist; an occupational therapist; a pharmacist; a speech pathologist; a dietitian; an exercise physiologist; a music or art therapist
- b. require providers to enter into arrangements with each of the following professional groups to provide services as required to care recipients: optometrists; audiologists
- c. provide funding to approved providers for the engagement of allied health professionals through a blended funding model, including:
 - i. a capped base payment per resident designed to cover about half of the costs of establishing ongoing engagement of allied health professionals
 - ii. an activity-based payment for each item of direct care provided with the Australian Aged Care Pricing Authority determining the quantum of funding for the base payment and the level of activity-based payments, including by taking into account the extra costs of providing services in regional, rural and remote areas, and
- d. ensure strict monitoring of the level of allied health services that are actually delivered, including collection and review of data on the number of full-time equivalent allied health professionals delivering services, the

³³⁹ Transcript, Sydney Hearing 2, Rik Dawson, 11 August 2020 at T.8564.22-29; Transcript, Perth Hearing, Anna Urwin, 26 June 2019 at T2524.41-2525.23; Exhibit 17-16, Melbourne 4 Hearing, Statement of Jennifer Hewitt, RCD.9999.0327.0001 at 0002 [v]; Transcript, Melbourne Hearing 4, Nicholas Young, 16 July 2020 at T8259.29-37; Transcript, Melbourne Hearing 4, Lidia Conci, 16 July 2020 at T8258.33-39; Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8302.21-45.

number of current allied health assessments, the volume of service provision, and expenditure on allied health services

363. Independent assessment should be triggered at entry into aged care, and ‘when initial needs are identified, or due to significant decline, injury or illness’.³⁴⁰ Allied health services should be scaled up or down based on a person’s fluctuating care needs.³⁴¹
364. There are a number of exemplary multidisciplinary allied health services in aged care, some of which we have outlined above.³⁴² However, multidisciplinary allied health care is not being systematically provided to people as part of aged care.

Designing for diversity

365. As far as possible, under the new program people will have fair and equitable access to aged care that meets their individual needs, and recognises where they live, their background, and their diverse needs.

Recommendation 19: Designing for diversity

19.1. The Australian Government (or, from 1 July 2023, the Australian Aged Care Commission) should:

- a. by 1 July 2022, implement:
 - i. training requirements as a condition of approval or continued approval of providers that all staff engaged by providers who are involved in direct contact with people seeking or receiving services in the aged care system undertake regular training about cultural safety and trauma-informed service delivery
 - ii. similar training requirements for people engaged to provide care finder and assessment services
 - iii. as a condition of approval or continued approval of any aged care providers who publicly represent their ability to provide specialised services for groups of people of diverse experience or background,

³⁴⁰ Exhibit 17-19, Melbourne Hearing 4, Allied Health Professions Australia – Supplementary response to allied health proposition, RCD.9999.0360.0001 at 0002 [6].

³⁴¹ Transcript, Melbourne Hearing 4, Josephine Boylan-Marsland, 17 July 2020 at T8308.17-41.

³⁴² Exhibit 17-21, Melbourne Hearing 4, Statement of Allen Candy, RCD.9999.0312.0001 at 0001-0007[5]-[6]; Transcript, Melbourne Hearing 4, Allen Candy, 17 July 2020 at T8298.8-31; Exhibit 17-17, Melbourne Hearing 4, Statement of Lidia Conci, RCD.9999.0345.0001 at 0002[6]; Exhibit 17-22, Melbourne Hearing 4, Statement of Josephine Boylan-Marsland, WIT.1348.0001.0001 at 0001-0006 [5]-[29]; Transcript, Melbourne Hearing 4, Tim Henwood, 17 July 2020 at T8299.9-26; Exhibit 17-18, Melbourne Hearing 4, Statement of Angeline Violi, RCD.9999.0344.0001 at 0001-0004 [4].

a requirement to verify to the satisfaction of the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) that the provider has proper grounds for making that representation

- b. by 1 July 2022:
 - i. formulate a standard dataset and data collection mechanism for collecting, monitoring, analysing and using data about the diverse characteristics and life experiences of older people seeking or receiving aged care, including, as considered appropriate, people whose circumstances are not currently included in the 'special needs' provision, such as those living with mental illness, dementia or disability, and
 - ii. commence collection and analysis of those data for the purpose of identifying variations in and improving equity of access and utilisation of aged care by people of diverse backgrounds and experiences
- c. complete, by 1 July 2024, a national audit evaluating regional and local variation in levels of services for people from diverse backgrounds and life experiences, and, in light of the outcomes of the national audit, thereafter undertake commissioning arrangements to address deficits in meeting the needs of people from diverse backgrounds on a regional and local basis as required, and
- d. report to the Inspector-General and the public on the extent to which the needs of diverse older people are being met by the aged care system by 31 December 2024

366. The aged care system is structured and subsidised by various responses to 'special needs', a term defined in section 11-3 of the *Aged Care Act 1997* (Cth). Aspects of the statutory framework are intended to provide an incentive to approved providers to give priority to people with so called 'special needs'.

367. We do not endorse the expression 'special needs' and recommend that a different way of referring to diversity should be adopted. In approaching this task, it will be important to be mindful that 'diversity' has different meanings for different people. For some people and in some contexts, diversity is something to be celebrated. For others, their diverse experiences are related to hardship and trauma. There are significant challenges in choosing better language in this area. Different people use different language to describe

similar things. Many people choose that language carefully and for good reason. The way that we describe people and issues matters. Further and in any event, a singular approach to 'people with special needs'³⁴³ is insufficient. It does not recognise that each person is unique with or without a defined 'special need'. Individuals may choose not to be identified as part of a group and some may identify across more than one group. Within each 'group' of people with defined 'special needs' there should not be an assumption of homogeneity. People may have multiple diverse needs or face additional issues or barriers accessing aged care services as a result of one or more of their unique attributes.³⁴⁴

368. If an approved provider or care finder is ignorant of or insensitive to a person's diverse background or experience, there is the risk that communication may be compromised, and needs may go unrecognised. The impact of being unable to communicate was described in evidence including: social isolation;³⁴⁵ loneliness;³⁴⁶ undermining wellbeing and mental health;³⁴⁷ inability to control care plan and care experience including having needs appropriately represented and met;³⁴⁸ being unable to access information;³⁴⁹ undermining complaint mechanisms;³⁵⁰ being at risk or vulnerable to abuse;³⁵¹ and little to no understanding of or input into health treatments.³⁵² One witness felt that the inability to communicate posed a safety risk.³⁵³
369. Communication is central to the new program design which focusses on the needs of each person. Each approved provider and assessment person, care finder or care manager will be obligated to communicate in a way that takes into account the individual characteristics of each person seeking care. This may include preferred language, whether they live with a disability and whether workers must be trained in trauma-

³⁴³ Section 11-3 of the *Aged Care Act 1997*.

³⁴⁴ Transcript, Melbourne Hearing 2, Philip O'Meara, 10 October 2019 at T5283.7-17; Transcript, Melbourne Hearing 2, Samantha Edmonds, 7 October 2019 at T5407.23-46; Transcript, Melbourne Hearing 2, Helen Radoslovich, 8 October 2019 at T5283.7-17; Transcript, Melbourne Hearing 2, Samantha Edmonds, 7 October 2019 at T5283.7-17; Transcript, Melbourne Hearing 2, Noeleen Tunny, 7 October 2019 at T5305.4-12.

³⁴⁵ Transcript, Melbourne Hearing 2, Angelos Angeli, 7 October 2019 at T5272.37-43; T5273.33-35. Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5286.42-T5287.3. Transcript, Melbourne Hearing 2, Elizabeth Karn, 11 October 2019 at T5734.30-33.

³⁴⁶ Transcript, Melbourne Hearing 2, Angelos Angeli, 7 October 2019 at T5272.37-43; T5273.33-35.

³⁴⁷ Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5285.32-38; T5286.42-T5287.3.

³⁴⁸ Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5285.35-38; Transcript, Melbourne Hearing 2, Jaye Smith, 9 October 2019 at T5531.15-21; Transcript, Melbourne Hearing 2, Elizabeth Drozd, 10 October 2019 at T5637.44-5638.11; Transcript, Melbourne Hearing 2, Jaklina Michael, 11 October 2019 at T5724.38-5725.8.

³⁴⁹ Transcript, Melbourne Hearing 2, Elizabeth Drozd, 10 October 2019 at T5637.44-T5638.11.

³⁵⁰ Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5310.9-13.

³⁵¹ Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5310.9-13.

³⁵² Transcript, Melbourne Hearing 2, Angelos Angeli, 7 October 2019 at T5276.11-15; Transcript, Melbourne Hearing 2, Mary Patetsos, 7 October 2019 at T5286.4-12.

³⁵³ Transcript, Melbourne Hearing 2, Jaklina Michael, 11 October 2019 at T5725.21-24.

informed care. The Australian Aged Care Commission should ensure the design and development of the aged care system reflects and response to the diverse characteristics and life experiences of all older people.

Removal of population-based restrictions on subsidies

370. Currently, there are population-based limits on the availability of subsidies. We recommend this limit be abolished and that the Aged Care Provision Ratio as a tool for measuring and apportioning subsidies be removed. This Ratio is one of the road-blocks to ensuring a universal entitlement to aged care. The new program design must be demand-driven, based on assessed need and not rationed.

Recommendation 20: Planning based on need, not rationed

20.1. By 1 July 2024, the Australian Government should develop and implement a new planning regime, to replace the Aged Care Provision Ratio, which:

- a. supports a funding allocation that is sufficient to meet people's entitlements for their assessed need
- b. provides for demand-driven access to aged care based on assessed need
- c. funds cost-effective enabling care in the interests of people who need such care
- d. collects data to monitor outputs and outcomes, and
- e. aligns planning boundaries for Aged Care Planning Regions with boundaries based on Primary Health Network regions so that aged care planning is aligned with primary health care and hospital planning

371. After the transition to a removal of population-based limits on the availability of subsidies, the funding of the system should be based on the costs of providing high quality care on the basis of assessed need and should not be influenced by the Australian Government's fiscal policies, or be limited to past real per capita spending levels. An important element in achieving this goal is for an independent pricing process for the levels of funding for particular service types and bundles of services. Prices should be based on estimates of reasonable costs of providing services. Prices should be ascertained through a process that is independent of both government and the approved providers in the sector. We address this topic in more detail in Part 3.15.

Part 3.4 Quality and safety

372. This Royal Commission was established to examine quality and safety in our aged care system. It is tasked with inquiring into ‘what the Australian government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe’.³⁵⁴ We draw particular attention to the expression ‘high quality’. These submissions are directed to establishing an aged care system that will consistently deliver high quality aged care to older Australians. That is what the Terms of Reference require.
373. One of the most important pieces of research commissioned during the course of the Royal Commission is a study by a team from the University of Queensland entitled ‘The cost of residential care’.³⁵⁵ The authors examined both quality and efficiency in the residential aged care sector. We referred to some of the results from the study earlier in our discussion about the extent of substandard care.
374. In measuring aged care quality, the authors of that study drew on the seminal work of health services researcher, Avedis Donabedian, whose well-known quality model ‘remains the dominant theoretical framework for assessing the quality of health care’ and has in recent years ‘been extended to measure the quality of aged care’.³⁵⁶ Donabedian proposes a three-dimensional approach to quality of care which considers structure, process and outcomes.³⁵⁷ The authors of the University of Queensland Study draw on Donabedian’s work and explain that:
- a. *Structure* refers to the attributes of the setting in which care is provided
 - b. *Process* refers to the components of care delivery, and
 - c. *Outcome* refers to the changes in care recipients that can be attributable to the care.³⁵⁸
375. Donabedian explains that these three dimensions are inter-related and any comprehensive assessment of care quality needs to consider a combination of all three. The University of Queensland report built on this theoretical framework and assessed quality in aged care by reference to a set of quality indicators or measures they chose.

³⁵⁴ Letters Patent, 6 December 2018, as amended on 13 September 2019 and 25 June 2020, paragraph (d).

³⁵⁵ The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020.

³⁵⁶ The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 9.

³⁵⁷ A Donabedian, *An Introduction to Quality Assurance in Health Care*, 2003, p 46.

³⁵⁸ The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 9.

They considered clinical health outcomes of residents, process accreditation standards and service experience indicators.

376. These data were combined into a composite quality index which was in turn used to group residential aged care facilities into categories of differing levels of quality, Q1 (highest quality); Q2 (medium-level quality) and Q3 (lowest quality).³⁵⁹ Only 11% of facilities were in the highest quality category. These facilities 'had met all accreditation standards, had no issues or complaints, a higher customer rating, and lower utilisation of high-risk medicines'.³⁶⁰ 11% were in the lowest category (lower customer experience rating, higher failure of meeting accreditation standards and higher number of complaints) and the overwhelming majority, 78%, provided average quality aged care. In this larger category, facilities had a low failure of meeting standards, a moderate level of customer experience ratings, potentially suboptimal use of high-risk medicines and a low number of complaints.³⁶¹ It is noteworthy that the facilities that were found to be providing Q2 level quality were still failing accreditation standards, albeit not with the frequency of those in Q3. Facilities providing Q1 quality were not necessarily exceeding the minimum standards. In other words, the pass mark in aged care is low. As the authors note, the three quality levels they devised 'are not intended to reflect the future quality levels that the Australian community might aspire to achieve or that the Royal Commission is considering'.³⁶² The vision we have is for high quality care to be more than just merely meeting accreditation standards. Similarly, average quality care cannot be provided in a facility that is failing to meet such standards even if only sometimes.
377. While there are limitations associated with this study because of the incompleteness and unevenness of the data,³⁶³ it does suggest that there is a lot aged care in Australia which is, at best, of average quality. However, there are also, as other evidence reveals, some shining examples of high quality aged care which is provided within the funding and other constraints in the current system. There are providers which value their staff and attract loyalty in return. This enables the consistent staffing that promotes high quality, relationship based care, a theme to which we will return later in these submissions. These providers are well governed and they value feedback from the people who live in their facilities and their families. As Professor Kathy Eagar stated at the recent hearing

³⁵⁹ The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 3.

³⁶⁰ The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 3.

³⁶¹ The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 3.

³⁶² The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 3.

³⁶³ The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 31.

about funding, financing and prudential regulation, the current aged care system contains 'pockets of excellent practice' but current average practice is a long way from uniformly good practice.³⁶⁴

378. The challenge is to make these 'pockets of excellence' the norm and not the exception – to flip the figures so that the majority of providers are providing high quality care and those that are not, are providing at least average quality care. There should be no place for low quality care in the future aged care system.

High quality aged care

379. What do we mean by 'high quality aged care'? Flinders University's Caring Futures Institute completed a large scale study for the Royal Commission assessing the views and preferences of the general public about the quality of aged care and the future funding of quality aged care.³⁶⁵ In excess of 15,000 people participated in a survey as part of the study. Of these, 65% fully completed the survey and passed all specified quality control criteria.³⁶⁶

380. The study found 'high levels of agreement amongst members of the general public about what constitutes quality in aged care'.³⁶⁷ It concluded that 'the salient characteristics consistently rated as highly important in encapsulating quality in aged care service delivery are largely reflective of the fundamentals of care:

- a. older people being treated with respect and dignity;
- b. aged care staff having the skills and training needed to provide appropriate care and support;
- c. the provision of services and supports for daily living that assist older people's health and wellbeing;
- d. older people feeling safe and comfortable'.³⁶⁸

381. Respondents 'feel very strongly that an older person has a right to be treated with respect and dignity by a skilled and trained workforce should they need access to

³⁶⁴ Transcript, Sydney Hearing 5, Kathleen Eagar, 17 September 2020 at T9360.28-30.

³⁶⁵ Flinders University, *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020.

³⁶⁶ Flinders University, *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 22.

³⁶⁷ Flinders University, *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 47.

³⁶⁸ Flinders University, *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 47.

- care'.³⁶⁹ Being supported in making your own decisions about care and services was 'among the less influential characteristics'.³⁷⁰
382. The authors of the Caring Futures Institute study noted that the findings concurred with a 2018 study of older people and family carers which found 'being treated with respect and dignity and the qualifications and skills of staff were among the most important characteristics that they would look for when choosing an aged care provider'.³⁷¹
383. The survey revealed that only a small proportion (5%) of people consider that the current aged system does not achieve these characteristics at all. About half of respondents thought that the characteristics are achieved 'sometimes'.³⁷²
384. More recently, the National Ageing Research Institute conducted a study into the perspectives of people receiving residential aged care services.³⁷³ NARI surveyed 391 residents or their proxies about how they felt about their lives and the care they received. A 'significant share' of those surveyed 'indicated that some aspect of the quality of their care and services was failing them'.³⁷⁴ The study concludes that the share could be at least 1/3 of residents depending on one's perspective.
385. The NARI study also concluded that 'about 41% of residents were 'rarely' or 'sometimes' satisfied with the amount of time staff spent with them'.³⁷⁵
386. Drawing on the results of these surveys and the other evidence about the attributes of high quality aged care, we submit that the following summary of those attributes should feature in the new aged care system.
387. High quality aged care puts older people first. It assists older people to live a self-determined and meaningful life through expert clinical and personal care services and

³⁶⁹ Flinders University, *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 47.

³⁷⁰ Flinders University, *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 48.

³⁷¹ Flinders University, *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 48. The 2018 study is COTA Australia, *Measuring Quality and Consumer Choice in Aged Care*, Barton, ACT, 2018.

³⁷² Flinders University, *Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 47.

³⁷³ National Ageing Research Institute Ltd, *Inside the system: aged care residents' perspectives*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020.

³⁷⁴ National Ageing Research Institute Ltd, *Inside the system: aged care residents' perspectives*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 7.

³⁷⁵ National Ageing Research Institute Ltd, *Inside the system: aged care residents' perspectives*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 7.

other support, provided in a safe and caring environment. High quality aged care is respectful, timely and responsive to older people's preferences and needs and assists them to live a dignified life. High quality aged care is provided by caring and compassionate people who are skilled in the care they provide. It enables older people to maintain their capacities for as long as possible, while supporting them when they experience functional decline or need end-of-life care. High quality aged care delivers a high quality of life.

388. A measurable definition of high quality care needs to be formulated and refined over time. It should be measurable in terms of the amounts of care time per recipient per day that a person within a particular casemix classification should receive from the different identified skill categories of care staff. This will enable the costs of high quality care to be estimated, and that estimate may be iteratively reviewed and refined over time by the Australian Aged Care Pricing Authority. We will return to the pricing implications of this later in these submissions. This is an example of the linkages between different aspects of these submissions – quality of care, workforce requirements and pricing and funding of care. It highlights the importance of the entirety of what we are recommending being implemented as a complete package.

Recommendation 21: Embedding high quality aged care

21.1. The *Aged Care Act 1997* (Cth) should be amended to provide that the Australian Commission on Safety and Quality in Health and Aged Care, in setting and amending safety and quality standards for aged care (under the functions referred to in Recommendation 23), give effect to the following characteristics of high quality aged care:

- a. diligent and skilful care
- b. safe and insightful care
- c. caring relationships
- d. empowering care, and
- e. timely care.

Approved providers must have a statutory duty of care to care recipients

389. Section 54(1)(a) of the *Aged Care Act 1997* (Cth) imposes a responsibility on an approved provider 'in relation to the quality of aged care that the approved provider provides' to 'provide such care and services as are specified in the Quality of Care

Principles...'.³⁷⁶ The Principles in turn require a provider to provide the care and services specified in Schedule 1 'in a way that complies with the Aged Care Quality Standards set out in Schedule 2'.³⁷⁷

390. Importantly, it is not an offence for an approved provider to fail to comply with this duty; nor may a civil penalty be imposed.³⁷⁸
391. Nowhere in the *Aged Care Act 1997* (Cth) is there set out a clear statement of the approved provider's basic responsibility to ensure that the care provided to residents is safe and of high quality. We submit that this is a major gap in the current legislative scheme. Its effect was apparent in the evidence at Sydney Hearing 2 in August 2020 in which there was evidence of at least one approved provider (Anglican Community Services) being, in effect, a spectator as Commonwealth and State authorities argued about the best care that should be provided to the residents in its home during a major COVID-19 outbreak that ultimately took 19 lives.³⁷⁹ The evidence in the Hobart hearing revealed that another approved provider, Bupa, introduced a policy entitled 'save a shift' under which, to reduce costs, workers who were on sick leave would not be replaced. Such policies will invariably have a deleterious effect on quality and safety of care.
392. We submit that there needs to be a general duty on an approved provider to ensure, so far as is reasonable, the quality and safety of its aged care services. This would send a clear message to providers, the community and the regulator about the primary duty of an approved provider: to protect the health, wellbeing and safety of its residents. This amendment should be made in the existing *Aged Care Act 1997* (Cth) and transferred into the new Act we are proposing.
393. The duty we propose is based in part on the employer's duty under occupational health and safety law, a duty that the vast majority of approved providers already owe to their employees and contractors.³⁸⁰ Such a duty has operated in Australian law since the 1980's. It has been described as requiring employers to 'take an active, imaginative and flexible approach to potential dangers'.³⁸¹ It requires employers, guided by experts, to

³⁷⁶ *Aged Care Act 1997* (Cth) s 54(1)(a).

³⁷⁷ *Quality of Care Principles 2014*, s 7(1) and (3).

³⁷⁸ The consequences of such a failure are outlined in Part 7B of the *Aged Care Quality and Safety Commission Act 2018* (Cth).

³⁷⁹ Exhibit 18-3, Sydney Hearing 2, Newmarch House tender bundle, tab 121, CTH.1000.0005.8876 at 8876.

³⁸⁰ See, for example, *Occupational Health and Safety Act 2004* (Vic), s 21.

³⁸¹ *Holmes v R.E. Spence & Co Pty Ltd* (1992) 5 VIR 119 at 123 (Harper J).

be proactive not reactive.³⁸² It requires employers to ensure that their staff are instructed, informed, trained and supervised so that they can work safely.³⁸³

394. Approved providers currently have a non-delegable *common law* duty to exercise reasonable care for the health and safety of residents. The notion of ‘reasonable care’ is not fixed but evolves as scientific and medical knowledge increases and in line with changing community expectations.³⁸⁴
395. The duty we are proposing would build on this common law duty and encourage a provider to do more than merely meet accreditation standards. It will clearly state that the duty of a provider is to service the needs of residents first and foremost. It will be an aspirational duty. To adapt the words of Professor Joseph Ibrahim of Monash University, accreditation should be a by-product and not the focus of providers.³⁸⁵ That focus needs to be to provide the highest quality care that is reasonable.
396. In addition to providing clarity for residents and their families, the inclusion of such a duty in aged care legislation would provide a focus for the compliance and enforcement work of the aged care regulator, a point we will address later in these submissions. The introduction of a general occupational health and safety duty on employers in recent decades has dramatically shifted the approach of regulators away from enforcing prescriptive standards to targeting compliance with the general duty.³⁸⁶ This effect was recently recognised by a comprehensive review of Victoria’s environmental laws³⁸⁷ and has led, for the first time, to the inclusion of a general duty in those laws.³⁸⁸
397. The new Act should also include a provision like section 96-4 of the *Aged Care Act 1997* (Cth), stating that for the purposes of the new Act (including the new general duty) a reference to care provided by an approved provider includes any care provided by another person on behalf of the approved provider under a contract or arrangement entered into between the approved provider and the other person. This is intended to address the circumstance where the actual provision of care is by a third party such as a worker engaged through a labour hire firm or through an on-line brokerage service and not by an employee of the approved provider.

³⁸² *Occupational Health and Safety Act 2004* (Vic), s 4(3); W Creighton and P Rozen, *Health and Safety Law in Victoria*, (2017, Federation Press) at [6.29]-[6.48].

³⁸³ See, for example, *Work Health and Safety Act 2011* (NSW), s 19(3)(f); *Occupational Health and Safety Act 2004* (Vic), s 21(2)(e).

³⁸⁴ *Bankstown Foundry Pty Ltd v Braistina* (1986) 160 CLR 301 at 314.

³⁸⁵ Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0059 [314].

³⁸⁶ R Johnstone, L Bluff and A Clayton, *Work Health and Safety Law and Policy*, (2012, Thomson Reuters) at [8.455]; W Creighton and P Rozen, *Health and Safety Law in Victoria*, (2017, Federation Press) at [10.60]-[10.66].

³⁸⁷ P Armytage, J Brockington and J van Reyk, *Independent Inquiry into the Environment Protection Authority*, 2016, pp 221-222.

³⁸⁸ *Environment Protection Amendment Act 2018* (Vic), s 7 (which will come into effect in July 2021).

398. In addition, for the avoidance of doubt, the new provision should provide that a reference to care provided by an approved provider includes any care provided by another person under an arrangement between a person for whom the provider is engaged to provide care and the other person, where the approved provider has consented to the transfer to the other person of any funding provided under the new Act.
399. Finally, the new Act should impose a duty on any entity which facilitates the provision of subsidised aged care services. The evidence in the recent home care hearing was that organisations like Mable and Hire-Up are arranging for care workers to provide care under arrangements with approved providers. Often there is no direct relationship between the provider and the care worker. We discuss the implications of these arrangements in more detail in our submissions about the aged care workforce.
400. How can the law ensure that care provided in such circumstances is of high quality and safe? We submit that, in addition to the duty on the provider in such circumstances, there also needs to be a duty on the facilitator of the labour. Unless the workers sourced through such arrangements are appropriately supervised, trained and qualified, there is a risk that they will not provide care to the desired standard.
401. One approach to this issue is to deem such a facilitator of labour to be an approved provider of aged care services for the purposes of the general duty. However, such an approach has a degree of artificiality about it and could lead to unintended consequences. We favour a more limited duty that is proportionate to the risk. A facilitator of labour, such as an on-line platform like Mable or Hire-Up, should have a duty to ensure that any worker who they make available to perform care work has the experience, qualifications, skills and training to perform the particular care work they are being asked to perform. This will require, at the very least, that the platform:
- a. investigate the work and the circumstances in which it is to be performed
 - b. investigate the particular worker who is to perform the work, and
 - c. ensure that the worker has the experience, qualifications, skills and training that match the job.
402. The duty would require the entity to be active in ensuring the workers it is offering receive regular training. For example, it will not be enough to make training available via a portal – the entity will need to ensure the training is completed by taking an active rather than a passive approach. The duty will be ongoing so that any change in the nature of the work would require reconsideration of the worker’s suitability. The duty we have in mind

is similar to the duty such entities already owe to third parties as the conductors of businesses or undertakings under work health and safety laws.³⁸⁹

403. The need for a clearly articulated enforceable duty of care on approved providers was recognised by the 2019 Senate Inquiry into aged care quality.³⁹⁰ The time for this important reform is now.

Recommendation 22: A general duty to provide high quality and safe care

22.1. The new Act should include a general, positive and non-delegable statutory duty on any approved provider to ensure that the personal care or nursing care they provide is of high quality and safe so far as is reasonable having regard to:

- f. any reasonably foreseeable risks to any person to whom the provider provides, or is engaged to provide, that care
- g. the wishes of any person for whom the provider provides, or is engaged to provide, that care, and
- h. any other relevant circumstances.

22.2. Any entity which facilitates the provision of aged care services funded in whole or in part under the new Act should have a duty to ensure that any worker whom it makes available to perform personal care work has the experience, qualifications, skills and training to perform the particular personal care work the person is being asked to perform.

Aged care quality standards

How should aged care standards be set?

404. Section 54-2 of the *Aged Care Act 1997* (Cth) provides that Aged Care Quality Standards 'are standards for quality of care and quality of life for the provision of aged care'. 'Aged care' means 'residential care', 'home care' or 'flexible care'.³⁹¹ The section also provides that such standards may be set out in the *Quality of Care Principles*.

³⁸⁹ See, for example, *Work Health and Safety Act 2011* (NSW), s 19(2).

³⁹⁰ Senate Community Affairs References Committee, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised*, Final Report, 2019, pp 94–95 [5.14]–[5.19].

³⁹¹ *Aged Care Act 1997* (Cth), Sch 1–Dictionary.

405. Quality standards are a powerful tool to maintain and improve quality of care across the aged care sector. They are statutory-based obligations of services that set the characteristics of aged care and the care environment that contributes positively to, or alternatively places at risk, the safety, health, wellbeing and quality of life of the people receiving care.³⁹² Such standards also function as motivators for providers to achieve quality expectations, and set the regulatory parameters for ‘objective, consistent assessment and reporting of provider performance’.³⁹³
406. The *Quality of Care Principles 2014* (Cth) are made by the Minister pursuant to section 96-1 of the *Aged Care Act 1997* (Cth) in the form of a legislative instrument. There is no guidance in the Act on the process by which such legislative instruments are made. In practice the Department of Health develops the Standards in consultation with the aged care sector and the aged care regulator. While it consults relevant experts the evidence suggests that the views of such experts are not always followed.³⁹⁴
407. By contrast, Quality Standards for the health sector are made by a specialist statutory body, the Australian Commission on Safety and Quality in Health Care. That Commission is established with the express purpose of formulating written standards, guidelines and indicators relating to ‘health care safety and quality matters’.³⁹⁵ It operates under an appropriate governance framework for the task.
408. The Australian Commission on Safety and Quality in Health Care answers to an independent Board made up of nine members appointed by the Australian Minister of Health after consulting with each of the State and Territory Health Ministers.³⁹⁶ To be eligible for appointment to the Board, a person must have ‘substantial experience or knowledge’ and ‘significant standing’ in at least one of a range of fields including public administration in relation to health care, provision of professional health care services, financial management, corporate governance, representation of the interests of consumers or law.³⁹⁷ The Minister must ensure that the members of the Board

³⁹² Submissions of the Commonwealth of Australia, Adelaide Hearing 4, Future aged care program design, 22 April 2020, AWF.660.00167.0002_0001 at 0002_0010.

³⁹³ Submissions of the Commonwealth of Australia, Adelaide Hearing 4, Future aged care program design, 22 April 2020, AWF.660.00167.0002_0001 at 0002_0010.

³⁹⁴ See, for example, Exhibit 3-62, Sydney Hearing 1, Submission made by Dr Juanita Westbury (now Breen), RCD.9999.0057.000 relating to Aged Care Quality Standards; Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0008–0010 [36]–[43].

³⁹⁵ *National Health Reform Act 2011* (Cth), s 9(1)(e)-(g). The Commission was initially established by the Council of Australian Governments in 2006: *National Health Reform Act 2011* (Cth), s 9(1)(e)-(g). The Commission was initially established by the Council of Australian Governments in 2006: Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0002 [13].

³⁹⁶ *National Health Reform Act 2011* (Cth), s 20(1) and (6).

³⁹⁷ *National Health Reform Act 2011* (Cth), s 20(3).

'collectively possess an appropriate balance of experience and knowledge' in the identified fields.³⁹⁸

409. The Chief Executive Officer of the Australian Commission on Safety and Quality in Health Care, Professor Debora Picone AO, gave evidence in the Brisbane hearing. Professor Picone explained that there are currently eight National Safety and Quality Services Standards which apply to all hospitals and day procedure services.³⁹⁹ They also apply to residential aged care services provided by State and Territory authorities and to multi-purpose services.⁴⁰⁰ The Australian Commission on Safety and Quality in Health Care has developed an 'Aged Care Module', which is designed for application in these services.⁴⁰¹
410. Professor Picone considers that there should be 'greater harmonisation between the quality standards that apply in health care and those standards that apply in aged care'.⁴⁰² We agree. Her statement sets out a core set of safety standards below which care 'must never fall'.⁴⁰³ She considers that a 'core set of standards' could be developed and implemented in health and the long-term aged care sectors thus both improving quality and safety and reducing the regulatory burden that arises currently from having to comply with more than one set of standards on the same or similar topics.⁴⁰⁴
411. In addition to the *clinical* standards it has promulgated, the Australian Commission on Safety and Quality in Health Care has also developed and validated certain *quality of life* measures which may be applicable in aged care settings.⁴⁰⁵
412. The question of how aged care quality standards should be set in the future aged care system is a difficult one to answer. On the one hand, the dedicated Australian Aged Care Commission that we are proposing might seem to be the obvious body to perform this function. As the system governor and regulator, it will have access to relevant complaints and performance data about the sector. There is no reason in principle why the functions of standard setting and compliance monitoring should not be combined. In

³⁹⁸ *National Health Reform Act 2011* (Cth), s 20(4).

³⁹⁹ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0019 [102].

⁴⁰⁰ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0020 [105]–[106], 0024–0025 [126]–[127].

⁴⁰¹ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0025 [128]–[131].

⁴⁰² Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0020 [107].

⁴⁰³ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0020–0022 [109].

⁴⁰⁴ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0023 [119]–[120].

⁴⁰⁵ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0038–0039 [176].

fact, as Professor Picone pointed out, combining these functions ‘allows information from the assessment of standards to be used to guide future standards development’.⁴⁰⁶

413. The alternative is to confer the function on the Australian Commission on Safety and Quality in Health Care by expanding its existing statutory remit. The obvious advantage of this approach is that it is an existing body with the governance arrangements and processes in place to perform the role. It is a well-respected body with many years of experience in setting health standards. As Professor Picone explained, there is good reason to have consistency or even uniformity across the aged care and health sectors. Further, some aged care facilities already comply with the Health Standards.
414. We submit that the standards prepared by the Australian Commission on Safety and Quality in Health Care are far more comprehensive, rigorous and detailed than the existing Aged Care Quality Standards. For example, the Australian Commission on Safety and Quality in Health Care’s Clinical Care Standard contains 33 actions, each of which has an intent, some reflective questions, some key tasks, strategies for improvement and examples of evidence of compliance. By contrast, Standard 8(3)(e) of the Aged Care Quality Standards merely states that an approved provider is to demonstrate that it has a clinical governance framework including but not limited to antimicrobial stewardship, minimising use of restraint and open disclosure. We return to this topic of provider governance below.
415. One concern about the standard-setting role being transferred to the Australian Commission on Safety and Quality in Health Care is that aged care quality is about more than health care, as important as that is. It would be necessary for quality of life aspects of aged care to be the subject of appropriate standards. In this regard we submit that the Royal Commissioners can draw comfort from the work that the Australian Commission on Safety and Quality in Health Care has done on quality of life measures as noted earlier.
416. On balance we submit that the advantages of the role being transferred to the Australian Commission on Safety and Quality in Health Care outweigh the disadvantages. Its constitutive statute should be amended and it should be re-named the Australian Commission on Safety and Quality in Health and Aged Care.
417. Clearly the Australian Commission on Safety and Quality in Health Care would need additional resources and it will need to liaise closely with the proposed Australian Aged Care Commission in its standards development work.⁴⁰⁷ Appropriate changes to the Board of the Australian Commission on Safety and Quality in Health Care may need to

⁴⁰⁶ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0018 [99]–[120].

⁴⁰⁷ Kathleen Eagar, Public submission, AWF.670.00037.0001_0001 at 0002.

be made perhaps by adding aged care as an additional area of expertise. It would also be open to the Australian Commission on Safety and Quality in Health Care to employ experts in aged care as staff or engage them as consultants.⁴⁰⁸ Short term secondments from the staff of the Australian Aged Care Commission may be appropriate.

418. The work of the Australian Commission on Safety and Quality in Health Care in setting aged care standards should be kept under review by the Australian Aged Care Commission and the Inspector-General of Aged Care in its oversight of the implementation of these reforms.

Recommendation 23: Aged care standard setting by the re-named Australian Commission on Safety and Quality in Health and Aged Care

23.1. Section 9 of the *National Health Reform Act 2011* (Cth) should be amended urgently to:

- a. rename the Australian Commission on Safety and Quality in Health Care as the 'Australian Commission on Safety and Quality in Health and Aged Care', and
- b. confer upon that body the functions of formulating standards, guidelines and indicators relating to aged care safety and quality.

23.2. Amendments to section 10 of the *National Health Reform Act 2011* (Cth) should also be made to provide for an appropriate consultation process for the Commission's aged care functions.

What should happen to the existing standards?

419. On 1 July 2019, eight new Aged Care Quality Standards replaced the 44 previous Accreditation Standards, Home Care Standards and the standards for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Transition Care.
420. The former Standards were quite specific and prescriptive. For example, there were 17 Standards in the category of 'Health and Personal Care' including 2.4, 'Care recipients receive appropriate clinical care'; 2.10, 'Care recipients receive adequate nourishment and hydration' and 2.11, 'Care recipients' oral and dental health is maintained'.
421. By contrast, the current Standards are far more general. They address:
- a. Consumer dignity and choice

⁴⁰⁸ *National Health Reform Act 2011* (Cth) s 47, 49.

- b. Ongoing assessment and planning with consumers
 - c. Personal care and clinical care
 - d. Services and supports for daily living
 - e. Organisation's service and environment
 - f. Feedback and complaints
 - g. Human resources, and
 - h. Organisational governance
422. The Standards were developed through consultation with 'consumers' and the aged care sector and are intended to focus on outcomes for 'consumers' rather than provider processes.⁴⁰⁹ They are the existing aged care system's articulation of quality for accreditation processes. They operate universally, and are intended to set standards for identifying and addressing people's individual care needs regardless of setting or need and inclusive of individual choices and preferences.
423. The evidence in this Royal Commission about the Standards was mixed. There was support for what was described as their consumer focus.⁴¹⁰ However, experts in a number of fields were critical of their lack of detail and lack of objective measurements. For example, a nutrition expert, Dr Sandra Iuliano, of the University of Melbourne and the Nutrition Society of Australia, considered that the standards need quantifiable measures against which compliance can be assessed.⁴¹¹
424. Dr Iuliano gave an example of how the human resources standard (Standard 7) could be modified so that it required that 'food service staff are specifically trained in food provision in residential aged care'.⁴¹² Similarly, Dr Iuliano suggested that Standard 3, the personal care standard, could include a requirement that menu details include quantities of serves of each of the food groups so the adequacy of the menu can be benchmarked against Australian standards.⁴¹³ Dr Iuliano explained that she had made these, and other such practical suggestions, in response to the draft standards when they were released for

⁴⁰⁹ Exhibit 1-23, Adelaide Hearing 1, Statement of Glenys Beauchamp, 4 February 2019, WIT.0022.0001.0024.

⁴¹⁰ Transcript, Adelaide Hearing 1, Patricia Sparrow, 19 February 2019 at T423.21–25; Transcript, Perth Hearing, Jason Burton, 25 June 2019 at T2415.35–42; Transcript, Darwin and Cairns Hearing, Michael Murray, 11 July 2019 at T3280.18–32; Transcript, Darwin and Cairns Hearing, Adrienne Lewis, 16 July 2019 at T3689.40–42; Transcript, Darwin and Cairns Hearing, Natasha Chadwick, 17 July 2019 at T3764.25–26.

⁴¹¹ Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0010 [44].

⁴¹² Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0010 [43].

⁴¹³ Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0009 [39].

public comment.⁴¹⁴ We endorse this as a practical approach to aged care quality standards. Experts in the fields of dementia care, continence care, palliative care and oral health have expressed similar concerns about the existing quality standards.⁴¹⁵

425. The lack of objectively measurable standards in aged care is of concern. Standard 7, which requires that a provider has a workforce ‘that is sufficient, and is skilled and qualified to provide safe, respectful and quality care and services’ provides a good example. What does ‘sufficient’ mean? Against what objective standard is compliance to be judged? This uncertainty serves no-one well – not people receiving care, not approved providers and not the regulator itself.
426. Some of the Standards have been demonstrated to be entirely inadequate. For example, the COVID-19 outbreaks of 2020 have shown that the infection control standards are in urgent need of attention.⁴¹⁶
427. Further, aged care standards are sometimes developed in isolation and separate from any strategic context in response to a particular issue of public concern.⁴¹⁷
428. Despite these concerns, we are conscious that the current Standards are still being bedded down and are the result of an extensive process of consultation with providers, people receiving care, experts and others. We are therefore not calling for a new set of Quality Standards at this time.
429. However, it is appropriate for the expert and independent body which we submit should have the task of maintaining the Standards, to be asked by the Australian Minister for Health to review as a matter of urgency the Standards having regard to a list of matters the evidence has identified. The Australian Commission on Safety and Quality in Health and Aged Care should consult as it considers necessary including with people receiving aged care, and should pay particular heed to the views of experts including those who have given so generously of their time to assist this Royal Commission.

⁴¹⁴ Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0008 [36].

⁴¹⁵ Transcript, Adelaide Hearing 1, Maree McCabe, 19 February 2019 at T410.6–41; Exhibit 6-24, Darwin and Cairns Hearing, Statement of Michael Murray, WIT.0273.0001.0001 at 0002–0003; Transcript, Perth Hearing, Jane Fischer, 27 June 2019 at T2776.46–47; Transcript, Sydney Hearing 1, Peter Foltyn, 14 May 2019 at T1635.39–43; Transcript, Darwin and Cairns Hearing, Adrienne Lewis, 16 July 2019 at T3689.42–46; Exhibit 17-9, Melbourne Hearing 4, Janet Wallace – response to draft propositions, RCD.9999.0317.0001 at 0002.

⁴¹⁶ *Quality of Care Principles 2014* (Cth), Sch 2: Aged Care Quality Standards, Standard 3(3)(g); see generally, Royal Commission into Aged Care Quality and Safety, *Aged care and COVID-19: a special report*, 2020, pp 23–24.

⁴¹⁷ See, for example, Exhibit 1-54, Adelaide Hearing 1, Statement of Matthew Richter, WIT.0012.0001.0001 at 0011 [5.8].

Recommendation 24: Urgent review of the Aged Care Quality Standards

24.1. By 15 July 2021, the responsible Minister should refer to the Australian Commission on Safety and Quality in Health and Aged Care the following matters for urgent ad hoc review and, if the Commission considers appropriate, amendment of the Aged Care Quality Standards:

- a. requiring best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention, and infection control, and providing sufficient detail on what these requirements involve and how they are achieved
- b. imposing appropriate requirements to meet resident nutritional needs and ensure meals are desirable to eat, having regard to a person's preferences and religious and cultural considerations
- c. sufficiently reflecting the needs of people living with dementia and providing high quality dementia care
- d. implementing a new governance standard, and
- e. requiring residential aged care providers to demonstrate their capacity to provide high quality palliative care, including staff capacity (number, skill and type), processes and clinical governance, for recognising deterioration and dying

24.2. The Australian Commission on Safety and Quality in Health and Aged Care should complete its review by 31 December 2022.

Recommendation 25: Priority issues for periodic review of the Aged Care Quality Standards

25.1. By 1 July 2022, the responsible Minister should refer the following matters for the Australian Commission on Safety and Quality in Health and Aged Care to consider as part of the first comprehensive review of the Aged Care Quality Standards:

- f. imposing appropriate requirements relating to the professional development and training for staff
- g. including sufficient reference to and delineation between staff practice roles and responsibilities

- h. requiring providers to assist people receiving care to make and update advance care plans if they wish to, and ensuring that those plans are followed
- i. reflecting the Aged Care Diversity Framework and underlying Action Plans, including considering making them mandatory.

Recommendation 26: Aged Care Quality Standards

26.1. The renamed Australian Commission on Safety and Quality in Health and Aged Care should complete a comprehensive review of the Aged Care Quality Standards within three years of taking on the standard-setting function and every 5 years after that. It should also be empowered to undertake ad hoc reviews and make corresponding amendments either of its own motion or where issues are referred to it for consideration by the Australian Aged Care Commission or the responsible Minister.

430. While the evidence at the Royal Commission has addressed a wide range of concerns about aged care quality and safety, three concerns are worthy of special mention and attention. They are food and nutrition, dementia care and the use of restraints. This is not to downplay the importance of other concerns.

Food and nutrition

431. It goes without saying that the quality and quantity of food that is available in residential aged care is a central feature of the quality of that care. While not all people living in residential aged care need continence care, dementia care or wound care, they all need to eat, at least three times a day, every day that they are receiving care. Many need physical help to eat; many have difficulty chewing.

432. A theme in the evidence has been that this is one area that is of great concern to many. A number of witnesses who gave evidence as part of the case studies raised similar concerns.

433. For example, in a case study in the Cairns hearing, Ms Johanna Aalberts-Henderson described the meals her late mother received in the residential aged care facility where she lived:

Some of the evening meals that I saw were terrible - some nights Mum was given soup, bread and cheese, which was fine. But other nights they served meals with very little nutritional value.⁴¹⁸

434. Her evidence was that the meals at the home were prepared offsite and brought in by a contractor. The food was put in plastic containers and then dispensed by the staff.⁴¹⁹ Such arrangements are not unusual in aged care.⁴²⁰ This is not high quality aged care.
435. The Darwin and Cairns hearing in July 2019 had a particular focus on food and nutrition. Experts on the nutritional needs of elderly people gave evidence. They shared their practical suggestions about how the situation could be improved.
436. Ms Maggie Beer AM, a former Senior Australian of the Year and a well-known celebrity chef, gave evidence in Cairns. Ms Beer explained that people receiving aged care have 'a reduced capability to detect the flavours and aromas that they enjoyed when they were younger; they may have reduced appetites; they may also have difficulty chewing and swallowing; and they may have conditions that require specific dietary construction'.⁴²¹
437. Dr Luliano, to whom we have already referred, was the principal investigator in a representative study of 60 Australian residential aged care facilities which was conducted in 2017. The study concluded that a staggering '68% of residents were malnourished or at risk of malnutrition based on the mini nutrition assessment tool'.⁴²²
438. Dr Luliano explained that poor nutrition in aged care is related to falls, fractures, pressure sores and unnecessary hospitalisation.⁴²³
439. Ms Beer spoke of the Maggie Beer Foundation she established in 2014 to transform the food experience of older people.⁴²⁴ The Foundation delivers education about food and nutrition to practitioners in the aged care sector. It adopts a 'train the trainer' approach and promotes fresh seasonal food that is full of flavour.⁴²⁵ It is a long way from party

⁴¹⁸ Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, WIT.0220.0001.0001 at 0006 [41].

⁴¹⁹ Exhibit 6-36, Darwin and Cairns Hearing, Statement of Johanna Aalberts-Henderson, WIT.0220.0001.0001 at 0006 [39].

⁴²⁰ Exhibit 6-43, Darwin and Cairns Hearing, Statement of Nicholas Hall, WIT.0215.0001.0001 at 0002 [10]–[13]; Transcript, Darwin and Cairns Hearing, Timothy Deverell, 16 July 2019 at T3615.27–30.

⁴²¹ Exhibit 6-46, Darwin and Cairns Hearing, Statement of Maggie Beer, WIT.0202.0001.0001 at 0004 [18].

⁴²² Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Luliano, WIT.0204.0001.0001 at 0001–0002 [9]–[10]; S Luliano et al, 'Dairy food supplementation may reduce malnutrition risk in institutionalised elderly', *British Journal of Nutrition*, 2017, Vol 117, 1, pp 142–147.

⁴²³ Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Luliano, WIT.0204.0001.0001 at 0002–0003 [12]–[16].

⁴²⁴ Exhibit 6-46, Darwin and Cairns Hearing, Statement of Maggie Beer, WIT.0202.0001.0001 at 0002–0003 [9].

⁴²⁵ Exhibit 6-46, Darwin and Cairns Hearing, Statement of Maggie Beer, WIT.0202.0001.0001 at 0003 [13]–[16].

pies and similar foods that are served in some aged care facilities. That is not a diet for an adult; it is barely acceptable for a child.

440. Ms Beer gave evidence that ‘there are so many people in aged care working so hard but often without the support or being empowered to do things better but when given the respect together with the skill, the practical ideas along with the inspiration, it is an incredibly powerful thing that we have seen individuals bring about amazing change’.⁴²⁶
441. Dr Iuliano referred to a 2016 Australian study by Dr Cherie Hugo and others which collected data from 817 residential aged-care facilities. The study reported that in 2016 the average expenditure of food for people living in residential aged care in Australia was \$6.08 per resident per day. This cost had declined from \$6.39 the previous year while expenditure on protein supplements increased from \$0.39 to \$0.89 over this period. This allocation of funds to feed residents is less than money spent in corrective services (\$8.25 per day) and nearly one third the average daily household expenditure on food and drinks in older adults in the community.⁴²⁷
442. Dr Iuliano concluded that food and beverage expenditure must be sufficient to meet the nutritional needs of people living in residential aged care, taking into account their specific needs and preferences. Nutritional adequacy can be modelled based on the Australian Guide to Healthy Eating. The mean expenditure of \$6.08 is insufficient for nutritional adequacy to be achieved.⁴²⁸
443. A 2015 study by the University of Queensland examined menu planning in Australian residential aged care facilities. The authors concluded that ‘when asked to rate the importance of control and choice over certain areas of their everyday life in a home, residents prioritised having choice over their foods as the most important’.⁴²⁹
444. The study concluded that ‘regulation and monitoring of the [Aged Care] Standards needs to be strengthened to mandate improvement of the choice and variety offered to residents, particularly those on texture modified diets’.⁴³⁰ The authors were critical of the

⁴²⁶ Exhibit 6-46, Darwin and Cairns Hearing, Statement of Maggie Beer, WIT.0202.0001.0001 at 0005 [25].

⁴²⁷ Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0007 [27].

⁴²⁸ Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0008 [35].

⁴²⁹ K Abbey, O Wright and S Capra, ‘Menu Planning in Residential Aged Care – The Level of Choice and Quality of Planning of Meals Available to Residents’, *Nutrients*, 2015, Vol 7, p 7581 (Exhibit 6-1, Darwin General Tender Bundle, tab 81, DAA.0001.0001.0066 at 0067); see also K Adams et al, ‘Defining skilled nursing facility residents’ dining style preferences’, *Journal of Nutrition in Gerontology and Geriatrics*, 2013, Vol 32, pp 213–232; G Kane et al, ‘Everyday matters in the lives of nursing home residents: Wish for and perception of choice and control’, *Journal of the American Geriatrics Society*, 1997, Vol 54, pp 1086–1093.

⁴³⁰ K Abbey, O Wright and S Capra, ‘Menu Planning in Residential Aged Care – The Level of Choice and Quality of Planning of Meals Available to Residents’ *Nutrients*, 2015, Vol 7, p 7589 (Exhibit 6-1, Darwin General Tender Bundle, tab 81, DAA.0001.0001.0066 at 0075).

previous standard (Standard 2.10) which they said did 'not provide guidance on the process for achieving adequate/any choice in menu planning'.⁴³¹

445. Finally, a 2017 Australian study of consumer preferences in residential aged care and willingness to pay for food service highlighted that 'strategies to maintain and improve taste of the food provided are critical to consumer satisfaction in the area, and these should be prioritised'.⁴³² The authors provided an example of an appropriate food preparation strategy that echoes the evidence given so memorably by Maggie Beer in the Cairns hearing:

...maintaining food preparation and cooking within facilities (so that residents can smell food as it is being prepared, and to minimize loss in flavour compounds during transport and reheating), access to professional development and improved education for food service professionals, and investment toward better quality ingredients.⁴³³

446. There is nothing more basic than food. People living in residential aged care have no choice but to eat the food they are served. There are real questions about the nutritional standards of the food in our aged care homes despite the need older people have for nutritious meals that are high in protein. Why shouldn't people living in residential aged care be able to smell their food being cooked? That is one of the joys of life. Why shouldn't they be able to cook their own meals or at least participate in the preparation? These are practical, simple aspects of quality of life. They are also relevant to maintenance of physical and cognitive capacity.
447. We submit that the current Standards are a slight improvement on the previous Standard 2.10. The current Standard 3(f) provides that 'where meals are provided, they are varied and of suitable quantity and quality'. However, this leaves much to the discretion of the provider and is not easily enforceable. How 'varied' do meals have to be? What does 'suitable' mean? The practical suggestions that were made by Dr Sandra Iuliano, as noted earlier, are a good basis for the review of that Standard that we recommend.⁴³⁴
448. The process of reviewing the Standards will necessarily take some time. However, there is an urgent need for action. The evidence before the Royal Commissioners about the levels of under-nutrition in residential aged care is very concerning. People living in residential aged care today should not have to wait.

⁴³¹ K Abbey, O Wright and S Capra, 'Menu Planning in Residential Aged Care – The Level of Choice and Quality of Planning of Meals Available to Residents' *Nutrients*, 2015, Vol 7, p 7582 (Exhibit 6-1, Darwin General Tender Bundle, tab 81, DAA.0001.0001.0066 at 0068).

⁴³² R Milte et al, 'Taste, choice and timing: Investigating resident and carer preferences for meals in aged care homes' *Nursing and Health Sciences*, 2018, Vol 20, p 123.

⁴³³ R Milte et al, 'Taste, choice and timing: Investigating resident and carer preferences for meals in aged care homes' *Nursing and Health Sciences*, 2018, Vol 20, p 123.

⁴³⁴ Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0008–0010 [36]–[43]. Dr Iuliano's evidence was that she made these submissions as part of the development process for the new Quality Standards.

449. As we explain later in these submissions, the cost of food in residential aged care is covered by the Basic Daily Fee which is capped at 85% of the basic single aged pension. In the funding part of these submissions we recommend an immediate conditional increase to the Basic Daily Fee of \$10 per resident per day. The additional funds are to be spent on daily living needs including nutrition.
450. Finally, the evidence before this Royal Commission is that training programs specifically tailored to nutrition requirements for people living in residential aged care are currently available. They should become the norm. An example is provided by the training programs, both face-to-face and online, that have been developed by the Maggie Beer Foundation.⁴³⁵

Dementia care must be core business for approved providers

451. The terms of reference specifically direct the Royal Commissioners to consider how best to deliver aged care services to the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged care services.⁴³⁶ The aged care system needs the leadership and capacity to ensure that people living with dementia receive high quality care.
452. The Australian Institute of Health and Welfare estimates that in Australia in 2020, between 400,000 and 459,000 people have dementia.⁴³⁷ Approximately one in five of the people with dementia have a cultural and linguistically diverse background.⁴³⁸ The Aboriginal and Torres Strait Islander population experiences a much higher incidence and prevalence of dementia related risk factors and dementia diagnoses than non-Aboriginal and Torres Strait Island people.⁴³⁹
453. The number of older people who are living with dementia is expected to increase in line with our ageing population.⁴⁴⁰ It is expected that there will be between 550,000 and

⁴³⁵ Exhibit 6-46, Darwin and Cairns Hearing, Statement of Maggie Beer, WIT.0202.0001.0001 at 0004–0007 [18]–[31].

⁴³⁶ Letters Patent, 6 December 2018, as amended on 13 September 2019 and 25 June 2020, paragraph (b)(ii).

⁴³⁷ Australian Institute of Health and Welfare, *Australia's health 2020*, <https://www.aihw.gov.au/reports/australias-health/dementia>, viewed 10 August 2020; Dementia Australia, *Dementia statistics—Key facts and statistics, 2020*, <https://www.dementia.org.au/statistics>, viewed 10 August 2020.

⁴³⁸ University of Canberra National Centre for Social and Economic Modelling, *Economic Cost of Dementia in Australia 2016–2056*, 2017, p 11.

⁴³⁹ S Li et al, 'Dementia prevalence and incidence among the Indigenous and non-Indigenous populations of the Northern Territory', *Medical Journal of Australia*, 2014, Vol 200, 8, pp 465–469; L Flicker and K Holdsworth, *Aboriginal and Torres Strait Islander People and dementia: a review of the research*, 2014, p 8.

⁴⁴⁰ World Health Organization, *Risk Reduction of Cognitive Decline and Dementia: WHO Guidelines*, 2019, p 1 (Exhibit 3-85, Sydney Hearing 1, Risk Reduction Of Cognitive Decline And Dementia: WHO Guidelines, RCD.9999.0063.0001 at 0017; G Livingston et al, 'Dementia prevention, intervention, and care: 2020 report of the Lancet Commission', *The Lancet*, 2020, Vol 396, 10248, p 414.

590,000 people in Australia with dementia by 2030 and that approximately 50% of these people will be aged between 65-84 years.⁴⁴¹

454. Over half of people permanently living in residential aged care in 2019 had a diagnosis of one of the forms of dementia.⁴⁴² An expert who gave evidence estimated the real percentage to be as high as 70%, given the prevalence of undetected dementia.⁴⁴³
455. Despite this, this inquiry has revealed that the quality of aged care that people living with dementia receive is, at times, abysmal. This is particularly so for those with more complex needs. The Royal Commissioners have heard in evidence time and time again that staff do not have the time or the skills to deliver the care that is needed. The response is often to rely on restrictive practices, which restrict a person's freedom and diminish their quality of life. The quality of dementia care in the aged care system needs significant improvement.
456. All mainstream aged care services should have the capacity to deliver high quality aged care for most people living with dementia. This includes having the right number and mix of staff who are trained in dementia care, having the right physical environment (in residential care), and having the right model of care. Approved providers should continue to be supported with specialist advice and services where people receiving aged care have complex needs.
457. Ensuring people living with dementia receive the support and services they need does not begin when they access aged care services. Dementia care extends across a continuum from diagnosis through to palliative care, and this includes prevention, primary care and hospital care.⁴⁴⁴ The evidence is that ensuring people diagnosed with dementia have a clear and accessible pathway post-diagnosis is critical to managing the condition, a person's quality of life, and their need for aged care.

A dedicated dementia support pathway

458. Unlike other significant conditions such as diabetes, cancer or pneumonia, there is not yet an established support pathway for people who are diagnosed with dementia in Australia. This impacts on how people manage the condition and how and when they interact with the aged care system.
459. For example, Ms Kate Swaffer, a person living with dementia and Chair and Chief Executive Officer of Dementia Alliance International, explained that, after her diagnosis,

⁴⁴¹ Australian Institute of Health and Welfare, *Australia's health 2020*, <https://www.aihw.gov.au/reports/australias-health/dementia>, viewed 10 August 2020.

⁴⁴² Australian Department of Health, *2018-19 Report on the Operation of the Aged Care Act 1997*, 2019, p 8.

⁴⁴³ Transcript, Sydney Hearing 1, Stephen Macfarlane, 15 May 2019 at T1764.20–23.

⁴⁴⁴ See, for example, Transcript, Sydney Hearing 1, Glenn Rees, 13 May 2019, T1541.42–46; T1542.1–2; World Health Organization, *Towards a dementia plan: a WHO guide*, 2018, p 35.

rather than being offered ‘disability assessment and advice towards continuing living’, she was advised to get her ‘end of life affairs in order and to get acquainted with aged care’.⁴⁴⁵

460. There is a lack of pathways and appropriate support structures for people after they are diagnosed with dementia. This reduces the quality of life of those people and the family and friends who care for them.
461. Since 2015, the Australian Government has funded and prioritised particular activities for dementia care, including information and awareness activities, training, dementia behaviour advisory services, incentives to meet the extra costs of dementia care, and research.⁴⁴⁶ The Australian Department of Health’s ‘National Framework for Action on Dementia 2015–2019’ proposed:
- a. The development of a coordinated care pathway for people with dementia
 - b. The development of health and other care providers’ knowledge and skills
 - c. An improvement in the quality of care towards the end of life
 - d. A shift from hospitals to multidisciplinary, community based settings
 - e. An enhancement of access to person centred, gender-sensitive, culturally appropriate care.⁴⁴⁷
462. Professor Henry Brodaty, an internationally recognised expert on dementia care, gave evidence that Australia and most other countries do not have a clear dementia care pathway.⁴⁴⁸ His view was that the current pathway generally ceases after people are referred by their general practitioner to a specialist for diagnosis.⁴⁴⁹
463. By contrast, Scotland’s National Dementia Strategy has 21 commitments developed through consultation with people living with dementia and carers, as well as other stakeholders across Scotland.⁴⁵⁰
464. An Australian national dementia pathway, perhaps modelled on the approach in Scotland, has the potential to assist people living with dementia to navigate the complex systems through which care is presently provided. This should be an important part of the work of the Australian Aged Care Commission that we propose. That work should be done in consultation with the Australian Departments of Health and Social Services.

⁴⁴⁵ Transcript, Sydney Hearing 1, Kate Swaffer, 17 May 2019 at T1929.37–44.

⁴⁴⁶ Transcript, Sydney Hearing 1, Glenn Rees, 13 May 2019 at T1541.22–26.

⁴⁴⁷ World Health Organization, *Towards a dementia plan: a WHO guide*, 2018, p 37.

⁴⁴⁸ Transcript, Sydney Hearing 1, Henry Brodaty, 17 May 2019 at 1886.42–45.

⁴⁴⁹ Transcript, Sydney Hearing 1, Henry Brodaty, 17 May 2019 at 1887.4–9.

⁴⁵⁰ Scottish Government, Convention of Scottish Local Authorities, Alzheimer Scotland, *Scotland’s National Dementia Strategy 2017-2020*, 2017.

465. Dementia service pathways are a means to achieve the goals established in dementia plans. Dementia service pathways are reported to improve quality standards; multidisciplinary and consumer communication, care planning and satisfaction; and decrease unwanted practice variation.⁴⁵¹

466. A dementia care pathway describes the information, coordination, care, education and social support services, when and in what order to meet the needs of people living with dementia and their carers (across the dementia continuum). As Ms Swaffer explained:

If we don't fix the root cause which is increased diagnosis rates and then change what happens at the time of diagnosis to enable people to live more independently for longer, then everything we do after that is a very expensive bandaid.⁴⁵²

Recommendation 27: Establishment of a dementia support pathway

27.1. By 1 January 2023, the Australian Government should establish a comprehensive, clear and accessible post-diagnosis support pathway for people living with dementia and their carers and families. This should involve:

- a. providing information and advice on dementia and support services, including the aged care system
- b. facilitating access to peer support networks
- c. providing education courses, counselling and support services for both people living with dementia and their family and carers
- d. providing assistance with planning for continued living and access to care, including regular and planned respite for carers.

27.2. The Australian Government should provide information and material to general practitioners and geriatricians on the pathway and encourage them to refer people to the pathway at the point of diagnosis.

467. The Specialist Dementia Care Program is the most recently established tier of support for people living with very severe behavioural and psychological symptoms of dementia. The program comprises a national network of Specialist Dementia Care Units.⁴⁵³ The Specialist Dementia Care Program supports people exhibiting very severe behavioural and psychological symptoms of dementia who are unable to be appropriately cared for

⁴⁵¹ KPMG, *Dementia services pathways—an essential guide to effective service planning*, 2011, p 5.

⁴⁵² Transcript, Sydney Hearing 1, Kate Swaffer, 17 May 2019 at T1930.

⁴⁵³ Exhibit 3-79, Sydney Hearing 1, Statement of Josephine Mond, WIT.0144.0001.0001 at 0009 [48].

in mainstream aged care services.⁴⁵⁴ It is expected there will be 35 Specialist Dementia Care Units, with at least one unit operating in each of the 31 Primary Health Networks by full rollout in 2022–23.⁴⁵⁵

468. Because the Specialist Dementia Care Program was introduced as the inquiry was being conducted, there has been no evidence about its effectiveness. However, Associate Professor Macfarlane said that the program may address a small part of the unmet need to provide safe and quality care for people living with dementia.⁴⁵⁶ It is unclear if this program will be able to care for and meet the needs of people experiencing the most severe and extreme changed behaviours.⁴⁵⁷ There is also concern that the proposed number of units, with only eight or nine beds per unit, is insufficient to meet demand.⁴⁵⁸
469. We therefore submit that Commissioners should recommend a review of the capacity of the program with appropriate action to be taken by the Australian government in light of the findings of the review to ensure sufficient capacity for this important program.

Recommendation 28: Specialist dementia care services

28.1. By 1 July 2023, the Australian Government should review and publicly report on:

- a. whether the number of Specialist Dementia Care Units established or planned to be established is sufficient to meet need within the areas and populations they are designed to cover
- b. the capacity of those Units to meet the needs of people exhibiting extreme changed behaviour and whether any further resources are required, and
- c. the suitability of the Units for shorter stay respite for people living with moderate to extreme changed behaviour

28.2. The outcome of the review should be implemented by the Australian Government as a matter of urgency.

⁴⁵⁴ Department of Health, *Specialist Dementia Care Program (SDCP)*, Australian Government, 2020, <https://www.health.gov.au/initiatives-and-programs/specialist-dementia-care-program-sdcp>, viewed 4 May 2020.

⁴⁵⁵ Exhibit 3-79, Sydney Hearing 1, Statement of Josephine Mond, WIT.0144.0001.0001 at 0009 [48]–[50].

⁴⁵⁶ Exhibit 3-68, Sydney Hearing 1, Statement of Stephen Macfarlane, WIT.0125.0001.0001 at 0028 [142].

⁴⁵⁷ Transcript, Sydney Hearing 1, Stephen Macfarlane, 15 May 2019 at T1752.32–35; Transcript, Sydney Hearing 1, Josephine Mond, 16 May 2019 at T1877.30–37.

⁴⁵⁸ Transcript, Sydney Hearing 1, Josephine Mond, 16 May 2019 at T1876.27–1877.2; Transcript, Sydney Hearing 1, Henry Brodaty, 17 May 2019 at T1906.12–17.

28.3. The Australian Government should immediately ensure that the specialist dementia service it funds provides treatment to people with a mental health condition if they meet other eligibility criteria (including, for instance, a diagnosis of dementia).

Eliminating or reducing restrictive practices

Recommendation 29: Regulation of restraints

- 29.1. By 1 July 2021, the Australian Government should introduce new requirements regulating the use of chemical and physical restraints in residential aged care to replace Part 4A of the *Quality of Care Principles 2014* (Cth).
- 29.2. The new requirements should comprehensively regulate the use of chemical and physical restraints in residential aged care and should be informed by:
- a. the report of the review conducted pursuant to section 15H of the *Quality of Care Principles 2014* (Cth)
 - b. the report of the Parliamentary Joint Committee on Human Rights on the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth), and
 - c. the operation of the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth).
- 29.3. A person receiving aged care who is the subject of a restraint should be readily able to seek an independent review of the lawfulness of the conduct.
- 29.4. Any breach by an approved provider of the new requirements should expose the provider to a civil penalty.
- 29.5. The Australian Commission on Safety and Quality in Health and Aged Care should review the operation of the new requirements as part of its first comprehensive review of the Aged Care Quality Standards.

470. The term 'restrictive practices' refers to activities or interventions that have the effect of restricting a person's free movement or ability to make decisions. A restrictive practice could involve secluding a person in their room or it might involve a physical restraint or one achieved by the administration of a drug (commonly known as a 'chemical

restraint').⁴⁵⁹ Types of restrictive practices used in aged care include applying lap belts; locking over bed or chair tray tables; seating residents in deep chairs from which they are unable to stand; and removing mobility aids. Restrictive practices may also include confining a person in a residential facility or specialised unit.

471. The nature and extent of restrictive practices in aged care were noted earlier in our submissions. Their use raises fundamental human rights questions. As we discussed earlier in these submissions, the new Act should give clear effect to the human rights of older Australians.

472. Restrictive practices impact the liberty and dignity of people receiving aged care. The right to personal autonomy is recognised in domestic laws and international human rights instruments. The common law in Australia recognises that each person has the right to choose what occurs with respect to their own body.⁴⁶⁰ Providing care or treatment, or detaining someone, without consent can be a civil wrong or a criminal offence. The rights enshrined in the *International Covenant on Civil and Political Rights* include rights to: self-determination; liberty and security of the person; and recognition and equality before the law.⁴⁶¹ The *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment* may also be relevant in the context of residential aged care facilities where people are not free to leave, such as when they are in locked dementia units.⁴⁶²

473. These are complex issues. The evidence is that changed behaviours, often associated with dementia, can be disruptive and even dangerous to the person themselves, other residents and, at times, can be very difficult to manage. They can endanger staff. This is particularly so in residential aged care facilities without access to adequate expertise and resources.

474. An aged care worker told the inquiry that:

There is an over-reliance on chemical restraint in the [aged care facilities]; however alternatives such as support staff spending more one to one time with clients cannot effectively happen because the support staff are so busy performing the tasks they are expected to do....I think it would be good to have a staff member with therapeutic skills who can be on site for all the shifts...⁴⁶³

⁴⁵⁹ See, for example, the definition of 'regulated restrictive practice' in *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) s 6.

⁴⁶⁰ *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992) 175 CLR 218.

⁴⁶¹ *International Covenant on Civil and Political Rights* Art 1(1), Art 9(1), Art 16; see also *international Covenant on Economic, Social and Cultural Rights*, Art 12.

⁴⁶² The objective of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment* is to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment. A residential care home where people may not be free to leave could fall within the scope of a 'place of detention.'

⁴⁶³ Sharon Liava'a, Public submission, AWF.001.04939.

475. In chapter 8 of the Interim Report, Commissioners Tracey and Briggs expressed serious concerns about the over-use of restrictive practices in aged care. The report noted that ‘the overwhelming evidence before the Royal Commission is that there is a lack of knowledge about restraints and their impacts, alternatives to their use and the safe and appropriate management of the behavioural and psychological symptoms of dementia’.⁴⁶⁴
476. In response to the Interim Report, the Australian Government announced an increased focus on minimising restraints in aged care, including in relation to use of medicines and access to expertise in dementia care.⁴⁶⁵
477. Regulation of restrictive practices in aged care is lacking. There is a mixture of Commonwealth, State and Territory legislation and policy, with disparities in the principles and approaches to consent to care and treatment and restraint. Deficiencies in regulation of restrictive practices have been identified as a significant human rights issue in Australia.⁴⁶⁶ Recent changes to regulation of restraint in aged care have not adequately addressed this important issue.
478. The Council of Attorneys-General launched the *National Plan to Respond to the Abuse of Older Australians [Elder Abuse] 2019 – 2023*, which identified the need to review State and Territory legislation to strengthen safeguards for vulnerable people but did not specifically address the issue of restrictive practices.⁴⁶⁷ States and Territories have variously embarked on review and reform of legislation in this area.
479. In 2014, States and Territories committed to advance towards a national approach to reducing and eliminating restrictive practices in disability as described in the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.⁴⁶⁸ The *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth), made under the *National Disability Insurance Scheme Act 2013* (Cth), set out rules for the use of restrictive practices that apply to

⁴⁶⁴ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 1, p 205.

⁴⁶⁵ Australian Department of Health, *Minimising inappropriate use of restraint in aged care*, <https://www.health.gov.au/initiatives-and-programs/minimising-inappropriate-use-of-restraint-in-aged-care>, viewed on 9 July 2020; Australian Government, *Australian Government Response to the Parliamentary Joint Committee on Human Rights report on the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*, 2020, p 2.

⁴⁶⁶ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws Report No 124*, 2014, p 243; Queensland Public Advocate, Public submission, AWF.600.00946.0001 at 0001_0004; *Parliamentary Joint Committee on Human Rights report on the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*.

⁴⁶⁷ Council of Attorneys-General, *National Plan to Respond to the Abuse of Older Australians [Elder Abuse] 2019 – 2023*, 2019, p 32.

⁴⁶⁸ Commonwealth, State and Territory disability Ministers endorsed the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* on 21 March 2014.

providers registered under the National Disability Insurance Scheme. These apply together with obligations under State and Territory laws.⁴⁶⁹ The Australian Law Reform Commission has recommended that there should be a consistent approach to regulation of restrictive practices in aged care and disability services.⁴⁷⁰ We agree.

480. Regulation of restrictive practices should be underpinned by a consistent set of principles that are aligned with Australia's human rights obligations, respecting and supporting people's dignity and personal autonomy while providing clarity about the circumstances in which care or treatment including restrictive practices may be authorised by another person.
481. Inconsistencies in understanding what constitutes 'restraint' contribute to uncertainty about its prevalence and lawful justification for its use. A national approach should clarify definitions of restrictive practices as well as the circumstances in which a person may be detained and the legal safeguards that apply.
482. Secluding a person in a residential unit or confining a person to a place where they are not free to leave is restrictive and may deprive a person of their liberty. A national approach should clarify circumstances in which a person may be detained and the legal safeguards that apply.
483. Mechanisms for older people to seek a review or challenge the use of restrictive practices should be readily accessible. Access to independent review of restrictive practices is an important safeguard and an obligation under international human rights instruments.⁴⁷¹ Although there is significant public concern about the use of restrictive practices in aged care, we are aware of few cases in which existing avenues for review and redress for unlawful restraint have been pursued.⁴⁷² Submissions to the Royal Commission have identified limitations and barriers to people pursuing concerns about their care or treatment.⁴⁷³ In its 2014 report, the Australian Law Reform Commission also reported receiving a number of submissions about the form regulation concerning restrictive

⁴⁶⁹ *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth), s 7A.

⁴⁷⁰ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws Report No 124*, 2014, p 256.

⁴⁷¹ *International Covenant on Civil and Political Rights*, Art 9.

⁴⁷² See for example *Skyllas v Retirement Care Australia (Preston) Pty Ltd* [2006] VSC 409; *Saitta Pty Ltd v Secretary, Department of Health and Ageing* (2008) 105 ALD 55; *BC v The Public Advocate & ors* [2018] SASC 193.

⁴⁷³ See, for example, Felicity Lathrop, Public submission, AWF.001.04977; Queensland Public Advocate, Public submission, AWF.600.00946.0001 at 0017–0018; Elderlaw Legal Services, Public submission, AWF.500.00207.0001 at 0038–0050; Office of the Public Advocate (Victoria), Public submission, AWF.600.01348.0001 at 0021–0023.

practices should take, but deferred to the expertise of the Council of Australian Governments and others to determine the best path for reform in this area.⁴⁷⁴

Minimum requirements for aged care

484. Previous inquiries and reviews have recommended strong regulation of restrictive practices in aged care.⁴⁷⁵ New aged care quality standards concerning restrictive practices under the *Aged Care Act 1997* (Cth) came into effect on 1 July 2019.⁴⁷⁶ The Standards are made under s 54-1(l)(h) of the *Aged Care Act 1997* and impose ‘other responsibilities’ on an approved provider of aged care that is residential care or flexible care in the form of short-term restorative care provided in a residential care setting.⁴⁷⁷ They provide that both physical and chemical restraints are to be used only ‘as a last resort’ and where specified conditions are met.⁴⁷⁸ However, these requirements are time limited because Part 4A will be repealed with effect from 1 July 2021.⁴⁷⁹
485. Section 15H of the *Quality of Care Principles 2014* (Cth) requires the Minister for Aged Care to ensure there is a review of Part 4A by 31 December 2020. Such a review must ‘make provision for consultation’ and ‘must consider the effectiveness of [Part 4A] in minimising the use of physical restraints and chemical restraints by approved providers in relation to consumers in the period 1 July 2019 to 30 June 2020’.⁴⁸⁰ A copy of the report of the review must be published on the internet and tabled in Parliament. There is no requirement for the Minister for Aged Care to give effect to any recommendations that might be in the report.
486. The Parliamentary Joint Committee on Human Rights conducted an inquiry into the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth).⁴⁸¹ The Report of that Inquiry was published on 13 November 2019.⁴⁸² The Report made two recommendations. The first was that, ‘at a minimum’, the Principles be amended to clarify that other laws prohibit the use of restraints and that detailed amendments be

⁴⁷⁴ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws Report No 124*, 2014, p 259.

⁴⁷⁵ Australian Law Reform Commission, *Elder Abuse – A National Legal Response Report 131*, 2017, p 142; K Carnell and R Patterson, *Review of National Aged Care Quality Regulatory Processes*, 2017, p 119; House of Representatives Standing Committee on Health, Aged Care and Sport, *Report on the Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, 2018, p 96.

⁴⁷⁶ *Quality of Care Principles 2014* (Cth), Part 4A as inserted by the *Quality of Care Amendment (Minimising the use of Restraints) Principles 2019*.

⁴⁷⁷ *Quality of Care Principles 2014* (Cth), s 15D.

⁴⁷⁸ *Quality of Care Principles 2014* (Cth) ss 15F–15G.

⁴⁷⁹ *Quality of Care Principles 2014* (Cth), s 15J.

⁴⁸⁰ *Quality of Care Principles 2014* (Cth), s 15H.

⁴⁸¹ The *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth) inserted Part 4A into the *Quality of Care Principles 2014* (Cth).

⁴⁸² Parliamentary Joint Committee on Human Rights, *Report on the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*, 2019.

made to the explanatory materials accompanying the Principles. The second recommendation was that the Minister undertake 'extensive consultation with relevant stakeholders to work towards better regulating the use of restraints in residential aged care facilities'.

487. The Australian Government accepted each of these recommendations 'in principle'.⁴⁸³ In relation to the second recommendation, the Government amended the *Quality of Care Principles 2014* to make it clear that the use of restraints 'must always be a last resort'. Part 4A of the *Quality of Care Principles 2014* was also amended to provide for the 12-month review discussed above. In its response, the Australian Government noted that:

The review must make provision for consultation. It is intended consultation will include engagement with a range of key stakeholders such as state and territory public guardians and public advocates, and state and territory tribunals which can appoint decision makers for consumers and/or give consent themselves.

It is also expected the review will consider concerns raised by the Parliamentary Joint Committee on Human Rights in its report, in addition to concerns raised by other individuals and groups, including consideration of the approach taken by the National Disability Insurance Scheme.⁴⁸⁴

488. We submit that, without the benefit of the outcome of the review, and without any evidence about how Part 4A of the *Quality of Care Principles 2014* has operated in practice, it would be undesirable for the Royal Commissioners to make recommendations about what specific requirements should replace those presently set out in Part 4A. We note the evidence of Associate Professor McFarlane, Head of Clinical Services at the Dementia Centre (an arm of HammondCare), that the Standards in Part 4A of the *Quality of Care Principles 2014* 'have some limitations which may prevent them from being an effective tool in regulating the use of physical and chemical restraints for people living with dementia in residential aged care facilities'.⁴⁸⁵ In particular, Associate Professor McFarlane explained that:

- a. the definition of 'chemical restraint' is problematic because the only way it can modify behavioural manifestations of dementia is by sedation
- b. the obligations are not imposed directly on medical practitioners
- c. there is no requirement to investigate alternatives to chemical restraints
- d. it is unclear what an 'assessment' involves – would a phone call suffice?⁴⁸⁶

⁴⁸³ Australian Government, *Australian Government Response to the Parliamentary Joint Committee on Human Rights report on the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*, 2020, pp 7 and 10.

⁴⁸⁴ Australian Government, *Australian Government Response to the Parliamentary Joint Committee on Human Rights report on the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*, 2020, p 10.

⁴⁸⁵ Exhibit 3-68, Statement of Stephen Macfarlane, WIT.0125.0001.0001 at 0026 [134].

⁴⁸⁶ Exhibit 3-68, Statement of Stephen Macfarlane, WIT.0125.0001.0001 at 0026–0027 [137].

489. We submit that this is another key area that should be a priority for the Australian Aged Care Commission that we propose and the Australian Department of Health in the interim period before the Commission is established. As noted, the work is urgent; new requirements must be in place in advance of the repeal of Part 4A on 1 July 2021.
490. We submit that this work should be guided by the outcome of the Review of the operation of Part 4A of the *Quality of Care Principles 2014*, the Report of the Joint Committee on Human Rights, the experience of the National Disability Insurance Agency in administering the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) and some fundamental principles and practices which should apply in connection with all forms of restrictive practices used in aged care facilities.
491. The starting point must be to ensure that there are sufficient numbers of appropriately skilled staff available to attend to the needs of all people receiving aged care. The evidence is that restraints are often used because staff do not have the time or expertise to address the causes of challenging behaviours. We make specific recommendations about residential aged care staffing levels below. Staff who are caring for residents with dementia must be led by nurse practitioners and registered nurses and must have access to specialist advice. While all people working in aged should have knowledge of the nature and symptoms of dementia, and appropriate care practices, it is unrealistic to expect personal care workers to become experts in psychosocial management of complex changed behaviour.
492. Secondly, all staff must be adequately trained to attend to the needs of residents with dementia. As Associate Professor McFarlane explained, there is a need for improved training for care workers and health professionals.⁴⁸⁷ Families of people with dementia and the wider community would also benefit from education about what safe and quality care for people living with dementia involves.⁴⁸⁸
493. Finally, aged care regulators should be less concerned with the correct documentation being in place and more concerned to observe staff as they go about their normal duties providing care.⁴⁸⁹
494. An approach to regulating restraints which may be worthy of consideration as a model for the aged care sector has quite recently been introduced into the National Disability Insurance Scheme (NDIS). The *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) impose requirements on the use of

⁴⁸⁷ Exhibit 3-68, Statement of Stephen Macfarlane, WIT.0125.0001.0001 at 0027–0029 [139]–[147].

⁴⁸⁸ Exhibit 3-68, Statement of Stephen Macfarlane, WIT.0125.0001.0001 at 0029 [148]–[152].

⁴⁸⁹ Exhibit 3-68, Statement of Stephen Macfarlane, WIT.0125.0001.0001 at 0029 [153].

'regulated restrictive practices' by registered NDIS providers.⁴⁹⁰ The *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* contains a comprehensive suite of requirements including the need for 'behaviour support plans' prepared by 'specialist behaviour support providers'.⁴⁹¹ A specialist behaviour support provider must also be registered and such registration is subject to the condition that 'a behaviour support plan for a person with disability that contains a regulated restrictive practice must be developed by an NDIS behaviour support practitioner engaged by the provider'.⁴⁹²

495. In developing the requirements to replace Part 4A of the *Quality of Care Principals* the Australian Government should consider the NDIS provisions and how they are operating in practice. There is much to be said for the approach in the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* that requires restrictive practices only to be utilised under plans prepared by accredited experts. However, before any such scheme could be considered for the aged care sector, it would be important to have in place the necessary processes and structures. Further, the setting of an residential aged care facility staffed by at least one registered nurse (as we propose later in these submissions) would need to be considered in the formulation of Standards for aged care and may necessitate a different approach to that which applies under the NDIS.
496. The standard we are proposing that regulates the use of restrictive practices in aged care should set out requirements that ensure the use of restrictive practices is premised on a holistic assessment of a person's needs, informed by specialist advice. Caring for older people should be based on an understanding of their needs and preferences. That is no less the case for people who have impaired cognitive capacity or have challenging behaviours arising from illness or deterioration in physical function. Any new standards should ensure that restrictive practices are only used where alternative strategies to meet a person's needs have been tried and found unsuccessful. Any exception that applies if a restrictive practice is necessary in an emergency should only apply for a short period, such as to prevent a person from imminent risk of significant harm.⁴⁹³
497. The evidence is that changed behaviours of people receiving aged care can be caused by unaddressed needs, including physical needs such as pain, and that restrictive

⁴⁹⁰ The Rules are made pursuant to s 73H of the *National Disability Insurance Act 2013* (Cth) which enables Rules to be made that impose conditions on the registration of an NDIS provider. A provider may be liable to a civil penalty if it breaches such a condition: *National Disability Insurance Act 2013* (Cth), s 73J.

⁴⁹¹ *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth), s 10 and 11.

⁴⁹² *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth), s 18.

⁴⁹³ Exhibit 3-68, Statement of Stephen Macfarlane, WIT.0125.0001.0001 at 0026 [131].

practices can be reduced or avoided by identifying and addressing underlying unmet needs or triggers.⁴⁹⁴ Access to specialist advice is therefore imperative and should be legally required.

498. An assessment of whether it is necessary or appropriate to provide care in a way that is restrictive should consider the risks associated with the treatment or practice, as well as the risk that the person may cause harm to themselves or another person without the restrictive care or treatment. That is particularly so because restrictive practices not only affect the dignity and right to personal autonomy of older people, there is evidence that restrictive practices can have harmful physical and psychological effects and may not be effective in managing changed behaviours.
499. There has been concerning evidence about people receiving care who have been subjected to restrictive practices without informed consent by either the person or their legally authorised representative. Poor recording of informed consent was a particular feature of evidence in the first Sydney Hearing.⁴⁹⁵ Dr Juanita Breen, registered pharmacist and senior lecturer in dementia care at University of Tasmania, explained, that in her research, relatives of recipients of aged care services she had spoken to often said the first they were aware their relative was taking medications was when they received the pharmacy bill.⁴⁹⁶
500. The proposed new standard should make clear that restrictive practices are not permitted other than with the documented informed consent of the person or otherwise authorised in accordance with State or Territory law.
501. The proposed new standard should also require that a copy of any support plan, including any subsequent reviews, is provided to the person receiving care or their legally authorised representative. It is of great importance that the person is informed about the

⁴⁹⁴ Exhibit 3-61, Sydney Hearing 1, Statement of Juanita Westbury (now Breen), 29 April 2019, WIT.0117.0001.0001 at 0016 [24]; Exhibit 3-80, Sydney Hearing 1, Statement of Henry Brodaty, 16 May 2019, WIT.0116.0001.0001 at 0003 [13]; Exhibit 3-45, Sydney Hearing 1, Statement of Tamar Krebs, 30 April 2019, WIT.0124.0001.0001 at 0462; Exhibit 3-47, Sydney Hearing 1, Statement of Lucille O'Flaherty, 26 April 2019, WIT.0122.0001.0001 at 0011 [58]; Exhibit 1-14, Adelaide Hearing 1, Statement of Edward Strivens, 28 January 2019, WIT.0021.0001.0001 at 0007 [63].

⁴⁹⁵ Exhibit 3-9, Sydney Hearing 1, Statement of Michelle McCulla, WIT.0097.0001.0001 at 0003 – 0004 [24–33]; Exhibit 3-8, Sydney Hearing 1, Statement of Lillian Reeves, WIT.0141.0001.0001 at 0002 [15–17]; Transcript, Sydney Hearing 1, Miles Burkitt, 7 May 2019 at T1285.24–46; Transcript, Sydney Hearing 1, Kenneth Wong, 7 May 2019 at T1302.1–8; Transcript, Sydney Hearing 1, Kee Ling Lau, 7 May 2019 at T1318.28–45; Transcript, Sydney Hearing 1, DL/DM, 8 May 2019 at T1354.7-9; T1353.33–45; Exhibit 3-44, Sydney Hearing, Statement of Amy Tinley, 9 May 2019, WIT.0164.0001.0001 at 0006 [19]; Exhibit 3-23, Sydney Hearing 1, Statement of Richard Farmilo, WIT.0154.0001.0001 at 0005 [19]; Transcript, Sydney Hearing 1, Margaret Ginger, 8 May 2019 at T1407.12-16; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 81–94, 118.

⁴⁹⁶ Transcript, Sydney Hearing 1, Juanita Westbury (now Breen), 15 May 2019 at T1731.9-12.

restrictive practices and has the opportunity to question or challenge their application and ongoing use.

502. An appropriately qualified independent health practitioner should monitor the person subject to restraint and review the support plan regularly or if there is any change in the person's condition, not only to identify any signs of distress but also to ascertain whether the restraint remains necessary and proportionate to a risk of harm.
503. Finally, the legislative regime needs to be backed by strong regulatory requirements. Further, a breach of restraint requirements by an approved provider should expose it to a civil penalty at the suit of the regulator. This is consistent with the approach under the National Disability Insurance Scheme.⁴⁹⁷ The Australian Aged Care Commission should also be empowered to seek an order from a court that the approved provider pay compensation to the person unlawfully restrained if that is the person's wish.
504. As discussed above, older people with complex needs will increasingly be cared for at home. The Australian Law Reform Commission proposed in 2017 that consideration should be given to regulation of restrictive practices to care provided in people's own homes.⁴⁹⁸ This has not occurred and should also be part of the future work of the Australian Commission on Quality and Safety in Health and Aged Care in consultation with the Australian Aged Care Commission.
505. People receiving aged care should be equally protected from restrictive practices as other members of the community. Following the conclusion of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, it would be appropriate for there to be a further review of the arrangements for restrictive practices in aged care. Any such review should consider the relevance to the aged care sector of any recommendations of that Royal Commission, to ensure that the treatment of people receiving aged care services is consistent with the treatment of other members of the community.

Quality Indicators: measuring aged care quality

Recommendation 30: Quality indicators

30.1. By 15 July 2021, the responsible Minister should refer to the Australian Commission on Safety and Quality in Health and Aged Care responsibility for the introduction, implementation and amendment of aged care quality indicators, including:

⁴⁹⁷ *National Disability Insurance Scheme Act 2013* (Cth), s 73J.

⁴⁹⁸ Australian Law Reform Commission, *Elder Abuse – A National Legal Response Report No 131*, 2017, p 147.

- a. ongoing research into the use and evidence basis for quality indicators
 - b. publication of guidance on use of indicator data to identify risks and to undertake evidence-based risk management.
- 30.2. By 1 July 2023, the Australian Commission on Safety and Quality in Health and Aged Care should:
- a. expand the suite of quality indicators for care in residential aged care
 - b. develop quality indicators for care at home, and
 - c. implement a comprehensive quality of life assessment tool for people receiving aged care in residential care and at home.
- 30.3. In the interim, in addition to the existing commitment to implement quality indicators in the new domains of falls and fractures and medication management, the Australian Government should expand the National Mandatory Indicator Program, as set out in the 2019 PwC Consultation Paper 'Development of Residential Aged Care Quality Indicators', to use more comprehensive indicators for the existing domains of pressure injuries, physical restraint and unplanned weight loss.

506. If the aged care standards set the rules for aged care quality, quality indicators enable quality to be measured. There needs to be an alignment between the two—what the standards identify as high quality aged care ought to be what is measured. To take a simple example, if there is a standard for skin integrity that requires the minimisation of pressure sores, approved providers should have to report on the numbers of pressure sores suffered by people in their care. That way, the regulator and members of the public can know how providers are performing.

507. At Sydney Hearing 5 which took place in September 2020, the Secretary of the Australian Department of Health, Dr Brendan Murphy, was asked by Senior Counsel Assisting about funding shortfalls in the aged care system. While Dr Murphy acknowledged that there had been significant reductions in government funding for approved providers in real terms in recent years, he balked at any suggestion that the funding shortfalls may have caused deficiencies in the quality of the care delivered by those providers. He said that 'we don't have any evidence at the moment that there is an impact on quality and safety from financial performance'.⁴⁹⁹

508. At first blush, one might derive some reassurance from this statement that the lack of aged care funding has not impacted deleteriously on aged care quality. But that

⁴⁹⁹ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9429.21–22.

assumes that there is in place a robust process by which the Department of Health measures aged care quality. But not only is there no robust process. Quality is not adequately measured in our aged care system. Until last year, there were no mandatory quality indicators. There are presently three.

509. We noted earlier in these submissions how difficult it has been for the staff of the Royal Commission to assess the extent of substandard aged care in Australia. This is in no small part because of the lack of quality indicator data.
510. Quality indicators are also used in Australian hospitals to report publicly on key quality metrics such as hospital acquired infections, wait lists, costs and time to admissions.⁵⁰⁰
511. Quality indicators can also be used as a basis to help inform people's choice of approved provider. For example, in the United States, residential aged care providers are given a star rating based on performance against a wide range of quality indicators. These indicators include hospitalisations, antipsychotic medication use, urinary tract infections, use of catheters, changes in mobility and flu vaccinations.⁵⁰¹
512. The usefulness of the Australian National Mandatory Quality Indicator Program has been questioned by witnesses before the Royal Commission because of its limited scope. Complaints about the program include that the suite of current indicators are too clinically focused and that they do not adequately measure the experience of care from a person-centred, or quality of life, perspective.⁵⁰² It has also been said that the current indicators do not capture many characteristics that impact wellbeing or which recipients of aged care believe are important.⁵⁰³ As a result, the program does not address the information asymmetry which exists between providers and people accessing aged care. There has also been a lack of digital development regarding the collection and collation of this data which places an administrative burden on approved providers.⁵⁰⁴
513. A 2019 review of the National Mandatory Quality Indicator Program highlighted deficiencies in the scope of the current indicators and recommended the introduction of

⁵⁰⁰ GE Caughey et al, *International and National Quality and Safety Indicators for Aged Care. Report for the Royal Commission into Aged Care Quality and Safety*, March 2020, South Australian Health and Medical Research Institute, pp 4–5.

⁵⁰¹ United States Medicare, *About Nursing Home Compare Data*, <https://www.medicare.gov/NursingHomeCompare/Data/About.html>, viewed 20 August 2020.

⁵⁰² Transcript, Adelaide Hearing 1, Deborah Parker, 13 February 2019 at T235.29–236.5; Transcript, Adelaide Hearing 1, Transcript, Matthew Richter, 20 February 2019 at T524.14–20; Adelaide Workshop 2, Ben Lancken, 16 March 2020, T7983.8–21; Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9624.25-29;

⁵⁰³ Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0010 [56]–[57].

⁵⁰⁴ Transcript, Adelaide Workshop 2, Ben Lancken, 16 March 2020, T7983.15–34.

two new indicators for medication management and falls and fractures.⁵⁰⁵ The Australian Government plans to introduce these two indicators with effect from July 2021.⁵⁰⁶

514. While this is a positive first step, we submit that these two additional indicators do not go far enough. A more comprehensive suite of quality indicators is required.
515. Earlier in these submissions we referred to the Australian Commission on Safety and Quality in Health Care in the context of standard setting. It also has significant expertise in developing quality indicators for use in health care settings.
516. In her evidence before the Royal Commissioners, Professor Picone, that Commission's Chief Executive Officer, said that through its recent experience in developing, implementing and evaluating health safety and quality indicators, the Australian Commission on Safety and Quality in Health Care has 'developed and refined a process [that] may be applicable to the aged care sector'.⁵⁰⁷
517. Just as the body headed by Professor Picone is responsible for the development of *health care* standards and quality indicators, so too should the same body be responsible for *aged care* standards and quality indicators. This part of its work should also be performed in close consultation with the proposed Australian Aged Care Commission.
518. It is submitted that the Australian Commission on Safety and Quality in Health Care should be tasked with developing a more comprehensive suite of quality indicators for residential aged care and aged care in the home.
519. In undertaking this task, it should be informed by the following three matters.
520. First, indicators related to measuring quality of life outcomes should be included. Quality of life is a measurable outcome of good person-centred care,⁵⁰⁸ and good quality of life is shown to have positive impact on clinical outcomes.⁵⁰⁹
521. Secondly, quality indicators should be formulated in a way that efficiently harnesses data from providers' clinical information technology systems. Currently, there is a burden on approved providers and their staff to meet reporting requirements, which is predominately based on clinical observations by staff. This burden could be reduced by designing the scope of the reporting requirements to inform compliance with quality

⁵⁰⁵ PricewaterhouseCoopers Australia, *Development of Residential Aged Care Quality Indicators*, Consultation Paper, 18 November 2019.

⁵⁰⁶ Exhibit 3-78, Sydney Hearing 1, Statement of Amy Laffan, WIT.0105.0001.0001 at 0004 [20c].

⁵⁰⁷ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0034–0037 [163]–[172].

⁵⁰⁸ See, for example, Exhibit 6-22, Darwin and Cairns Hearing, Statement of Johanna Westbrook, WIT.0196.0001.0001. Tools to measure quality of life currently available include The Adult Social Care Outcomes Toolkit, the ICEPOP CAPability Measure for Older People and the Older Person's Quality of Life questionnaire.

⁵⁰⁹ See, for example, Exhibit 5-29, Perth Hearing, Statement of Mike Rungie, WIT.0158.0002.0001.

indicators so it aligns with data available in the clinical information technology systems used by approved providers.

522. Thirdly, appropriate benchmarks need to be set for each of the quality indicators against which providers can measure their own performance and the quality regulator can judge performance across the system. Data collected should be used as part of the star ratings system that we recommend should be established based on the star ratings system in the United States of America with the addition of consumer experience information.
523. Quality indicator data can be used to measure the quality of care, and help drive improvements in quality. They can also provide transparency to care recipients and their family members and advocates.
524. As an example of how quality indicator data has been used in the Australian setting, we note the quality indicators measured in Victorian public sector residential aged care services. From 2006 onwards, Victorian public sector residential aged care services have collected data on five different quality indicators. These include the indicators recorded in the National Mandatory Quality Indicator Program as well as additional indicators for medication management and falls and fractures.
525. These indicators have been collected for the purpose of improving monitoring processes and quality, with the important caveat that quality indicator data have not been used for regulatory findings. As a result, the Victorian government has amassed a substantial amount of data and has been able to use it to develop benchmarks for different quality indicators. These benchmarks help residential care services to identify whether they fall into a category of concern and to identify areas of potential improvement.
526. The quality indicators implemented in Victoria have given the State government the ability to monitor progress in different indicators over the past decade. At Melbourne Hearing 3, Kym Peake, Secretary of the Victorian Department of Health and Human Services, described the significant reduction observed in pressure injuries and physical restraint.⁵¹⁰
527. In addition to driving improvements in service quality, quality indicators can be used to inform consumer choice. Mr Glenn Rees of Alzheimer's Disease International described the way that aged care quality indicators are used to generate star ratings in the United States.⁵¹¹
528. However, we note there is also evidence that poor use and implementation of quality indicators data can lead to unintended consequences. Some of these consequences

⁵¹⁰ Exhibit 11-29, Melbourne Hearing 3, Statement of Kym Lee-Anne Peake, WIT.0481.0001.0001 at 0013 – 0014 [84-86].

⁵¹¹ Exhibit 3-40, Sydney Hearing 1, Statement of Glenn Eric Rees, WIT.0126.0001.0001 at 0012 [63-65].

were outlined by Professor Lisa Trigg, Assistant Director of Research, Data and Intelligence at Social Care Wales, at the Perth Hearing of the Royal Commission:

These unintended consequences include tunnel vision, where an emphasis is placed on what is measured, at the expense of what is not; myopia, a focus on short-term objectives at the expense of longer term benefits; gaming, where actual behaviour (rather than just reporting) is manipulated, for example, risk selection and cream skimming; and measure fixation, or 'hitting the target and missing the point'.⁵¹²

529. To avoid such consequences, care must be exercised in the selection of aged care quality indicators. The implementation of any quality indicator program must be carefully monitored and any necessary adjustments made by the Australian Commission for Safety and Quality in Health and Aged Care in conjunction with the Australian Aged Care Commission.

Recommendation 31: Using quality indicators for continuous improvement

31.1. By 1 July 2022, the Australian Government should implement reporting and benchmarking of provider performance against quality indicators. To achieve this:

- a. the Australian Commission for Safety and Quality in Health and Aged Care should develop a methodology to enable providers to be benchmarked against similar providers
- b. the Australian Government should track sector and provider performance and set progressive improvement targets to raise performance against quality indicators over time
- c. the Australian Government should publicly report on sector and provider performance against benchmarks.

31.2. From 1 July 2023 onwards, the Australian Aged Care Commission should assume responsibility for the functions and powers in subparagraphs 31.1. b. and c.

⁵¹² Exhibit 5-40, Perth Hearing, Statement of Lisa Jane Trigg, WIT.0156.0001.0001 at 0016 [95].

Part 3.5 Aged care for Aboriginal and Torres Strait Islander people

Background

530. Commissioners Tracey and Briggs concluded in the Interim Report that Aboriginal and Torres Strait Islander people were not being well served by the current aged care system.⁵¹³ Although it is well understood that the aged care needs of some Aboriginal and Torres Strait Islander people go unmet; the extent of the problem remains unclear. In these submissions we describe a new approach to the aged care of the first Australians. We do so from the starting point that although Aboriginal and Torres Strait Islander people have particular cultural needs and requirements that may parallel other CALD sectors, they are ultimately unique.
531. There is also a great diversity in the Aboriginal and Torres Strait Islander population who need care; in their various rich cultures and the diverse locations where care needs to be delivered. This means that 'culture' means different things to different Aboriginal and Torres Strait Islander people in different communities across the country. Cultural matters are also likely to develop and change over time. The system we describe is about recognising this: seeking to understand need, whether it be in Redfern or Broome, and responding accordingly.
532. Aboriginal and Torres Strait Islander people are entitled to aged care when they turn 50. In the 2016 Census, 124,000 Australians aged 50 years and older identified as an Aboriginal and/or Torres Strait Islander person. . Sixty percent of this group lived in New South Wales and Queensland.⁵¹⁴ Although nationally around 81% of older Aboriginal and Torres Strait Islander people were recorded as living in inner and outer regional areas or in a major city, the position is largely reversed in the Northern Territory, where nearly 80% lived in remote and very remote areas.⁵¹⁵

⁵¹³ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, p 166.

⁵¹⁴ Australian Institute of Health and Welfare, *Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over in-brief*, 2019, pp 6 and 8, <https://www.aihw.gov.au/getmedia/a87628df-a3ea-4e9c-8453-892d6f3c6fdc/aihw-ihw-207.pdf.aspx?inline=true>, viewed 16 June 2020.

⁵¹⁵ Australian Bureau of Statistics, *3238.0 - Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031*, 2019, <https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3238.0Main%20Features402006%20to%202031?opendocument&tabname=Summary&prodno=3238.0&issue=2006%20to%202031&num=&view>, viewed 2 June 2020; M Lowe and P Coffey, 'Effect of an ageing population on services for the elderly in the Northern Territory', *Australian Health Review*, 2019, Vol 43, p 72 citing the Productivity Commission for Steering Committee for the Review of Government Services, *Report on Government Services 2016*, Vol F: Community services, <https://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/rgs-2016-volumef-community-services.pdf>, viewed 11 September 2017.

Cultural matters

533. Respect and cultural safety in providing care to Aboriginal and Torres Strait Islander people is the starting point of any consideration of how care should be delivered to them. Three essential matters stand out.

The Aboriginal and Torres Strait Islander Elder

534. The first concerns the notion of the Aboriginal and Torres Strait Islander Elder and how they are revered and looked up to within their communities. Elders are ‘cultural knowledge holders’, providing the ‘social glue’ within their communities, and ‘fostering other humane qualities such as patience...empathy and communication’.⁵¹⁶ Many are themselves care givers for children or grandchildren and often reside in multi-generational households. They are recognised and honoured for their role in solving public problems, reinforcing culture and beliefs, and holding traditional knowledge about the Australian ecology and environment.⁵¹⁷ They are central to the continuation of Aboriginal and Torres Strait Islander cultures and communities.⁵¹⁸

Connection to community, Country, culture and family

535. The second matter is connected to the first. It concerns the strength of communal bonds and structures within Aboriginal and Torres Strait Islander communities and the importance of connection for Elders to their community, Country, culture and family; all matters touched upon in the Interim Report. All four elements are central to the social, emotional and physical wellbeing of the Aboriginal and Torres Strait Islander people and each plays a pivotal role in determining their health outcomes.⁵¹⁹ When an Elder has to move away from the community, Country, culture and family from which they derive their sense of identity, the consequences can be catastrophic.

Community Involvement and Participation

536. The third stems from the clearly expressed desire on the part of Aboriginal and Torres Strait Islander people to plan, run and deliver aged care services for themselves.⁵²⁰ This

⁵¹⁶ Exhibit 4-16, Broome Hearing, Statement of Venessa Curnow, WIT.0243.0001.0001 at 0005 [31].

⁵¹⁷ Exhibit 4-16, Broome Hearing, Statement of Venessa Curnow, WIT.0243.0001.0001 at 0006–0007 [35]–[36].

⁵¹⁸ National Aboriginal Community Controlled Health Organisation, Public submission, AWF.001.04347.01_0001 at 0011.

⁵¹⁹ Exhibit 4-5, Broome Hearing, Statement of Tamra Bridges, WIT.0166.0001.0001 at 0005 [38].

⁵²⁰ Transcript, Broome Hearing, Roslyn Malay, 19 June 2019 at T2176.30–35; Aboriginal and Torres Strait Islander roundtable, 28 May 2019. Transcript, Sydney Hearing, Lynette Goldberg, 14 May 2019 at T1625.30–1626.5; Transcript, Perth Hearing, Matthew Moore, 26 June 2019 at T2575.43–2576.11; Exhibit 4-7, Broome Hearing, Statement of Martin Laverty, WIT.0157.0001.0001 at 0004 [28]–0005 [1]; Exhibit 10-5, Melbourne Hearing 2, Statement of Noleen Tunny, WIT.0422.0001.0001 at 0021 [53]; Transcript, Broome Hearing, Leon Flicker, 17 June 2019 at T2041.34–44.

extends not only to the leadership and governance of providers but to the staff that are engaged in the face-to-face delivery of care.

537. The new aged care system must recognise these matters and facilitate on the ground service delivery which values and seeks to embed these relationships in care. This means community engagement and a preference for delivery through community-controlled organisations and existing trusted providers.
538. Against this background, there are significant structural matters that need to be addressed.
539. First, Aboriginal and Torres Strait Islander people make up 3.3% of the Australian population yet comprise only 1.5% of the population aged 50 years and older.⁵²¹ Aboriginal and Torres Strait Islander people are significantly under-represented in residential aged care, with just 2663 people receiving residential aged care throughout FY2019 under the *Aged Care Act 1997* and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP), occupying around 1% of total places.⁵²² Point in time data suggests that there may be even less Aboriginal and Torres Strait Islander representation since, as at 30 June 2020, there were only 1842 Aboriginal and Torres Strait Islander people in permanent residential aged care. There is slightly higher representation in home care, but at all levels this falls well short of the 3.3% of the total population. Aboriginal and Torres Strait Islander people make up 2.8% of Home Care Package and 2.5% of Commonwealth Home Support Programme places.
540. Sitting outside of the *Aged Care Act 1997*, the NATSIFACP is the principal program that is relied upon to target culturally appropriate aged care close to home and community.⁵²³ It delivers a mix of high care residential, low care residential and home care places on a block or grant funded basis.⁵²⁴ Because it is outside of the *Aged Care Act*, providers do not have to be approved providers.
541. NATSIFACP is funded to deliver 1264 operational residential and home care places across Australia through 37 providers.

⁵²¹ See p 5 of <https://www.aihw.gov.au/getmedia/a87628df-a3ea-4e9c-8453-892d6f3c6fdc/aihw-ihw-207.pdf.aspx?inline=true>, also in evidence at RCD.9999.0075.0058.

⁵²² Australian Institute of Health and Welfare, *Aged care data snapshot 2019—fourth release*, Australian Government, 2019, https://www.gen-agedcaredata.gov.au/www_ahwgen/media/Data-Snapshot/Aged-Care-Data-Snapshot-2019-Release-v4-1-final.xlsx, viewed 16 June 2020.

⁵²³ Department of Health, *National Aboriginal and Torres Strait Islander Flexible Aged Care Program: Program Manual 2019*, Australian Government, 2019, p 1, <https://www.health.gov.au/sites/default/files/documents/2019/12/national-aboriginal-and-torres-strait-islander-flexible-aged-care-program-manual.pdf>, viewed 16 June 2020.

⁵²⁴ Department of Health, *National Aboriginal and Torres Strait Islander Flexible Aged Care Program: Program Manual 2019*, Australian Government, 2019, p 6, <https://www.health.gov.au/sites/default/files/documents/2019/12/national-aboriginal-and-torres-strait-islander-flexible-aged-care-program-manual.pdf>, viewed 16 June 2020.

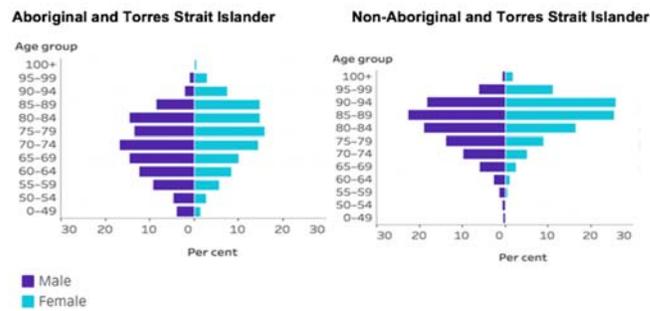
542. Recently published data from the Australian Institute for Health and Welfare states that as of 30 June 2020, 34 of the 42 NATSFACP Providers, 323 of the 498 residential places and 552 of the 670 home care places are located in remote and very remote locations.⁵²⁵
543. Given their earlier eligibility and the high incidence of chronic health conditions that can affect daily functioning, one might reasonably expect Aboriginal and Torres Strait Islander people to be significantly over-represented. Sadly, they are not.
544. Secondly, only around one in five Aboriginal and Torres Strait Islander people live in a residential care facility that has an Aboriginal and Torres Strait Islander focus (that is at least 30% Aboriginal and Torres Strait Islander residents). In contrast, 61% of Aboriginal and Torres Strait Islander people accessing home care did so from a provider with such a focus.⁵²⁶
545. Thirdly, and critically, a significant number of the Aboriginal and Torres Strait Islander people who do access aged care services (both home care and residential care) do so when they are much younger than non-Aboriginal and Torres Strait Islander people, as shown in the following charts.⁵²⁷

⁵²⁵ Australian Institute of Health and Welfare, Aged Care Data Snapshot-2020, October 2020, <https://www.gen-agedcaredata.gov.au/Resources/Access-data/2020/October/Aged-care-data-snapshot%E2%80%942020>, viewed 21 October 2020.

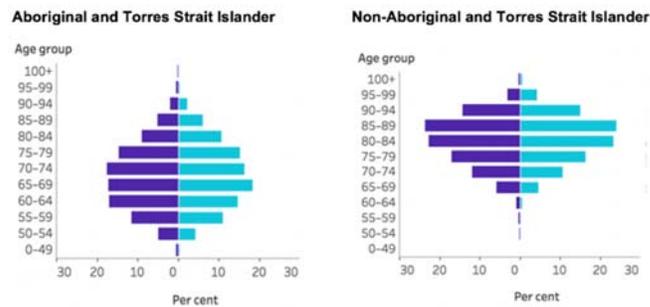
⁵²⁶ Australian National Audit Office, *The Auditor-General ANAO Report No.53 2016–17 Performance Audit, Indigenous Aged Care*, 2017, p. 24.

⁵²⁷ Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander people using aged care*, 2019, <https://www.gen-agedcaredata.gov.au/Resources/Dashboards/Aboriginal-and-Torres-Strait-Islander-people-using> viewed, 15 October 2020.

People using residential aged care by Aboriginal and Torres Strait Islander status, age and sex as at 30 June 2019.¹⁸



People using home care by Aboriginal and Torres Strait Islander status, age and sex as at 30 June 2019.¹⁹



546. The number of Aboriginal and Torres Strait Islander people under the age of 65 who receive some form of aged care services is significant. In 2017–18, there were 9199 Aboriginal and Torres Strait Islander people between the ages of 50 and 65 and 1309 people under 50 years receiving some form of aged care.⁵²⁸
547. A substantial reason for this is the early onset of ageing related conditions and disability for Aboriginal and Torres Strait Islander people compared to other sections of the community; a matter that was touched upon in the Interim Report.⁵²⁹ Aboriginal and Torres Strait Islander people also experience a burden of disease at around 2.3 times the rate of the general population.⁵³⁰
548. Disabling health conditions, including falls, pain, urinary incontinence, type 2 diabetes, renal failure and frailty that are common in older people affect Aboriginal and Torres Strait Islander people at younger ages. Eighty-eight percent of Aboriginal and Torres Strait Islander people over the age of 55 are at a higher risk of long-term health

⁵²⁸ Australian Institute of Health and Welfare, *Aged Care for Indigenous Australians*, 2020, <https://www.aihw.gov.au/reports/australias-welfare/aged-care-for-indigenous-australians>, viewed 16 June 2020.

⁵²⁹ Transcript, Broome Hearing, Leon Flicker, 17 June 2019 at T2026.28–35; Transcript, Melbourne Hearing 3, Moreen Lyons, at T5688.18–36; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 3, p 167.

⁵³⁰ Australian Institute of Health and Welfare, *Alcohol, tobacco and other drugs in Australia*, web report, 2020, <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-people>, viewed 16 July 2020.

conditions.⁵³¹ Dementia is also more prevalent: with one study reporting that 12.4% of Aboriginal and Torres Strait Islander people in the Kimberley region aged 45 years and over were living with dementia.⁵³²

549. Aboriginal and Torres Strait Islander people also find it difficult to access disability services and are forced to seek aged care as a result.⁵³³
550. Although there is an expectation that the maturation of the National Disability Insurance Scheme will result in the delivery of more appropriate services for Aboriginal and Torres Strait Islander people living with disability, there is no guarantee this need can be met in the short to medium term.⁵³⁴ It follows that Aboriginal and Torres Strait Islander people aged between 50 and 65 years should remain able to access aged care services even though they may have an entitlement under the National Disability Insurance Scheme. Put simply, they should be serviced by the system that best meet their needs.

Looking Towards the Future

551. Across 2015–17, the life expectancy for Aboriginal and Torres Strait Islander people was 71.6 years for men and 75.6 years for women compared to 80.2 years for men and 83.4 for women who do not identify as an Aboriginal and Torres Strait Islander person.⁵³⁵ This is a difference of nearly 8.5 years for men and 8 years for women.
552. The future offers hope that this gap is closing. The Australian Bureau of Statistics forecasts that to 2031, the Aboriginal and Torres Strait Islander populations will grow at a rate faster than the total Australian population: with the highest projected growth in major cities. Substantial growth is projected amongst the 65 and over population, which is likely to increase as a proportion of the Aboriginal and Torres Strait Islander population, from 4.3% in 2016 to between 8.1% and 8.2% in 2031, an increase of between 154% and 163.4%, meaning today's population of 34,000 could grow to as many as 89,600.⁵³⁶ The 50–64 age group is likely to remain relatively stable as a proportion of the total

⁵³¹ Exhibit 4-6, Broome Hearing, Statement of Leon Flicker, WIT.0161.0001.0001 at 0004 [15]; Australian Institute of Health and Welfare, *Older Australia at a glance: Aboriginal and Torres Strait Islander people*, 2018, <https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/diversity/aboriginal-and-torres-strait-islander-people>, viewed 16 June 2020.

⁵³² Exhibit 4-1, Broome Hearing, General tender bundle, tab 3, RCD.9999.0069.0054 at 0055.

⁵³³ Transcript, Broome Hearing, Professor Flicker, 17 June 2019 at T2028.28–35.

⁵³⁴ Transcript, Broome Hearing, Professor Flicker, 17 June 2019 at T2028.32–42; Transcript, Broome Hearing, Belinda Robinson, 18 June 2019, T2143.19–29; Exhibit 5-28, Perth Hearing, Statement of Matthew Moore, WIT.0162.0001.0001 at 0003–0004 [12].

⁵³⁵ National Indigenous Australians Agency, *Closing the Gap Report 2020*, 2020, p 77, <https://ctgreport.niaa.gov.au/sites/default/files/pdf/closing-the-gap-report-2020.pdf>, viewed 16 June 2020.

⁵³⁶ Australian Bureau of Statistics, *3238.0 - Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2031*, 2019, <https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3238.0Main%20Features402006%20to%202031?opendocument&tabname=Summary&prodno=3238.0&issue=2006%20to%202031&num=&view>, viewed 2 June 2020.

Aboriginal and Torres Strait Islander population but even this will see population growth from 90,000 to around 122,700 people.⁵³⁷

553. It is important to note that data concerning the Aboriginal and Torres Strait Islander population requires caution since it relies on people choosing to identify when they respond to the Census. This decision is affected by whether people feel comfortable reporting aboriginality to government, their personal experiences of racism and discrimination, how the question is asked as well as their ability complete the Census on behalf of each household.⁵³⁸
554. In the case of the 2016 Census there was an increase in the population that cannot be explained by population growth alone. It is thought that a significant element in this increase was the result of people identifying as Aboriginal and Torres Strait Islander who had not previously done so.⁵³⁹ This has important implications for planning, since it is likely to indicate the Aboriginal and Torres Strait Islander population is larger than expected and is likely to continue to grow in this way as societal changes make it possible for more people to report their Aboriginal and Torres Strait Islander status.⁵⁴⁰
555. This has significant implications for understanding the aged care needs of Aboriginal and Torres Strait Islander people. Not only are their unmet aged care needs not well understood, the number of people who need tailored aged care services cannot be definitively mapped.
556. A further factor that must inform the Royal Commissioners' recommendations is that the Aboriginal and Torres Strait Islander population as described in the 2016 Census had a younger age structure than the non-Indigenous population with a median age of 23.0 years, compared to 37.8 years for other Australians.⁵⁴¹ As a result there will be a larger pool of younger Aboriginal and Torres Strait Islander people who are of working age and potentially employable in aged care roles. The National Indigenous Australian Agency

⁵³⁷ Australian Bureau of Statistics, *ABS Dataset: Projected population, Aboriginal and Torres Strait Islander Australians, Australia, state and territories, 2016 to 2031*, 2019, http://stat.data.abs.gov.au/Index.aspx?DataSetCode=ABORIGINAL_POP_PROJ#, viewed 17 June 2020.

⁵³⁸ Australian Bureau of Statistics, *Indigenous status as a self-reported measure*, 2018, <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2081.0~ACLD~Main%20Features~Indigenous%20status%20as%20a%20self-reported%20measure~10003>, viewed on 9 October 2020.

⁵³⁹ N Biddle and F Markham, 'Indigenous identification change between 2011 and 2016: evidence from the Australian Census Longitudinal Dataset', *Centre for Aboriginal Economic Policy Research*, 2018, pp 1 and 7.

⁵⁴⁰ N Biddle and F Markham, 'Indigenous identification change between 2011 and 2016: evidence from the Australian Census Longitudinal Dataset', *Centre for Aboriginal Economic Policy Research*, 2018, pp 1 and 7.

⁵⁴¹ Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians*, 2016, <https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release>, viewed 9 October 2020.

estimates this 'demographic dividend' will result in a 28% increase in the prime working age population of Aboriginal and Torres Strait Islander people, or 73,250 more potential workers, by 2026.⁵⁴²

557. Against this background, we propose the following recommendations:

Recommendation 32: Aboriginal and Torres Strait Islander service arrangements within the new aged care system

32.1. The Australian Government should ensure that the new aged care system makes specific and adequate provision for the changing and diverse needs of Aboriginal and Torres Strait Islander people and that:

- a. Aboriginal and Torres Strait Islander people receive culturally respectful and safe, high quality, trauma-informed, needs-based and flexible aged care services regardless of where they live
- b. priority is given to existing and new Aboriginal and Torres Strait Islander organisations, including health, disability and social service providers, to cooperate and become providers of integrated aged care services
- c. regional service delivery models that promote integrated care are deployed wherever possible
- d. there is a focus on providing services within, or close to, Aboriginal and Torres Strait Islander populations while maximising opportunities for people to remain on, and maintain connection with, their Country and communities
- e. aged care is available and providers are engaged at the local aged care planning region level on the basis of objectively established need that is determined in consultation with Aboriginal and Torres Strait Islander populations and communities, and recognising that aged care needs and service delivery preferences may vary between locations and population centres
- f. older Aboriginal and Torres Strait Islander people are given access to interpreters on at least the same basis as members of culturally and linguistically diverse communities when seeking or obtaining aged care including health care services.

⁵⁴² National Indigenous Australian Agency, *The Indigenous Business Fact Sheet*, undated https://www.niaa.gov.au/sites/default/files/publications/ibss_factsheet.pdf, viewed 9 October 2020.

558. This new comprehensive, inclusive and responsive national system of aged care, must incorporate particular service arrangements to meet the particular aged care needs of Aboriginal and Torres Strait Islander people now and in the future. Flexibility is important given that people in major cities may have a very different perspective of cultural safety to someone in a more remote location. The system needs to recognise this and be capable of responding accordingly.
559. As a matter of principle however, each person should be entitled to receive support and care that is culturally safe for that person, recognising their individual experience and and understanding that each person will have their own cultural requirements.
560. The projected growth in the number of Aboriginal and Torres Strait Islander people needing care into the future means that NATSIFACP is not the answer. Were NATSIFACP to be expanded to meet the needs of all Aboriginal and Torres Strait Islander people, there would, in effect and over time, be two aged care systems. This is not a desirable outcome.
561. The new aged care system must be ready to accommodate the needs of the growing Aboriginal and Torres Strait Islander populations.
562. There is great opportunity for the new aged care system to embrace all Australians, and to have the capacity, the flexibility and the sophistication to respond to the unique aged care needs of Aboriginal and Torres Strait Islander people.
563. With this aim in mind, the service arrangements within the new system can and should ensure that:
- a. There are accessible pathways linking Aboriginal and Torres Strait Islanders to the care that they need. This will necessitate establishing a sufficient number of Aboriginal and Torres Strait Islander Care Finders and aged care assessors to assist Aboriginal and Torres Strait Islander people to navigate the aged care system and obtain necessary aged care services and ongoing support in the event of changes to personal circumstances or care requirements.
 - b. Where possible, and particularly in rural and remote locations, aged care should be delivered in conjunction with other existing services, such as Aboriginal and Torres Strait Islander primary health and community organisations.
 - c. In allocating places under the national aged care program, priority is given to existing and new Aboriginal and Torres Strait Islander organisations, including health, disability and social service providers, to cooperate and become providers of integrated aged care services.

564. What this should mean in practice is establishing real consultation with Aboriginal and Torres Strait Islander populations, communities and providers as a cornerstone of service delivery.
565. One critical aspect of the new system concerns the age at which younger Aboriginal and Torres Strait Islander people can and should access aged care service. Aboriginal and Torres Strait Islander people aged between 50 and 65 years are eligible for both the National Disability Insurance Scheme and aged care, should be serviced by the system that best meet their needs.
566. Care needs to be taken to ensure that Aboriginal and Torres Strait Islander people who are over 50 but under 65 years of age, with conditions that impact their ability to function are not moved straight into the aged care system where they may miss out on the full range of National Disability Insurance Scheme assistance they are entitled to.
567. In our submissions concerning young people in aged care, we recommend that younger people at risk of entering residential aged care should be assessed by National Disability Insurance Scheme assessors in the first instance. By extension, any Aboriginal and Torres Strait Islanders under 65 who have one or more conditions affecting their ability to function should be assisted by their care finder to apply to the National Disability Insurance Scheme. Each person who may be eligible for the National Disability Insurance Scheme should be able to test their eligibility. This will assist people to obtain the full range of services they are entitled to. It will also help to provide the National Disability Insurance Agency with a clearer picture of the disability needs of Aboriginal and Torres Strait Islander people, wherever they live. This information will help the National Disability Insurance Agency to better target its efforts to develop culturally safe disability services and accommodation options. Aboriginal and Torres Strait Islander people with significant disability needing residential care should be able to make real choices about where they live.
568. Until that time, there will be Aboriginal and Torres Strait Islander people under 65 years of age who will live in aged care facilities, either by choice or necessity. When this occurs, and the person is eligible under the National Disability Insurance Scheme, the National Disability Insurance Agency and the Aboriginal and Torres Strait Islander Aged Care Commissioner, proposed below, should coordinate to ensure that National Disability Insurance Scheme clients do not take up aged care beds. For this reason, the assessment of need that will form the basis for aged care planning for Aboriginal and Torres Strait Islander people across Australia must also take account of the need for disability services in each region.
569. Staff involved in administering NATSIFACP should be transferred to the Australian Aged Care Commission in the lead up to the new aged care program become operational.

Recommendation 33: An Aged Care Commissioner within the Australian Aged Care Commission with oversight of Aboriginal and Torres Strait Islander aged care

33.1. By 1 July 2023, there should be within the Australian Aged Care Commission a statutory role that involves the ongoing fostering, promotion and development of culturally safe, tailored and flexible aged care services for Aboriginal and Torres Strait Islander people across the country. The person appointed to this role shall be an Aboriginal or Torres Strait Islander person.

33.2. In advance of the formal establishment of the Commission, a person should be appointed by 31 December 2021 under interim administrative arrangements to perform relevant functions and exercise relevant powers.

570. The need for leadership to oversee the delivery of high quality aged care to Aboriginal and Torres Strait Islander people requires establishing an office within the Australian Aged Care Commission to oversee aged care for Aboriginal and Torres Strait Islander people under the leadership of a specifically designated Commissioner.

571. At the broadest level of generality, the principal responsibilities of the Aboriginal and Torres Strait Islander Aged Care Commissioner will be to identify, on an ongoing basis, the particular local and regional aged care needs of Aboriginal and Torres Strait Islander people so as to enable those needs to be met in a way that is culturally appropriate.

572. The Aboriginal and Torres Strait Islander Aged Care Commissioner should have direct expertise, preferably with a clinical background, in Aboriginal and Torres Strait Islander health and aged care, working with a network of staff located around the country, and be capable of travelling to Aboriginal and Torres Strait Islander populations and communities. To the greatest extent possible, staff at all levels should be Aboriginal and Torres Strait Islander people drawn from across Australia.

573. This is consistent with the principle that Aboriginal and Torres Strait Islander people should be involved at all levels in the planning and delivery of aged care services for their communities.

574. A principal focus of the Aboriginal and Torres Strait Islander Aged Care Commissioner will be on identifying unmet need, identifying strategies to meet that need and providing direction to the Australian Aged Care Commission in resource allocation and program delivery. They will collaborate with Aboriginal and Torres Strait Islander populations, communities and community health organisations about the types of aged care services they require. The Commissioner should work with and around local and regional aged

care infrastructure as well as existing Aboriginal Health networks. Consultation and co-design are crucial to this work.

575. The Aboriginal and Torres Strait Islander Commissioner will also be responsible for gathering data and providing information to the Aged Care Pricing Authority, proposed later in these submissions, about the real cost of delivering aged care to Aboriginal and Torres Strait Islander people around Australia. They will coordinate, plan and advocate for the strategic expansion of Aboriginal and Torres Strait Islander aged care.
576. Other responsibilities of the Aboriginal and Torres Strait Islander Aged Care Commissioner will include:
- a. Facilitating the transitioning of providers who currently operate outside of the *Aged Care Act 1997* (Cth) to become registered under the new national system.
 - b. Encouraging more Aboriginal and Torres Strait Islander organisations to become approved providers, either independently or in partnership or collaboration with existing trusted organisations as part of a regional, cooperative and integrated model of aged care service delivery.
 - c. Developing cultural safety training and assessment of providers to ensure it is consistent, high quality and available to provider staff and management, as well as to those who carry out care finder roles, aged care assessment, and provider regulation and compliance activities.
 - d. Providing technical assistance to Aboriginal and Torres Strait Islander approved providers on their technical, clinical, and gerontological and governance.
 - e. Developing of capacity in governance, recruitment and business expertise; including education, tools, templates and resources for Aboriginal and Torres Strait Islander approved providers and facilitate Aboriginal and Torres Strait Islander staff to attain the necessary skills and qualifications during transition.
 - f. Advocating for the aged care needs of Aboriginal and Torres Strait Islander populations across Australia and keep people informed about the degree to which the Aboriginal and Torres Strait Islander Aged Care service arrangements and other reforms arising from this report are meeting their aged care needs.
 - g. Collaborating with the Australian Commission on Safety and Quality in Health Care to develop a national Continuous Quality Improvement Framework for Aboriginal and Torres Strait Islander aged care to complement the existing framework for primary health care and the broader aged care framework that we recommend elsewhere in this report.

- h. Developing an evidence base surrounding the state of capacity for both aged care and the National Disability Insurance Scheme to meet the needs of those under 65 years and commission research to ascertain the appropriate age for Aboriginal and Torres Strait Islander people to receive aged care services.
 - i. Contributing to the oversight of the 'provider of last resort' model mentioned below, so that where the Commissioner is unable to identify and attract residential and / or home care approved providers in regions where there is identified Aboriginal and Torres Strait Islander aged care need, services are provided under a universal service obligation by negotiation with the relevant State or Territory and / or local governments until another provider can be identified and established.
 - j. Developing the workforce programs referred to below.
577. The functions required to deliver this sort of fundamental change are considerable and will require the establishment of a staff structure that has clinical, cultural and technical expertise. It will require resources to conduct outreach and consultation throughout Australia, identify opportunities for collaboration and regional responses to aged care needs, and build trust and rapport with providers. It will also need to work to increase awareness amongst Aboriginal and Torres Strait Islander people of the availability of aged care assistance within Aboriginal and Torres Strait Islander populations.
578. Although the Australian Aged Care Commission will not be formally established until 2023, a senior executive role, including the functions described above, should be established within the Department of Health on an interim or transitional basis before the end of 2021. This will allow the groundwork necessary to establish the proposed Aboriginal and Torres Strait Islander service arrangements to be done before the commencement of the new system.
579. The formal designation or title of the Aboriginal and Torres Strait Islander Aged Care Commissioner is a matter about which we seek the input of Aboriginal and Torres Strait Islander communities and representative bodies. Our preference would be for the Commissioner to bear a name that reflects the role and responsibilities in an Aboriginal and Torres Strait Islander language and we welcome submissions in this regard.

Recommendation 34: Cultural safety

34.1. By 1 July 2022, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should:

- a. require all of its employees who are involved in the aged care system, and any care finders who are not its employees, to undertake regular training about cultural safety and trauma-informed service delivery
- b. require all aged care providers which promote their services to Aboriginal and Torres Strait Islander people to:
 - i. train their staff in culturally safe and trauma-informed care, and
 - ii. demonstrate to the Australian Aged Care Commission that they have reached an advanced stage of implementation of the Aboriginal and Torres Strait Islander Action Plan under the Diversity Framework

34.2. From 1 July 2023, the Australian Aged Care Commission should:

- a. ensure care finders serving Aboriginal and Torres Strait Islander communities are local Aboriginal and Torres Strait Islander people who are culturally trained and familiar with existing Aboriginal and Torres Strait Islander service providers who are trusted by the local population
- b. wherever possible, ensure aged care assessments of Aboriginal and Torres Strait Islander people are conducted by assessors who are, wherever possible, Aboriginal or Torres Strait Islander people, or others who have undertaken training in cultural safety and trauma-informed approaches
- c. work with State and Territory Governments to establish culturally appropriate advance care directive processes, guidance material and training for aged care providers that account for the diversity of cultural practices and traditions within each State and Territory.

580. The Interim Report outlined the importance of cultural safety when it comes to aged care for Aboriginal and Torres Strait Islander people and how it is the person who is receiving care that is the judge of whether care is culturally safe or not. As the National Aboriginal

Community Controlled Health Organisation puts it, cultural safety 'must be both the starting point and central to any aged care offerings for our people'.⁵⁴³

581. The experiences of many Aboriginal and Torres Strait Islander people often leads to deep distrust of government and institutions.⁵⁴⁴ Aged care is no exception. Many will not engage with a service provider that they do not consider culturally safe.⁵⁴⁵
582. It follows that cultural safety must be embedded throughout aged care: from initial contact with the system, during assessment, and when an older person receives aged care services at home, in their community or in a residential setting.
583. Without the development of a culturally safe assessment process, some Aboriginal and Torres Strait Islander people in need of care can be reluctant to disclose the full extent of their needs and miss out on the services and supports they require.⁵⁴⁶ The risk is that without cultural safety in assessment, inappropriate levels of care will be approved or the person may walk away from the system altogether. Like so many other facets of care, time is required for some Aboriginal and Torres Strait Islander people in need of care to develop the trust to disclose significant personal information such as continence issues, and mainstream approaches may result in them telling assessors 'what they think they want to hear'.⁵⁴⁷
584. Further, given the number of members of the Stolen Generations who are going to need care in the years ahead, cultural safety demands a trauma-informed approach to care. This is particularly clear when it comes to members of the Stolen Generations aged 50 and over; a vulnerable section of the Australian community who often have a history of trauma. Their childhood experiences further compromise their ability to seek services and should dictate and inform how such services should be provided.⁵⁴⁸
585. Culturally safe and trauma-informed care must also be reflected in palliative and end-of-life processes. It must also extend into the period after a person has died to ensure that

⁵⁴³ National Aboriginal Community Controlled Health Organisation, Public submission, AWF.001.04347.01_0001, at 0005.

⁵⁴⁴ National Aboriginal Community Controlled Health Organisation, Public submission, AWF.001.04347.01_0001 at 0006; Exhibit 10-1, Melbourne Hearing 2, General tender bundle, tab 127, RCD.9999.0222.0001 at 0018–0019; Exhibit 4-5, Broome Hearing, Statement of Tamra Bridges, WIT.0166.0001.0001 at 0009 [66].

⁵⁴⁵ Koorie Caucus of the Aboriginal Strategic Governance Forum, Public submission, AWF.001.04763.00 at 0008 and 0012; National Aboriginal Community Controlled Health Organisation, Public submission, AWF.001.04347.01_0001 at 0005; Transcript, Broome Hearing, Leon Flicker, 17 June 2019 at T2038.7–34.

⁵⁴⁶ Koorie Caucus of the Aboriginal Strategic Governance Forum, Public submission, AWF.001.04763 at 0009 [6.3.2.2].

⁵⁴⁷ Transcript, Perth Hearing, Matthew Moore, 26 June 2019 at T2577.4–6; 19–28; T2576.44–2577.6.

⁵⁴⁸ Healing Foundation and Australian Association of Gerontology and Aboriginal and Torres Strait Islander Ageing Advisory Group, Public submission, AWF.001.04106.01at 0002.

cultural requirements are met.⁵⁴⁹ The evidence before the Royal Commission suggests that culturally safe assessment services for Aboriginal and Torres Strait Islander people to obtain an accurate assessment of need requires:

- a. Aged care assessments that are conducted in person by, wherever possible, Aboriginal or Torres Strait Islanders assessors or others who have undertaken training in cultural safety and trauma-informed approaches that have been approved by the Aboriginal and Torres Strait Islander Aged Care Commissioner. Where that is not possible, assessments should be conducted in the presence of Care Finders who are local Aboriginal and Torres Strait Islander people who are culturally trained and familiar with existing Aboriginal and Torres Strait Islander service providers who are trusted by the local population.⁵⁵⁰
- b. The provision of Aboriginal or Torres Strait Islander interpreting services.⁵⁵¹
- c. The use of a culturally appropriate assessment tool that does not make assumptions about education, literacy or lifestyle.⁵⁵²
- d. An adequate amount of time, including multiple visits if required, to develop relationships of trust, and to allow for a slower approach where appropriate.⁵⁵³
- e. Taking care to avoid actions that could trigger trauma, such as requiring a person to tell their story multiple times or assuming that all Aboriginal and Torres Strait Islander people have close family or ongoing connections to Country.⁵⁵⁴

Recommendation 35: Prioritising Aboriginal and Torres Strait Islander organisations as aged care providers

35.1. The Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should assist Aboriginal and Torres Strait Islander organisations to expand into aged care service delivery, whether on their own or in partnership with other organisations, including Aboriginal

⁵⁴⁹ N Sivertsen, A Harrington and M Hamiduzzaman, 'Two-eyed seeing: the integration of spiritual care in Aboriginal residential aged care in South Australia', *Journal of Religion, Spirituality and Ageing*, 2020, Vol 32, No 2, pp 155–156.

⁵⁵⁰ Exhibit 6-4, Darwin Hearing, Statement of Kim McRae, WIT.0264.0001.0001 at 0003 [7]; Transcript, Mildura Hearing, Lynette Bishop, 29 July 2019 at T3937.17–22.

⁵⁵¹ Transcript, Darwin Hearing, Sarah Giles, 8 July 2019 at T2889.42–45; T2890.19–29.

⁵⁵² Transcript, Darwin Hearing, Kim McRae, 8 July 2019 at T2863.5–22; Transcript, Broome Hearing, Leon Flicker, 17 June 2019 at T2037.21–32.

⁵⁵³ Transcript, Broome Hearing, Belinda Robinson, 18 June 2019 at T2125.30–35.

⁵⁵⁴ Healing Foundation and Australian Association of Gerontology Aboriginal and Torres Strait Islander Ageing Advisory Group, Public submission, AWF.001.04106.00 at 0001.

Community Controlled Organisations and existing Aboriginal and Torres Strait Islander providers.

35.2. In fostering additional providers, the Australian Government and the Commission should provide a degree of flexibility in the approval and regulation of Aboriginal and Torres Strait Islander aged care providers to ensure:

- a. existing Aboriginal and Torres Strait providers are not disadvantaged and should continue to provide high quality and safe aged care while being assisted to meet the new provider requirements
- b. other organisations that wish to move into aged care to enhance services to Aboriginal and Torres Strait Islander people across Australia are given special consideration.

35.3. Flexible mechanisms should include additional time to meet new requirements, alternative means of demonstrating the necessary capability or requirement, and, in some very limited cases, exemptions. Assistance should include financial assistance for capacity building.

586. Aboriginal and Torres Strait Islander people seek to be involved in the planning, running and delivery of aged care services that meet the aged care needs of their people.

587. There is a capacity to build on the successes achieved in the health space where there are approximately 144 Aboriginal Community Controlled Health Organisations and around 85 Aboriginal Medical Services across the country.⁵⁵⁵ Similarly, organisations that already deliver services in complementary or interrelated areas, such as wellbeing and mental health services, could expand into aged care service delivery.

588. The importance of developing links between primary health and aged care is evident in the Australian Government's *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (the Health Plan), a central framework for Aboriginal and Torres Strait Islander health services.⁵⁵⁶

⁵⁵⁵ National Aboriginal Community Controlled Health Organisation, *2018-19 Annual Report*, 2019, <https://www.naccho.org.au/wp-content/uploads/NACHHO0043-Annual-Report-18-19-web-version.pdf>, viewed 3 June 2020; National Aboriginal Community Controlled Health Organisation, Public submission, AWF.660.00185.0001 at 0008.

⁵⁵⁶ Department of Health, *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, A2013, [https://www1.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/\\$File/health-plan.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf), viewed 10 June 2020.

589. Aboriginal and Torres Strait Islander community controlled health organisations are recognised for their holistic approach to service delivery with aged care a core component of primary health care functions.⁵⁵⁷ These organisations are well positioned to lead the expansion of culturally safe, integrated aged care services for Aboriginal and Torres Strait Islander people across Australia.⁵⁵⁸ A small number of these services already provide aged care services.⁵⁵⁹ Services, particularly where they are community-controlled, that have the trust of the Aboriginal and Torres Strait Islander people they serve should be prioritised when consideration is being given to assisting expansion into aged care services. The same priority should extend to services that are delivered to Aboriginal and Torres Strait Islander people by staff members ‘who speak their language and understand their culture and their circumstances’.⁵⁶⁰
590. In fostering additional providers, the Australian Government should provide a degree of flexibility in the approval and regulation of Aboriginal and Torres Strait Islander approved providers to ensure existing Aboriginal and Torres Strait providers are not disadvantaged and should continue to provide high quality and safe aged care while being assisted to meet the new provider requirements.
591. Other Aboriginal and Torres Strait Islander organisations that wish to move into aged care to enhance services to Aboriginal and Torres Strait Islander people across Australia should be given special consideration, including additional time to meet new requirements, alternative means of demonstrating the necessary capability or requirement, and, in limited cases, exemptions.

Recommendation 36: Employment and training for Aboriginal and Torres Strait Islander aged care

36.1. By 1 December 2022, the Australian Government should:

- a. develop a comprehensive national Aboriginal and Torres Strait Islander Aged Care Workforce Plan in consultation with the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care, including:

⁵⁵⁷ N Sivertsen, A Harrington and M Hamiduzzaman, ‘Two-eyed seeing: the integration of spiritual care in Aboriginal residential aged care in South Australia’, *Journal of Religion, Spirituality and Ageing*, 2020, Vol 32, No 2, pp 150; National Aboriginal Community Controlled Health Organisation, Public submission, AWF.001.04347.01_0001 at 0015.

⁵⁵⁸ National Ageing Research Institute, *Research Paper 7: Models of Integrated Care, Health and Housing*, a report for the Royal Commission into Aged Care Quality and Safety, 2020, p 22.

⁵⁵⁹ National Aboriginal Community Controlled Health Organisation, Public submission, AWF.001.04347.01_0001 at 0013.

⁵⁶⁰ Darwin Community Legal Service, Public submission, AWF.001.02120.02 at 0013.

- i. the refinement of existing Aboriginal and Torres Strait Islander training and employment programs
 - ii. targets for the training and employment of Aboriginal and Torres Strait Islander people across the full range of aged care roles
 - b. provide the funds necessary to implement the Plan and meet the training and employment targets
 - c. work with the State and Territory Governments to implement the Plan, including making vocational educational training facilities, teachers and courses available in urban, rural, regional and remote Australia.
- 36.2. In the interim, the Australian Government should ensure, in consultation with the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care, that the existing employment programs and initiatives for Aboriginal and Torres Strait Islanders are aligned to the needs of the aged care sector.

592. In the same way that Aboriginal and Torres Strait Islander people prefer to receive care from organisations that have ties to their own local communities, they often have a strong preference for face to face care being provided by other Aboriginal and Torres Strait Islander people.⁵⁶¹

593. Local Aboriginal and Torres Strait Islander staff are also better placed to meet the language needs of the people they provide aged care services to. This is particularly apposite in the case of people living with dementia where knowledge of the local language is likely to facilitate communication with previously withdrawn residents.⁵⁶²

594. Cultural safety is most readily provided and trust established, when Aboriginal and Torres Strait Islander people deliver aged care services.⁵⁶³

595. Uncle Brian Campbell put it this way in Melbourne Hearing 2:

I find them friendly and culturally safe and they understand our needs...they're young and they're still learning but they still respect us as elders and as Aboriginal people. They don't stop learning from us and we don't stop teaching them. So...they actually ask you questions, "Is this going to be all right for you?" and you go yes or no. That's how it is with them.⁵⁶⁴

⁵⁶¹ Exhibit 5-28, Perth Hearing, Statement of Matthew Moore, WIT.0162.0001.0001 at 0013–0014 [52]–[53]; Transcript, Melbourne Hearing 2, Maureen Lyons, 11 October 2019 at T5690. 20–30; Exhibit 4-5, Broome Hearing, Statement of Tamra Bridges, WIT.0166.0001.0001 at 0011–0012 [75]; 0012 [76].

⁵⁶² B Hocking, M Lowe, T Nagel, C Phillips, M Lindeman, A Farthing, H Jensen, A Cass and K Dingwall, 'Dementia in Aboriginal people in Residential Aged Care Facilities in Alice Springs: A Descriptive Study', *Brain Impairment*, 2019, Vol 20, p 178.

⁵⁶³ Transcript, Broome Hearing, Roslyn Malay, 19 June 2019 at T2176.30–35.

⁵⁶⁴ Transcript, Melbourne Hearing 2, Brian Campbell, 11 October 2019 at T5707.17–22.

596. The Royal Commission has seen evidence of best practice in this area:
- a. Almost 80% of the staff at Star of the Sea on Thursday Island are recruited locally, including the service manager.⁵⁶⁵
 - b. Ninety-five percent of the staff who deliver centre-based care in the Anangu Pitjantjatjara Yankunytjatjara lands for Aboriginal Community Care in South Australia are local to the area.⁵⁶⁶
 - c. In the Kimberley region, 90% of the aged care workers and coordinators in remote locations are Aboriginal people from the communities where they work.⁵⁶⁷
 - d. Eighty percent of Purple House's aged care staff in the Northern Territory are Aboriginal and Torres Strait Islander people.⁵⁶⁸
597. That being said, there are significant barriers that work against greater Aboriginal and Torres Strait Islander employment in this sector, including:
- a. limited access to suitable pre-employment and employment training opportunities⁵⁶⁹
 - b. employers lacking flexibility or cultural awareness to accommodate cultural requirements⁵⁷⁰
 - c. a lack of wraparound support services to help people get and retain a job⁵⁷¹
 - d. negative perceptions of the aged care sector⁵⁷²
 - e. less favourable pay and conditions in comparison with health sector opportunities.
598. Given the likely demand for culturally appropriate aged care services for Aboriginal and Torres Strait Islander people over the next 10 to 20 years there is a real need to increase the number of Aboriginal and Torres Strait Islander people who fulfill the full range of aged care roles, within providers and also in the broader aged care system.
599. Against this background, the 2008 report, *A Matter of Care* by the Aged Care Workforce Strategy Taskforce reported that 'a program to expand the recruitment of Aboriginal and

⁵⁶⁵ Transcript, Broome Hearing, Tamra Bridges, 17 July 2019 at T2010.8–12; Exhibit 4-5, Broome Hearing, Statement of Tamra Bridges, WIT.0166.0001.0001 at 0006 [43]–[45].

⁵⁶⁶ Exhibit 4-8, Broome Hearing, Statement of Graham Aitken, WIT.1134.0001.0001 at 0005 [41].

⁵⁶⁷ Exhibit 4-9, Broome Hearing, Statement of Ruth Crawford, WIT.0185.0001.0001 at 0015 [84].

⁵⁶⁸ Exhibit 6-3, Darwin Hearing, Statement of Sarah Brown, WIT.0254.0001.0001 at 00010 [57].

⁵⁶⁹ Aboriginal Medical Services Alliance Northern Territory, Public submission, AWF.600.01078.0001 at 0006.

⁵⁷⁰ Transcript, Broome Hearing, Roslyn Malay, 19 June 2019 at T2174.20–30;

⁵⁷¹ Exhibit 6-4, Darwin Hearing, Statement of Kim McRae, WIT.0264.0001.0001 at 0006 [13]; Exhibit 10-26, Melbourne Hearing 2, Statement of Moreen Lyons, WIT.0424.0001.0001 at 0013 [37]–[39].

⁵⁷² Exhibit 6-34, Darwin Hearing, Statement of Anna Morgan, WIT.0255.0001.0001 at 0009 [47]–[49].

Torres Strait Islander staff into the My Aged Care workforce is vital to support Indigenous consumers who are seeking information to meet cultural safety'.⁵⁷³

600. *A Matter of Care* did not address how to ensure more Aboriginal and Torres Strait Islander people enter the aged care workforce, but it did recommend the establishment of an Aged Care Workforce Remote Accord.
601. In its submissions, the Aged Care Workforce Remote Accord identified a number of particular challenges in delivering aged care in remote and very remote settings, including: worker safety due to the distances that often have to be travelled, isolation and difficulties attracting staff to remote locations. It submitted that remote Aboriginal and Torres Strait Islander communities need a 'workforce that understands the need for cultural sensitivity and respect of traditional law and customs' and highlighted the opportunities for local Aboriginal and Torres Strait Islander people to work in aged care and provide advice on services delivery and design.⁵⁷⁴ It also said that more needed to be done to recruit local Aboriginal and Torres Strait Islander people. It explained that: 'levels of education and community engagement may not be high, and roles in aged care may be seen as inaccessible'.⁵⁷⁵
602. Gaps in data presents a problem in tracking the number of Aboriginal and Torres Strait Islander people working in aged care. The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives points out, there is 'no data on the number of Aboriginal and Torres Strait Islander nurses who work in aged care'.⁵⁷⁶ We see a role for the Aboriginal and Torres Strait Islander Aged Care Commissioner in collating data and feeding this into broader initiatives about training and employment gaps.
603. Existing Aboriginal employment programs such as the Indigenous Advancement Strategy and the Tailored Assistance Employment Grants program, both administered by the National Indigenous Australians Agency, are not targeted at aged care. For example, the Health Plan includes measures that concern aged care, but the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016–2023)*, which looks to provide a workforce for the Health Plan does not.
604. Plans for the Aboriginal and Torres Strait Islander health workforce must support integration and engagement with aged care services. The Australian Association of Gerontology's Aboriginal and Torres Strait Islander Ageing Advisory Group has called for 'an Aboriginal and Torres Strait Islander aged care workforce training and

⁵⁷³ J Pollaers, *A Matter of Care: Australia's Aged Care Workforce Strategy*, June 2018, p 79.

⁵⁷⁴ Accord on the Remote Aged Care Workforce, Public submission, AWF.600.01338.0002_0001 at 0005.

⁵⁷⁵ Aged Care Workforce Remote Accord, Public submission, AWF.650.00082.0001_0001 at 0001.

⁵⁷⁶ Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Public submission, AWF.600.01046.0001 at 0002.

employment strategy, and for measures to promote recruitment and retention of Aboriginal and Torres Strait Islander aged care employees'.⁵⁷⁷

Recommendation 37: Funding cycle

37.1. The Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should block fund providers under the Aboriginal and Torres Strait Islander Aged Care Service Arrangements (see Recommendation 32) on a three to seven year rolling assessment basis.

37.2. The Australian Aged Care Pricing Authority should:

- a. set the funding of the Aboriginal and Torres Strait Islander aged care service arrangements following advice from the Aged Care Custodian
- b. annually assess and adjust the block funding on the basis of the actual costs incurred while providing culturally safe and high quality aged care services to Aboriginal and Torres Strait Islander people in the preceding year.

605. The level of commitment required on the part of approved providers to establish infrastructure and operate in more remote locations should not be understated.

606. Ruth Crawford, manager at Kimberly Aged and Community Services, told the Royal Commission in Broome about how block funding allows for her organisation to provide remote communities with aged care services which covers the costs of running the facilities and providing aged care services. Ms Crawford also said that individualised funding results in some high need clients not having enough individual funds, whereas the service can have \$300,000 accumulated in unspent funds because of the low care needs of others.⁵⁷⁸

607. One of the ways in which the issues outlined by Ms Crawford can be tackled is to fund operations on an extended 3 to 7 year rolling basis.

608. A more direct way to do so is through block funding that covers the actual costs to provide culturally safe and high quality aged care services to Aboriginal and Torres Strait Islander people. Such an approach will account for the costs burden involved in providing care to

⁵⁷⁷ Exhibit 5-7, Perth Hearing, General tender bundle, tab 39, MAM.0001.0001.0132 at 0151; Australian Association of Gerontology's Aboriginal and Torres Strait Islander Ageing Advisory Group, Public submission, AWF.001.04106.01 at 0005; Healing Foundation, Australian Association of Gerontology Aboriginal and Torres Strait Islander Ageing Advisory Group, Public submission, AWF.800.00491.0001 at 0007.

⁵⁷⁸ Exhibit 4-09, Broome Hearing, Statement of Ruth Crawford, WIT.0185.0001.0001 at 0007–0008 [35]–[37]; [40.1]; 0013 [62].

Aboriginal and Torres Strait Islander people wherever they live, whether that means meeting the actual costs of culturally safe processes in urban locations or bringing suitably qualified nurses to very remote locations. In this respect there was evidence at the Broome Hearing about what is required to bring nursing staff to a remote location like Docker River or Halls Creek.⁵⁷⁹

609. For smaller providers who have trouble in attracting staff and rely upon local community medical services for clinical care, the provision of funding by reference to the actual cost of delivering care in that location is likely to remove significant financial pressure. This is essential if we are to ensure that Aboriginal and Torres Strait Islander people receive the high quality care that should be the hallmark of the new aged care system.
610. The Aboriginal and Torres Strait Islander Aged Care Commissioner will play an essential role in the process whereby the Aged Care Pricing Authority determines the particular levels of funding that should be available in a given location.

Recommendation 38: Program streams

- 38.1. Under the Aboriginal and Torres Strait Islander Aged Care Service Arrangements, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should:
- a. provide flexible grant funding streams that are able to be pooled for:
 - i. home and community care
 - ii. residential and respite care (including transition)
 - b. establish funding streams under the Aboriginal and Torres Strait Islander aged care service arrangements that allow Aboriginal and Torres Strait Islander aged care service arrangement providers to apply for funding for:
 - i. capital development and expenditure
 - ii. provider development
 - c. make funds available, on application, for any residential aged care provider that has Aboriginal and Torres Strait Islander residents who require assistance to retain connection to their Country, including meeting the costs of:

⁵⁷⁹ Transcript, Broome Hearing, Craig Barke, 17 June 2019 at T2019.29–34; Exhibit 4-10, Broome Hearing, Statement of Belinda Robinson, WIT.0211.0001.0001 at 0007 [27]–[30]; 0009 [43]–[44]; Exhibit 4-11, Broome Hearing, Statement of Rejane Le Grange, WIT.0212.0001.0001 at 0017 [27.2a].

- i. travel to and from Country, as well as the costs of any people needed to provide clinical or other assistance to the resident to make the trip
- ii. a family member travelling to and from the older person at a distant residential facility
- iii. establishing, maintaining and using infrastructure that facilitates connection between the residential facility and communities on Country, such as videoconferencing technology.

611. We propose five funding streams for approved providers that operate:

- a. home and community care
- b. residential and respite care
- c. capital development and expenditure
- d. provider development
- e. retaining connection to country (return to Country).

612. Funding for the first two streams should be able to be pooled, recognising the flexibility that is needed by approved providers to deliver care in this space.

613. Funding for capital would enable the development of the infrastructure needed to deliver aged care, particularly residential aged care, and to establish respite facilities. It may also be necessary to pay for accommodation for staff who have to travel to remote locations. We anticipate that this stream will require the Australian Government to fund or establish physical infrastructure for providers where there is currently unmet need.

614. The provider development stream (an enhancement to the current Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel program) would provide funding to assist in organisational development as opposed to bricks and mortar. This would establish small regional cooperatives that work through, and in conjunction with, a number of service providers in that region to provide tailored:

- a. workforce training, retention and career development solutions
- b. integrated service delivery across program types such as health, disability, aged care and social services
- c. solutions to address resource restrictions, administrative challenges, program reporting obligations and the need for improved data collection.

615. The retaining connection to country (return to Country) stream is intended to provide funding to assist Aboriginal and Torres Strait Islander people who have left Country or community in order to receive aged care services to return to their home or community or to return for visits in circumstances where they are unable to return to Country or community on an ongoing basis. This stream should also assist the older person to maintain connection to Country and community through the use of technology for communication and by assisting a family member to travel to the older person when they are too unwell to travel themselves.

Part 3.6 The aged care workforce

616. Paragraph (j) of the Terms of Reference require regard to be had to ‘the critical role of the aged care workforce in delivering high quality, person-centred care’.⁵⁸⁰

617. We made detailed submissions on the subject of the aged care workforce earlier this year.⁵⁸¹ Those submissions included 11 proposed recommendations aimed at improving the size and quality of that workforce.

618. The written submissions were published on the Royal Commission’s website and an invitation was issued for submissions in reply.⁵⁸² Twenty-two submissions in reply were received from bodies as varied as the Aged Care Workforce Industry Council, the Australian Physiotherapy Association and South West TAFE. They raised a number of very good points and we have modified our thinking on some of the recommendations as a result. For example, we have modified our proposed recommendation on staffing ratios in residential aged care.

619. In the submissions we delivered in February, at Adelaide Hearing 3, we identified areas, such as the home care workforce and the challenge of increasing remuneration levels that required more work before we would be in a position to make concrete suggestions about the recommendations the Commissioners should make. Staff of the Royal Commission have completed a great deal of work on the subject of the aged care workforce. This has included:

- a. a roundtable with a group of industrial relations experts in February
- b. consultations with independent experts such as Professor Andrew Stewart, John Bray Professor of Law, the University of Adelaide and Professor Kathy Eagar and her team at the University of Wollongong

⁵⁸⁰ Letters Patent, 6 December 2018, as amended on 13 September 2019 and 25 June 2020, paragraph (j).

⁵⁸¹ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001.

⁵⁸² Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at .0160 [683].

c. a public hearing on home care in September.

620. The hearing that examined the impact of the COVID-19 pandemic on aged care in August, Sydney Hearing 2, also raised a number of issues about the aged care workforce and we have drawn on that evidence in preparing these submissions as appropriate.⁵⁸³
621. While the COVID-19 outbreak has revealed the structural weaknesses in the aged care workforce, it has also thrown up a number of inspirational examples of the dedication of aged care workers. We will briefly mention two.
622. During Sydney Hearing 2, Dr Stephen Judd, the former Chief Executive Officer of the HammondCare, described a home care staff worker whose car broke down in suburban Sydney. She was attending to a palliative client and knew the roster was very tight, so she walked the seven or eight kilometres to care for that client.⁵⁸⁴
623. The second story involved a Perth-based nurse who volunteered to come to Melbourne at the height of the crisis in aged care homes in this city in early September of this year. She contracted the virus working in an aged care home and had to be repatriated back to Perth.⁵⁸⁵
624. There are of course many other such stories some of which have been the subject of evidence in this inquiry.
625. It is high time that this dedication and commitment by aged care workers to those for whom they provide care is properly recognised and rewarded. The vast majority are women and the low pay they receive is nothing less than the aged care system exploiting the goodness of their hearts. As we said in February, aged care workers do not need to be told they are heroes. They need better wages and conditions and enough colleagues to be able to complete their work safely and to the standard that they consider is appropriate. That is how their work can be properly respected and acknowledged.
626. Unless we indicate today that we want to modify the submissions we made in February in some way, we rely on them and will not be repeating what we said at that time. For completeness and convenience, we have included all of the recommendations that we propose should be made about the aged care workforce in this document. But we will not be repeating the detailed reasoning or referring to the evidence and other information that we set out in February in support of our proposals.

⁵⁸³ Royal Commission into Aged Care Quality and Safety, *Aged care and COVID-19: a special report*, pp 9-10; 22-25.

⁵⁸⁴ Transcript, Sydney Hearing 2, Stephen Judd, 11 August 2020, T8541.17-23.

⁵⁸⁵ WA nurse Renee Freeman makes full recovery from COVID-19 after working in Melbourne aged care home, *Perth Now*, 22 September 2020 (viewed 9 October 2020).

627. It is difficult to over-state the importance of the aged care workforce. The quality of aged care is in large part determined by the people who deliver it on a day-to-day basis. During a recent webinar on 28 August 2020 about the impact of COVID-19 on aged care around the world, Professor Kathy Eagar of the University of Wollongong said that international research identifies four drivers of aged care quality:
- a. the number of staff
 - b. the mix of staff – including the number of nurses and allied health workers
 - c. staff continuity
 - d. clinical governance.⁵⁸⁶
628. We submit, as we did in February, that the Australian Government must exercise a leadership role in planning for the future needs of the aged care workforce. The sector has not done this and cannot be relied upon to do it in the future. Despite its best efforts and intentions, the existing industry-led Aged Care Workforce Industry Council has not implemented the ambitious recommendations of the Aged Care Workforce Strategy Taskforce within the timeframe of one to three years that was proposed in the Taskforce's June 2018 report, *A Matter of Care - Australia's Aged Care Workforce Strategy* (the Taskforce report).⁵⁸⁷ We consider that a re-named, re-constituted and properly resourced Aged Care Workforce Council can make a positive contribution to the implementation of the recommendations we propose. It is heartening that the Council has recognised in its submissions to this Royal Commission that there is a pressing need for it to play a leadership role along with government.⁵⁸⁸ The injection of funds for the work of the Council in the recent Federal Budget is welcome.
629. Representatives of the Council gave evidence at Melbourne Hearing 3. The Council has 10 members of whom only one (the Strategic Stakeholder Management Coordinator of the United Workers' Union) represents aged care workers. There is no representation of the thousands of nurses who work in aged care. Nor are the allied health professions represented on the Council.
630. The Taskforce itself had 13 members, none of whom represented aged care workers. This lack of representation of aged care workers on bodies designed to make fundamental changes to their working lives is as self-defeating as it is perplexing. The evidence in the COVID-19 hearing in August 2020 about the lack of consultation with

⁵⁸⁶ Australasian College for Infection Prevention and Control, Hong Kong's COVID-19 preparation for aged care, webinar, www.acipc.org.au (viewed 14 October 2020).

⁵⁸⁷ Aged Care Workforce Strategy Taskforce, *A Matter of Care - Australia's Aged Care Workforce Strategy*, 2018, p vi (Exhibit 1-4, Adelaide Hearing 1, Report of the Aged Care Workforce Strategy Taskforce, UVH.0001.0007.0000 at 0008).

⁵⁸⁸ Aged Care Workforce Industry Council, Public submission, AWF.650.00100.0001 at 0008.

aged care workers' representatives in April and May 2020 during the development of the visitors' code suggests that the sector continues to undervalue the contribution that those representatives can make. This sector and government blind spot stands in stark contrast with the experience of this Royal Commission which has benefitted greatly from a number of comprehensive submissions from unions with members working in aged care. A number of union officials have given evidence that has helped inform Commissioners of the day-to-day challenges faced by their members who work in aged care. This blind spot must be addressed as a matter of urgency and we suggest how in the submission we make about a recommendation re-constituting the Aged Care Workforce Council.

631. Workforce development and planning will be a key function of the Australian Aged Care Commission we are proposing. It is an important enough function to be part of the primary responsibilities of one of the Assistant Commissioners. However, this planning cannot await the formal establishment of the proposed Australian Aged Care Commission in 2023.
632. We therefore propose the establishment of an aged care workforce planning Agency within the Australian Department of Health on an interim basis. The Agency should be independent of Ministerial control. When the Australian Aged Care Commission is established, the Agency should become a Division of the Commission answering to an Assistant Commissioner.

Recommendation 39: Aged care workforce planning

39.1. The Australian Government should establish an Aged Care Workforce Planning Division within the Australian Department of Health by 1 January 2022. When the Australian Aged Care Commission is established, the Division should be transferred to the Commission, answering to an Assistant Commissioner. It should be responsible for developing workforce strategies for the aged care sector through:

- a. long-term workforce modelling on the supply and demand of health professionals, including allied health professionals, and care workers
- b. consultation with the providers of education and training for health professionals and personal care workers, in partnership with the State and Territory Governments, Universities, Registered Training Organisations, National Boards, professional associations, and specialist colleges

- c. ensuring an appropriate distribution of health professionals (including allied health professionals) and care workers to meet the needs of population across the aged care sector, particularly in regional, rural and remote Australia
 - d. aged care workforce planning, including through modelling, and shaping the role of immigration and changes to visa arrangements as a workforce strategy to address aged care workforce needs.
- 39.2. By 1 July 2022, the Aged Care Workforce Planning Division should prepare an interim workforce strategy and planning framework for the next 3 years (2022–25).
- 39.3. By 1 July 2025, the Aged Care Workforce Planning Division within the Australian Aged Care Commission should prepare a 10 year workforce strategy and plan, following the interim 3 year Workforce Strategy (2025–35).
- 39.4. The Aged Care Workforce Planning Division should be supported by an Aged Care Workforce Fund that can be used to support training, clinical placements, scholarships and other initiatives to respond in a targeted manner to the workforce challenges that the Division identifies.

Recommendation 40: Aged Care Workforce Council

- 40.1. By 1 July 2021, the Australian Government should strengthen the capacity of the Aged Care Workforce Council by:
- a. having an Australian Government representative become a member and assume the role of chair
 - b. reviewing membership of the Council to ensure it is comprised of individuals, including worker representatives who represent the diversity of the aged care workforce with an appropriate mix of skills and experience to lead and drive change across the sector
 - c. providing the necessary funding and resources to enable the Council to implement workforce recommendations of this Royal Commission and to build on its work implementing the Aged Care Workforce Strategy Taskforce’s strategic actions.
- 40.2. By 30 June 2022, the Aged Care Workforce Council should:

- a. re-profile all aged care occupational groups, jobs and job grades to ensure they reflect the skills, capabilities, knowledge and competencies as well as the structure required in the new aged care system
 - b. revise the competency and accreditation requirements for all job grades in the aged care sector to ensure education and training builds the required skills and knowledge
 - c. standardise job titles, job designs, job grades and job definitions for the aged care sector, and
 - d. lead the Australian Government and the aged care sector to a consensus to support applications to the Fair Work Commission to improve wages based on work value and or equal remuneration. This may include re-defining job classifications and job grades in relevant awards.
- 40.3. The Aged Care Workforce Council should work collaboratively with the proposed Aged Care Workforce Planning Division so that its work complements aged care workforce design and planning.
- 40.4. From 1 July 2022, the Aged Care Workforce Council, in conjunction with the National Careers Institute, peak industrial partners, Universities Australia and VET providers, and informed by its work on redefining the Aged Care Workforce structure, should develop and document a clear set of career pathways for the aged care sector. These career pathways should:
- a. highlight opportunities for nurses to advance in clinical and managerial roles in the aged care sector
 - b. facilitate personal care workers having opportunities to move laterally across aged care, disability care, community care and primary health care and vertically in aged care by advancing into nursing, specialist care roles and supervisory or managerial roles
 - c. develop and document career opportunities in the aged care sector for non-direct care workers, including kitchen hands, cooks, cleaners, gardeners, drivers, security and people performing administrative roles.
- 40.5. By 1 July 2022, the Human Services Skills Organisation should develop detailed multimedia careers information for prospective aged care workers including information about work experience opportunities and pre-employment programs with approved aged care providers and nominated Registered Training Organisations.

How can wages for aged care workers be increased and working conditions improved?

633. In our February submissions, we noted the wages gap that exists between aged care workers and workers performing equivalent functions in the acute health sector.⁵⁸⁹ We also noted that there have been several failed attempts to address that gap by governments providing additional funds to providers in the hope that they would be passed on to aged care workers by way of increased wages.⁵⁹⁰ We concluded that merely increasing subsidies without more is unlikely to translate into higher wages.⁵⁹¹ We remain of that view. Unless aged care workers have a legal right to be paid more, they won't be.
634. In the Taskforce report, after acknowledging the significant wages gap that exists between aged care workers and the workers performing equivalent functions in the acute health sector, the Taskforce recommended that the 'industry develop a strategy to support the transition of personal care workers and nurses to pay rates that better reflect their value and contribution to delivering care outcomes'.⁵⁹² The Taskforce considered that this, and its other 'strategic actions,' could be 'executed in one to three years'.⁵⁹³
635. Apart from the wage increases that have flowed as a result of the annual award reviews by the Fair Work Commission, and some minor improvements to penalty rates as a result of the four yearly review of the *Aged Care Award 2010* by the Fair Work Commission in 2019, there has been no discernible increase in aged care wage rates in the two and a half years since the Taskforce report was published.⁵⁹⁴ We have therefore concluded that the Taskforce's proposal of an industry-led process leading to substantial increases in aged care wages rates has failed. Further, it is unlikely to succeed in the foreseeable future.
636. A new approach is needed. It will only succeed if all parties—providers, unions and government—work together. There are three parts to our proposed recommendations on this topic.

⁵⁸⁹ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at 0131 [564].

⁵⁹⁰ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at 0126–0127 [545]–[549].

⁵⁹¹ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at 0127 [550].

⁵⁹² Aged Care Workforce Strategy Taskforce, *A Matter of Care - Australia's Aged Care Workforce Strategy*, 2018, p 95 (Exhibit 1-4, Adelaide Hearing 1, Report of the Aged Care Workforce Strategy Taskforce, UVH.0001.0007.0000 at 0103).

⁵⁹³ Aged Care Workforce Strategy Taskforce, *A Matter of Care - Australia's Aged Care Workforce Strategy*, 2018, p vi (Exhibit 1-4, Adelaide Hearing 1, Report of the Aged Care Workforce Strategy Taskforce, UVH.0001.0007.0000 at 0008).

⁵⁹⁴ *4 yearly review of modern awards – Award stage – Group 4 – Aged Care Award 2010 – Substantive claims* [2019] FWCFB 5078 at [159] and [195].

- a. The first is a work value case by the Fair Work Commission which examines the terms and conditions in the relevant awards. If successful, this will increase the wages of personal care workers and nurses in both residential and home care.
- b. The second is to make wage increases an explicit policy objective of the aged care funding system that we recommend elsewhere in these submissions. This will primarily impact on enrolled and registered nurses working in home and residential care.
- c. The third aspect of our prescription for increasing aged care wages is concerned with the immediate future. Because each of our first two proposals will take some time to bear fruit, the Australian Government and provider representative bodies should support a significant increase to the relevant award rates in the 2020–21 Annual Wage Review and each subsequent Review until such time as the Work Value Review has concluded.

637. We start with the work value case.

Recommendation 41: Increases in award wages

41.1. Employee organisations entitled to represent the industrial interests of aged care employees covered by the *Aged Care Award 2010*, the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2010* should collaborate with the Australian Government and employers and apply to vary wage rates in those awards to:

- a. reflect the work value of aged care employees in accordance with section 158 of the *Fair Work Act 2009* (Cth), and/or
- b. seek to ensure equal remuneration for men and women workers for work of equal or comparable value in accordance with section 302 of the *Fair Work Act 2009* (Cth).

638. The Fair Work Commission is empowered to make a determination varying modern award minimum wages if it is satisfied that the variation is ‘justified by work value reasons’ and such a determination outside of the system of annual wage reviews is necessary to ‘achieve the modern awards objective’.⁵⁹⁵

639. Section 157(2A) of the *Fair Work Act 2009* (Cth) states:

work value reasons are reasons justifying the amount that employees should be paid for doing a particular kind or work, being reasons related to any of the following:

⁵⁹⁵ *Fair Work Act 2009* (Cth), s 157(2)(a).

- (a) the nature of the work;
- (b) the level of skill or responsibility involved in doing the work;
- (c) the conditions under which work is done.

640. The ‘modern awards objective’ requires the Fair Work Commission to ensure that modern awards ‘provide a fair and relevant minimum safety net of terms and conditions’ taking into account a number of factors including ‘the principle of equal remuneration for work of equal or comparable value’.⁵⁹⁶
641. In an important part of its 2015 *Equal Remuneration Decision*, the Fair Work Commission indicated that any claim to increase modern award minimum wages based on the proposition that the existing wage rates are the product of a gendered undervaluation of the relevant work can be the subject of an application under sections 156(3) or 157(2) of the *Fair Work Act 2009*.⁵⁹⁷ It may even be possible to pursue parallel claims for an equal remuneration order and work value adjustments in the same proceeding.⁵⁹⁸
642. More recently, in its four yearly review of the *Aged Care Award 2010*, the Fair Work Commission stated that if United Voice, which represents many aged care personal care workers, was contending that ‘the minimum wages rates in the [Aged Care Award] undervalue the work to which they apply for gender-related reasons then it should make such an application’.⁵⁹⁹ This has not occurred. There is an urgent need for the review that the Fair Work Commission identified in 2019.
643. The evidence of Professor Andrew Stewart is that ‘work value’ assessments by industrial tribunals have a long history. He points out that historically, for such an assessment to lead to an increase in wages, the tribunal needs to have been satisfied that there has been a change in the nature of the work, the skill and responsibility required or the conditions of the work’.⁶⁰⁰ However, he notes that there is no such requirement in the current legislation and that establishing undervaluation of itself may suffice.⁶⁰¹ This should be tested.

⁵⁹⁶ *Fair Work Act 2009* (Cth), s 134(1)(e); *Application by the Australian Industry Group* [2020] FWCFB 2316 at [166]–[168]; Exhibit 20-1, Sydney Hearing 4, Statement of Andrew Stewart, General Tender Bundle, tab 36, RCD.9999.0350.0001 at .0007 [31]–[33].

⁵⁹⁷ *Equal Remuneration Decision* [2015] FWCFB 8200 at [292].

⁵⁹⁸ See Layton et al, *Equal Remuneration under the Fair Work Act 2009* (Fair Work Commission, Melbourne).

⁵⁹⁹ *4 yearly review of modern awards – Award stage – Group 4 – Aged Care Award 2010 – Substantive claims* [2019] FWCFB 5078 at [60].

⁶⁰⁰ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 36, RCD.9999.0350.0001 at 0008 [37], citing *National Wage Case March 2007* (1987) 17 IR 65 at 100.

⁶⁰¹ Exhibit 20-1, Sydney Hearing 4, Statement of Andrew Stewart, General Tender Bundle, tab 36, RCD.9999.0350.0001 at.0009 [37] citing *4 Yearly review of modern awards – Pharmacy Industry Award 2010* (2018) 284 IR 121 at [166]; *4 Yearly review of modern awards – Education Group* [2019] FWCFB 488 at [53].

644. Variations to awards for work value reasons may be made on the Fair Work Commission's own initiative or on the application of an employee or an employer covered by the relevant award or a relevant trade union or employer association.⁶⁰² The Fair Work Commission must be convinced, on the evidence before it, that such a variation is *necessary* and not merely *desirable* 'to achieve the modern awards objective' as set out in section 134 of the *Fair Work Act 2009*.⁶⁰³

645. While the Fair Work Commission would of course exercise an independent discretion if any such application was made, on the extensive evidence before this inquiry about the work performed by personal care workers and nurses in both home care and residential care, we submit that all three of the section 157(2A) reasons may well justify an across the board increase in the minimum pay rates under the applicable awards. We submit that it would be appropriate to so conclude in the Final Report.

646. We are under no illusions that this process will be simple; success is not assured. Ms Carolyn Smith, Secretary of United Voice (WA), explained that:

In our experience it is extremely difficult to make substantial changes to an Award. Awards operate as a safety net and are a low base. The Fair Work Commission in our view is reluctant to make radical changes which are what would be required for substantial movement to these Award.⁶⁰⁴

647. However, part of this reluctance may be due to the way cases have been advanced by unions. For example, in its 2019 review of the *Aged Care Award 2010*, the Fair Work Commission rejected one union claim for improved employment conditions due to the absence of evidence to substantiate those claims.⁶⁰⁵ The case we have in mind will need to be well argued and based on cogent evidence and argument.

648. Further, the Equal Remuneration Case for social and community services (SACS) workers suggests that the chances of success in such a case are significantly increased if the Fair Work Commission is presented with a consent position involving the unions, the employers and the principal funder, the Australian Government.⁶⁰⁶ As Professor Stewart puts it:

If the Commonwealth were willing to fund any increases in labour costs, that would not just improve the chances of turning a contested application into one by consent. It would remove an obvious reason for the FWC to be concerned about agreeing to an improvement in pay or other entitlements.⁶⁰⁷

⁶⁰² *Fair Work Act 2009* (Cth), section 157(3) and section 158(1).

⁶⁰³ *Fair Work Act 2009* (Cth), section 157(2)(b); see also *Application by Australian Industry Group* [2020] FWCFB 2316 at [169]-[170].

⁶⁰⁴ Exhibit 11-24, Melbourne Hearing 3, Statement of Carolyn Smith, WIT.0487.0001.0001 at 0008 [59].

⁶⁰⁵ *4 yearly review of modern awards – Award stage – Group 4 – Aged Care Award 2010 – Substantive claims* [2019] FWCFB 5078 at [68].

⁶⁰⁶ *Equal Remuneration Case* [2012] FWA FB 1000.

⁶⁰⁷ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 36, RCD.9999.0350.0001 at 0020 [95].

649. The reconstituted tripartite Aged Care Workforce Council will be well placed to encourage this co-operative approach.⁶⁰⁸ It will play a crucial role.
650. The application we are proposing should not be confined to the *Aged Care Award 2010* because that award only applies to the residential aged care sector. The evidence is that home care workers are perhaps in greater need of improved terms and conditions of employment than their counterparts working in the residential sector.⁶⁰⁹ Aged care workers who are employees are entitled to the minimum wages prescribed by the *Social, Community, Home Care and Disability Services Industry Award 2010*. The classifications set out in Schedule E of that Award should be the subject of the proposed work value case. An additional argument will be available to them for substantial wage increases because such increases have already been awarded to employees performing similar work covered by the classifications in Schedules B and C of the same Award.⁶¹⁰
651. Nor should nurses working in aged care be excluded from the scope of any such review. However, we note that the impact of a successful case would be less for nurses because there are far fewer award-reliant nurses compared to personal care workers.
652. What would be the effect of an increase in the award rates on the many aged care workers covered by enterprise agreements? Mr Paul Gilbert of the Australian Nursing and Midwifery Federation was concerned that even if award minima were increased, legislative change would still be needed for award rates to flow through to those on current enterprise agreements because the *Fair Work Act 2009* does not impose what he described as ‘an arbitrated outcome’ on people who are already covered by agreements.⁶¹¹ However, this view may not give sufficient weight to section 206(2) of the *Fair Work Act 2009* (which has the effect of incorporating into an agreement an award rate that exceeds the agreement rate.⁶¹² Section 306 of the *Fair Work Act 2009* has a similar effect where there is a conflict between an equal remuneration order and an Award term.
653. Further, while other new award conditions would not automatically flow through to workers covered by agreements, once those agreements expire, it will be open to parties to them to apply to the Fair Work Commission under section 225 of the *Fair Work Act*

⁶⁰⁸ See the discussion of the previous Aged Care Workforce Committee in S Kaine, ‘Collective Regulation of Wages and Conditions in Aged Care: Beyond Labour Law’, *Journal of Industrial Relations*, 2012, Vol 54, 2, p 216.

⁶⁰⁹ Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6156.17-19; Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5999.40-6000.4 and T6005.28-36; Melbourne Hearing 3, Statement of Carolyn Ann Smith, WIT.0487.0001.0001 at 0004 [29]-[30].

⁶¹⁰ See the discussion of the SACS *Equal Remuneration Case* Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at .0132-.0134 [568]-[579].

⁶¹¹ Transcript, Melbourne Hearing 3, Paul Gilbert, 16 October 2019 at T6003.40–T6004.25.

⁶¹² Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 36, RCD.9999.0350.0001 at 0020 [92].

2009 for termination of what would have become a 'sub-standard agreement'. As Professor Stewart points out, 'it is common for the FWC to be satisfied that it is in the public interest to terminate old agreements that now offer sub-award entitlements'.⁶¹³

Recommendation 42: Improved remuneration for aged care workers

42.1. In setting prices for aged care, the Aged Care Pricing Authority should take into account the need to attract sufficient staff with the appropriate skills to the sector, noting that relative remuneration levels are an important driver of employment choice.

654. This proposed recommendation is aimed at tying the process by which government aged care subsidies are set to an explicit policy of increasing wages and improving working conditions for aged care workers. We will make submissions about our proposed funding recommendations later in these submissions.
655. The starting point on the link between aged care funding and wages is the Productivity Commission's 2011 proposal that the process by which scheduled aged care prices are assessed and recommended should take account of 'the need to pay fair and competitive wages to nursing and other care staff delivering aged care services'.⁶¹⁴ The Productivity Commission considered that the applicable awards may be an 'important mechanism by which fair and competitive wages are determined'.⁶¹⁵ We agree with this observation and we would see the outcome of the review we propose above as informing the work of the proposed Australian Aged Care Pricing Authority.
656. The reconstituted Aged Care Workforce Council that we propose will be an important source of advice to the Australian Aged Care Pricing Authority in carrying out this task. The evidence of James Downie, the Chief Executive Officer of the Independent Hospital Pricing Authority, was that 'if there was a clear policy initiative to increase [aged care] wages by a defined quantum, then a casemix funding model could be [adjusted] prospectively to ensure that wage increases are accounted for in the price' paid by the government for aged care services.⁶¹⁶ Professor Eagar said 'whatever recommendations

⁶¹³ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 36, RCD.9999.0350.0001 at 0020 [92] and note 43 referring to *Re Merivale Employee Collective Agreement 2007* [2019] FWCA 293.

⁶¹⁴ Productivity Commission, *Caring for Older Australians*, 2011, recommendation 14.1, p 363–365.

⁶¹⁵ Productivity Commission, *Caring for Older Australians*, 2011, p 363.

⁶¹⁶ Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, 18 August 2020, RCD.9999.0463.0001 at .0012 [77].

are adopted in relation to staffing need to feed into the costing process. The costing process then determines the price in the following year.⁶¹⁷

657. These considerations are particularly important for the home care workforce. The evidence in this Royal Commission has been that many home care workers are not adequately compensated for their travel time.⁶¹⁸ Further, there are low minimum engagement requirements in the *Social, Community, Home Care and Disability Services Industry Award 2010*. Such working conditions are not conducive to workers having the time to deliver high quality relationship-based care.⁶¹⁹ They will not attract the workers to the sector that will be needed.
658. The review of the awards and our proposal about determining the level of aged care subsidies will both take some time to produce wage increases for aged care workers. However, the need for such increases is urgent. The third limb of our proposal for increasing wages in the sector seeks to address this immediate need. The Australian Government and provider representative bodies should support a significant increase to the relevant award rates in the 2020-21 Annual Wage Review and each subsequent Review until such time as the Work Value Review has concluded. Once again, the reconstituted Aged Care Workforce Council should play a role in garnering support for such a joint position to the Fair Work Commission's Expert Panel for Annual Wages Reviews. The Expert Panel for Annual Wages Reviews must report by 30 June 2021 and then by 30 June 2022.⁶²⁰

Skills Gaps

659. In February 2020, we made submissions about the future challenge of attracting people to work in aged care, given future demographic predictions. We submitted that 'the Royal Commissioners have the opportunity to set the policy parameters to provide aged care workers...with the training and support that they need to have a fulfilling career, with opportunities for professional development and an attractive career trajectory'.⁶²¹

⁶¹⁷ Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, 1 July 2020, RCD.9999.0351.0001 at .0016 [95].

⁶¹⁸ Transcript, Melbourne Hearing 3, Lisa Alcock, 16 October 2019 at T5999.47–6000.4; Transcript, Melbourne Hearing 3, Janice Hilton, 17 October 2019 at T6156.17–19; Exhibit 11-52, Melbourne Hearing 3, Statement of Sara Charlesworth, WIT.0381.0001.0001 at 0009 [31]; Exhibit 1-23, Adelaide Hearing 1, - 2016 National Aged Care Workforce Census and Survey-The Aged Care Workforce, CTH.1000.1038.0872 at 1016: Of the home care and support outlets, 70% provided paid time for travel between care appointments and 48% provided a petrol/vehicle depreciation allowance for work-related transport costs.

⁶¹⁹ See generally, G Meagher et al, *Meeting the Social and emotional support needs of older people using aged care service*, 2019, p 68.

⁶²⁰ *Fair Work Act 2009* (Cth), s 285(1); *Annual Wage Review 2019-20 (Summary)* [2020] FWCFB 3501 at [8].

⁶²¹ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at .0063 [273].

660. The Taskforce report of 2018 concluded that aged care ‘workforce competencies need to be boosted, particularly for personal care workers...in areas including:
- basic care skills, such as hydration and nutrition
 - specialist knowledge in areas like oral health, diversity, mental health, medication management, dementia and end-of-life care’.⁶²²
661. Those observations are consistent with the evidence in this Royal Commission. However, there is a limit to the improvements in aged care quality that can be achieved by increasing the skills of personal care workers. It is just as important to ensure that work that requires the skills of a nurse is performed by a nurse. In the case studies, there has been evidence of personal care workers dressing wounds—work that should clearly be performed by a nurse.⁶²³ The answer to this is not to train personal care workers to be better at wound dressing; the answer is to ensure there are more nurses working in aged care.
662. Our proposed recommendation about staffing levels and mix which will require the presence of at least one registered nurse at each facility will help to ensure that nurses’ work is performed by nurses.
663. At the urging of the Taskforce, an Aged Services Industry Reference Committee was established in March 2018 to ‘revisit national competency standards’ and ensure ‘that the national training system and higher education can address the current and future competencies and skill requirements of both new people entering the industry and existing employees needing to upskill’.⁶²⁴ In our February submissions we said that the staff of the Royal Commission would monitor the Committee’s work enabling us to make further submissions later in the year.⁶²⁵
664. The Industry Reference Committee has developed a case for endorsement of a single qualification for personal care workers in the aged care and disability sectors. It has made minor changes to the elective requirements for a Certificate III in Individual Support (Ageing), and an amendment to the elective groups by way inclusion of a module on infection prevention and control. Skills IQ, an independent Skills Service Organisation, reports that that the Aged Services Industry Reference Committee is working with the

⁶²² Aged Care Workforce Strategy Taskforce, *A Matter of Care - Australia’s Aged Care Workforce Strategy*, 2018, p 47 (Exhibit 1-4, Adelaide Hearing 1, Report of the Aged Care Workforce Strategy Taskforce, UVH.0001.0007.0000 at 0055).

⁶²³ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 320-322.

⁶²⁴ Aged Care Workforce Strategy Taskforce, *A Matter of Care - Australia’s Aged Care Workforce Strategy*, 2018, p 29 (Exhibit 1-4, Adelaide Hearing 1, Report of the Aged Care Workforce Strategy Taskforce, UVH.0001.0007.0000 at 0037).

⁶²⁵ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at .0076 [337].

Disability Support Industry Reference Committee and SkillsIQ to update the existing Certificate III in Individual Support, Certificate IV in Ageing Support and Certificate IV in Disability qualifications and units of competency.⁶²⁶ These are positive steps but progress has been slow and the need is great.

665. We submit that there is a pressing need to ensure that all aged care workers receive training in dementia care and palliative care. Recommendation 44 proposes that this become part of the core requirements for approval as a subsidised aged care provider.
666. Our proposed recommendation about the mandatory registration of personal care workers under the Australian Health Practitioners Regulation Agency system will result in the professionalisation of the personal care workforce over time. The National Personal Care Workers Board will be responsible for setting continuing professional education requirements for personal care workers.
667. In addition, we propose a recommendation that the Human Services Skills Organisation, which was established as a pilot program in August 2020 and has on its Board a number of members with experience of the aged and disability care sectors, should review the need for specialist aged care Certificate III and IV courses.
668. In conducting that review, the Organisation should consider expanding the existing Certificate course content to include additional competencies relating to: trauma informed care, mental health, wound care, oral health, physical health status, palliative care, falls prevention, first aid, monitoring medication, use of technology, dysphagia management, community participation and social inclusion, interventions with older people at risk and recognising and responding to crisis situations.
669. Further, as we noted in our submissions in February, there is a need to review the course content of courses for a range of health professionals to ensure that they are equipped when they graduate to attend to understand and meet the care needs of older people. Recommendation 45 is aimed at addressing this need.
670. These recommendations will necessarily take some time to be implemented. However, there is an urgent need for skills acquisition among aged care workers. To achieve improvements in the short term, we are proposing an immediate injection of funds into the sector for education and training. This is detailed in the aged care funding arrangements part of our submissions below. Under the proposed scheme, approved providers will be reimbursed for the cost of education and training of their direct care employed workforce for a two year period.⁶²⁷

⁶²⁶ Skills IQ, *Aged Care Training Package Product Development*, www.skillsiq.com.au/CurrentProjectsandCaseStudies/AgedCareTPD, viewed 14 October 2020.

⁶²⁷ See recommendation 84: Immediate funding for education and training to improve the quality of care.

Recommendation 43: Review of certificate-based courses for aged care

- 43.1. By 1 January 2022, the Human Services Skills Organisation should
- a. review the need for specialist aged care Certificate III and IV courses, and
 - b. commence an annual cycle of review of the content of the Certificate III and IV courses and consider if any additional units of competency should be included.

Recommendation 44: Dementia and palliative care training for workers

- 44.1. The Australian Government should implement, by 1 July 2022, as a condition of approval or continued approval of aged care providers that all staff engaged by providers who are involved in direct contact with people seeking or receiving services in the aged care system undertake regular approved training about dementia care and palliative care.

Recommendation 45: Review of health professions' undergraduate curricula

- 45.1. By 1 January 2023, the relevant national boards, professional associations, and accreditation bodies for nursing, medicine, audiology, optometry, dietetics, dental practice, psychology, social work, occupational therapy, osteopathy, podiatry, physiotherapy and speech therapy should review existing course accreditation standards to ensure professional entry qualifications for these professions are appropriately addressing age-related conditions and illnesses, including dementia, to ensure that graduates have the education and knowledge to meet the care needs of older people.

Teaching Residential Aged Care Services

671. Paragraph (f) of the Terms of Reference requires and authorises the Royal Commissioners to inquire into 'how best to deliver aged care services in a sustainable way, including through...investment in the aged care workforce'.⁶²⁸
672. In this part, we make submissions about a specific model of training and education for care workers, clinicians and allied health professionals to 'engender success across the reforms that will be required of the sector following the Royal Commission'.⁶²⁹
673. At the first Sydney hearing, Associate Professor Stephen Macfarlane, Head of Clinical Services, Dementia Centre at HammondCare described how he came to be working in aged care. He said that he didn't enter medical school with a burning ambition to become a geriatric psychiatrist. He had no idea what the speciality involved and no interest in it until he did a rotation in aged psychiatry during his training as a psychiatrist. At that point he said that he 'fell in love with it'. Associate Professor McFarlane said that if there are more opportunities for exposure to aged care for trainee nurses, 'that will have flow-on effects for recruiting passionate, qualified nurses into the sector'.⁶³⁰ This evidence was inspiring and shows how important quality placements are to encourage passion and interest about aged care on the part of students.
674. The Teaching and Research Aged Care Services (**TRACS**) program ran in Australia from 2012 to 2015. TRACS was based on the 'teaching nursing home' model operating in Scandinavian countries, the United States and Canada.⁶³¹ The teaching nursing home model involves strategic partnerships between aged care providers, educators and researchers, providing 'an opportunity for the aged care workforce to be trained in a setting designed to meet the needs of older people'.⁶³²
675. The TRACS program had the overarching goals of:
- a. increased involvement for education and training providers in ageing and aged care research that is based on clinical experience
 - b. increased involvement for aged care providers in research and clinical practices that enhance quality of care

⁶²⁸ Letters Patent, 6 December 2019, as amended on 13 September 2019 and 25 June 2020, paragraph (f).

⁶²⁹ The Wicking Dementia Research and Education Centre, University of Tasmania, Public submission, AWF.650.00098.0001 at 0003.

⁶³⁰ Transcript, Sydney Hearing 1, Stephen Macfarlane, 15 May 2019 at T1771.36–46.

⁶³¹ Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0034.

⁶³² Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0034.

- c. enhanced learning opportunities for students based on clinical experience with a Teaching Research and Aged Care Services affiliation, and
 - d. improved quality of care for aged care consumers and their families.⁶³³
676. Echoing the words of Associate Professor Macfarlane, at Adelaide Workshop 2, Dr Kate Barnett, who has played a significant role in the TRACS program, told the Royal Commissioners that students who participated in the TRACS program experienced a change in attitude towards working in the aged care sector on ‘statistically significant levels’.⁶³⁴ The involvement of residents in teaching aged care programs can also have significant benefits for resident wellbeing, providing purpose and increasing social interactions for residents.⁶³⁵
677. When appropriately funded and resourced, programs involving teaching aged care services can assist in improving the standards within the workforce, as well as addressing issues regarding recruitment and retention of workers.⁶³⁶ The environment enables interdisciplinary teaching experiences,⁶³⁷ improves student knowledge and attitudes towards aged care and allows for professional development of staff members by providing roles as student mentors.⁶³⁸
678. We submit that embedding teaching programs within aged care services will promote a ‘virtuous cycle’ between students on placement and the quality of care provided by the workforce. At Adelaide Workshop 2, Professor James Vickers, Director of the Wicking Dementia Research and Education Centre, explained that one of the reasons that teaching hospitals are really great places is because ‘they do have medical students, and medical students have this way of keeping the health professionals and the other doctors on their toes, because they don’t necessarily want to be caught out on a particular clinical scenario by the medical student’.⁶³⁹ We see this same approach applying in the future aged care system. It will be good for both the students and the workers.

⁶³³ Exhibit 16-1, Adelaide Workshop 2, general tender bundle, tab 2, RCD.9999.0296.0001 at 0036.

⁶³⁴ Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8030.19–26.

⁶³⁵ Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8032.19–39; K Elliot et al ‘Residents with mild cognitive decline and family members report health student’s “enhance capacity of care” and bring “a new breath of life” in two aged care facilities in Tasmania’, *Health Expect*, 2014, pp 1927–1940.

⁶³⁶ M Annear et al “Bringing the outside world in”: Enriching social connection through health student placements in a teaching aged care facility’, *Health Expect*, 2017 pp 1–9; E Lea et al, ‘Aspects of nursing student placements associated with perceived likelihood of working in residential aged care’ *Journal of Clinical Nursing*, 2015, Vol 25, pp 715–724.

⁶³⁷ Transcript, Melbourne Hearing 3, James Vickers, 17 October 2019 at T6191.14–21; Transcript, Adelaide Workshop 2, Megan Corlis, 17 March 2020 at T8031.19–24.

⁶³⁸ Exhibit 11-63, Melbourne Hearing 3, Statement of James Vickers, WIT.0462.0001.0001 at 0007 [36].

⁶³⁹ Transcript, Adelaide Workshop 2, Professor Vickers, 17 March 2020 at T8051.37–44.

679. The Australian Government should commit to recurring funding of such a program to ensure that it is sufficiently supported. Professor Vickers cautioned that the ‘the real danger in this is if we set up lots of these things across the country, but they still provide those students on placement a not very good placement experience, then you can have more health professionals ... with a very negative view about aged care and [who] run a mile once they graduate to work in that sector’.⁶⁴⁰
680. Funding teaching aged care services should be viewed as an investment, rather than a cost due to the clear evidence of its potential positive impact on the aged care workforce.⁶⁴¹

Hub and Spokes Model

681. To ensure that students, people receiving aged care services, aged care workers and approved providers in all parts of Australia access the benefits of teaching aged care services, we recommend that a ‘hub-and-spokes’ model be implemented. This model funds teaching aged care services on a regional basis, with a number of ‘hub’ services. The ‘hubs’ in turn, mentor and support other services within the ‘designated catchment area’ known as the ‘spokes’.
682. ‘Hub’ aged care services should be selected based on their expertise in aged care, education and research. This model will allow for essential information to be shared by approved providers operating as ‘hub’ teaching aged care services, development of workforce learning programs to support enhanced quality of care and practice which can then be initiated with other services, providing particular benefit to approved providers in rural and remote areas.⁶⁴²
683. Engagement with universities at a senior management level is required as ‘universities by and large are relatively unfamiliar with aged care’.⁶⁴³ Professor Robinson, Professor Emeritus at the Wicking Dementia Research and Education Centre, stated that similar a successful program requires a massive change for universities as well as approved providers, along with a ‘massive reallocation of resources and...interest’.⁶⁴⁴
684. For those approved providers funded to be ‘hub’ services, the commitment to being a learning organisation must be paramount, with the same involvement in lifelong learning

⁶⁴⁰ Transcript, Adelaide Workshop 2, Professor Vickers, 17 March 2020 at T8059.31–36.

⁶⁴¹ Exhibit 16-1, general tender bundle, tab 2, RCD.9999.0296.0001 at 0012; Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8040.44-8041.5.

⁶⁴² Exhibit 16-1, general tender bundle, tab 2, RCD.9999.0296.0001 at 0011; M Kirkevold, ‘Teaching nursing homes: the Norwegian experience 20 years on’, *Journal of Research in Nursing*, 2018, Vol 23, p 256; Transcript, Adelaide Workshop 2, Kate Barnett, 17 March 2020 at T8040.11-17.

⁶⁴³ Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8054.11-28.

⁶⁴⁴ Transcript, Adelaide Workshop 2, Andrew Robinson, 17 March 2020 at T8057.42-8058.4.

and promotion of professional development seen in teaching hospitals, including postgraduate degrees, continuing professional development and involvement in research.⁶⁴⁵

685. Ms Helen Loffler, Manager of Student Participation, at approved provider Helping Hand, gave evidence that Helping Hand has had some ‘small pilots of students going into home care situations’. However, she explained that there are further difficulties with the logistics of such programs.⁶⁴⁶
686. Ms Megan Corlis, Director of Research and Development at Helping Hand, explained that home care is a ‘much less controlled environment’ for students on placements and difficulties arise in ensuring adequate supervision is provided. Ms Corlis stated that such placements would be ‘doable’ however to date there have not been adequate resources and funding for this available.⁶⁴⁷ There should be in future.
687. We submit there should funding for teaching aged care programs in home care, as well as residential aged care. This is a matter that the Assistant Commissioner for workforce and training at the Australian Aged Care Commission should have on her or his agenda. It is a matter that the revamped Aged Care Workforce Council should examine in conjunction with providers like Helping Hand. Finally, these are matters that the Aged Care Research Council we are proposing should be encouraging in its allocation of funding research.

Recommendation 46: Funding for teaching aged care programs

- 46.1. By 1 July 2023, the Australian Government should fund teaching aged care programs for delivery to students in both residential aged care and home care settings. The teaching aged care programs should have designated catchment areas and should:
- a. operate on a ‘hub and spokes’ model
 - b. collaborate with educational institutions and research entities
 - c. facilitate clinical placements for university and vocational education and training sector students
 - d. train future aged care workers in local aged care services.

⁶⁴⁵ Transcript, Adelaide Workshop 2, James Vickers, 17 March 2020 at T8052.15–36.

⁶⁴⁶ Transcript, Adelaide Workshop 2, Helen Loffler, 17 March 2020 at T8043.4–14.

⁶⁴⁷ Transcript, Adelaide Workshop 2, Megan Corlis, 17 March 2020 at T8042.42–8043.2.

Mandated staffing ratios

688. In our February submissions we outlined the evidence linking low staffing levels with poor quality aged care.⁶⁴⁸ That evidence consists of both published studies and the evidence of witnesses from a wide range of disciplines in this Royal Commission.
689. Professor Charlene Harrington, of the University of California, San Francisco, who has been researching long term care around the world for over 40 years, summarised her research in the following terms:
- Nurse staffing levels are the most important factor that determines the quality of care provided by nursing homes. Insufficient staffing levels negatively impacts all residents in a nursing home on a systemic basis. Numerous studies of nursing home operations reveal an indisputable relationship between the number of nursing home staff who provide direct care to residents on a daily basis and the quality of care and the quality of life of residents. The dangers of understaffing have been common knowledge in the US nursing home industry since the 1980s and culminated with the findings from the study of Appropriateness of Minimum Staffing Ratios published by the Centers for Medicare & Medicare Services. There have been many research papers showing the link between staffing levels and quality of care.⁶⁴⁹
690. Professor Harrington stated that ‘the most important policy measure for ensuring appropriate staffing levels is to adopt a regulatory requirement that establishes a minimum staffing level’.⁶⁵⁰
691. This is consistent with a great deal of the evidence to this Royal Commission. The time for real action to improve staffing levels in residential aged care is now. We submit that a recommendation should be made that the Australian Government implement a minimum staff time quality and safety standard for residential aged care.
692. We accept that increasing staffing levels on its own is not a guarantee of high quality care. But it is an important piece of the puzzle—a necessary but not sufficient reform. The other pieces include the staffing mix (especially ensuring nurses and allied health professionals are present in greater numbers), the skills of the workers, how well they are supervised and managed and how well the organisations they work for are governed. We make submissions about all of those matters. If implemented as a comprehensive package of reforms with funding to match, real improvements in aged care quality and safety should follow.
693. Our proposed staffing recommendation is in two parts—a first step on 1 July 2022 and a second step on 1 July 2024. While the need for more aged care workers is pressing, it

⁶⁴⁸ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at 0020–0027 [80]–[107].

⁶⁴⁹ Exhibit 15-1, Adelaide Hearing 3, Statement and annexure of Charlene Harrington, RCD.0011.0042.0001 at 0003–0004.

⁶⁵⁰ Exhibit 15-1, Adelaide Hearing 3, Statement and annexure of Charlene Harrington, RCD.0011.0042.0001 at 0004.

is important that the new requirements are phased in across a reasonable time frame so that they align with the training reforms we are proposing and to give providers and government adequate time to prepare. In proposing 2022 for the first part of the reform, we are mindful that the mandatory staffing standard was flagged in our February 2020 submissions. An exemption mechanism has been built in to meet concerns that the new staffing standard may stifle innovation or may be impractical to comply with in some parts of the country. The proposed recommendation is as follows.

Recommendation 47: Minimum staff time standard for residential care

- 47.1. The Australian Government should require approved providers of residential aged care facilities to meet a minimum staff time quality and safety standard. This requirement should take the form of a quality and safety standard for residential aged care. The minimum staff time standard should allow approved providers to select the appropriate skills mix for delivering high quality care in accordance with their model of care.
- 47.2. From 1 July 2022, the minimum staff time standard should require approved providers to engage registered nurses, enrolled nurses, and personal care workers for at least 215 minutes per resident per day for the average resident, with at least 36 minutes of that staff time provided by a registered nurse.
- 47.3. In addition, from 1 July 2022, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility for the morning and afternoon shifts (16 hours per day).
- 47.4. From 1 July 2024, the minimum staff time standard should increase to require approved providers to engage registered nurses, enrolled nurses, and personal care workers for the average resident for at least:
 - a. 215 minutes per resident per day for the average resident, with at least 44 minutes of that staff time provided by a registered nurse, or
 - b. 264 minutes per resident per day for the average resident, with at least 36 minutes of that staff time provided by a registered nurse.
- 47.5. In addition, from 1 July 2024, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility at all times.
- 47.6. The minimum staff time standard should be linked to the casemix adjusted activity based funding model for residential aged care facilities. This means

that approved providers with a higher than average proportion of high needs residents would be required to engage additional staff, and vice versa.

47.7. Approved providers should be able to apply to the Australian Aged Care Commission for an exemption from the quality and safety standard relating to staff skills mix, but not the standard relating to numbers of staff. Any exemption should be granted for a limited time, and details of the exemption should be published on My Aged Care. The grounds for granting an exemption should include:

- a. specific purpose residential aged care facilities, such as specialist homeless facilities, where the profile of the residents is such that it may be appropriate to substitute a registered nurse with another qualified health professional
- b. residential aged care facilities that are co-located with a health service, such as Multi-Purpose Services, where registered and enrolled nurses are present at the co-located health service
- c. regional, rural and remote residential aged care facilities, where the approved provider can demonstrate it has been unable to recruit sufficient numbers of staff with the requisite skills, and
- d. innovative residential aged care facilities where an alternative skills mix is being trialled and it would be appropriate to substitute a registered nurse with another qualified health professional. There should be a requirement for any such trial to be comprehensively evaluated and publicly reported.

47.8. The Australian Commission on Safety and Quality in Health and Aged Care should review and update this standard as appropriate. At a minimum, this should occur in line with significant revisions of the casemix classification for residential aged care facilities, or at least every five years.

694. We mentioned that our thinking on this topic had evolved since February. We should explain how and why.

695. In our February submissions, we submitted that Commissioners should recommend mandated staffing ratios in residential aged care.⁶⁵¹ Specifically, we submitted that residential aged care facilities should be required to be staffed at a level that would attain a four star rating under the Centre for Medicare and Medicaid Services (CMS) star rating

⁶⁵¹ Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at 0034–0047 [134]–[189].

system in the USA. This submission drew heavily on the work of the University of Wollongong's Centre for Health Service Development, headed by Professor Kathy Eagar. The Centre reported in September 2019 on a research study commissioned by the Royal Commission.⁶⁵² The study examined how Australian residential aged care staffing compared with international and national benchmarks.

696. The University of Wollongong report concluded that on average, 'each Australian resident receives 180 minutes of care per day, of which 36 minutes are provided by RNs'.⁶⁵³ The evidence before this Royal Commission is that in some Australian homes, the residents receive far less care time than this, particularly from registered nurses. For example, in the MiCare case study that was examined in the Cairns Hearing last year, the evidence was that residents in a home on the Mornington Peninsula in Victoria were receiving an average of only seven minutes of care from registered nurses per day under a roster that had been passed as compliant by the then quality regulator.⁶⁵⁴ The approved provider's General Manager of Residential Services did not know if staffing levels at the facility had been discussed at board level.⁶⁵⁵
697. The recommendation we propose takes the CMS Nursing Home Compare rating system, which is designed as a transparency mechanism, and reframes it as a regulatory standard. The standard is based on the needs of the average resident in residential aged care in Australia. In applying the standard at a particular residential aged care facility, the actual level of staffing required needs to be adjusted to reflect the mix of cases in that facility. This means that a residential aged care facility with an above average proportion of high needs residents would be required to have additional registered nurses, enrolled nurses and personal care workers, and vice versa. The Australian National Aged Care Classification can be used to casemix adjust the staffing standard based on each particular facility's resident cohort.
698. The University of Wollongong report concluded that, based on international research, 'the minimum amount of staff time per resident per day for acceptable care is ... 30 minutes of [registered nurse] time and 215 minutes of total care time (RNs and other

⁶⁵² Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001. The work of the Australian Health Services Research Institute is summarised in Exhibit 11-2, Melbourne Hearing 3, Statement of Kathleen Eagar, 4 October 2019, WIT.0459.0001.0001 at 0002 [8]–[11].

⁶⁵³ Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0026.

⁶⁵⁴ Exhibit 6-35, Darwin and Cairns Hearing, general tender bundle, tab 211, MIC.5000.0001.0752 at 0002; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, p 328.

⁶⁵⁵ Transcript, Darwin and Cairns Hearing, Robert van Duuren, 15 July 2019, T3558.1–2.

care workers)'. The authors explained that these minimums apply across the sector as a whole and 'require casemix adjustment to make them suitable at the facility level'.⁶⁵⁶

699. A large number of submissions in response broadly supported, in full or in part, our proposed recommendation about minimum staffing requirements.⁶⁵⁷ The Australian Government opposed the proposal on the grounds that it 'could stifle innovation and create rigidity in individual provider approaches to workforce staffing which would not necessarily lead to more positive outcomes for care recipients'.⁶⁵⁸
700. However, the Australian Government 'supported the general principle that an aged care provider should have at least one registered nurse on-site at all times to provide clinical care'.⁶⁵⁹
701. We have modified the earlier version of this recommendation because its implementation would have enabled a provider to comply with the standard even though they were providing fewer minutes of registered nurse care per resident per day than the current sector average of 36 minutes per resident per day.
702. The intent of the proposed recommendation is to bring the entire sector up to a minimum level of staffing that equates to three star staffing under the CMS system by 1 July 2022. The principal beneficiaries of this will be the residents in the 57.6% of facilities that currently staff at levels the University of Wollongong study characterised as 'unacceptable'.⁶⁶⁰ These residents will experience an increase in staffing of 37.3%.⁶⁶¹ The sector as a whole will see a staffing increase of 20% as those currently staffing to 4 and 5 stars would be expected to continue to do so.

⁶⁵⁶ Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0038.

⁶⁵⁷ Johnson Village Services Pty Ltd, Public submission, AWF.650.00097.0001; Anglicare Australia, Public submission, AWF.650.00099.0001 at 0001–0002; Carers NSW, Public submission, AWF.650.00101.0001 at 0004; Joint submission of aged care providers and provider peak bodies, Public submission, AWF.650.00107.0001 at 0002; Australian Nursing and Midwifery Federation, Public submission, ANM.0018.0001.0001 at 0002 [9]; Allied Health Professionals Australia, Public submission, AWF.650.00103.0001 at 0003; Australian Physiotherapy Association, Public submission, AWF.650.00102.0001 at 0008; Dementia Australia, Public submission, AWF.600.01628.0001 at 0003; Pharmaceutical Society of Australia, Public submission, AWF.650.00111.0001 at 0002.

⁶⁵⁸ The Commonwealth of Australia (Department of Health, Department of Education, Skills and Employment and the Aged Care Quality and Safety Commission), Public submission, AWF.650.00110.0001 at 0004 [6].

⁶⁵⁹ The Commonwealth of Australia (Department of Health, Department of Education, Skills and Employment and the Aged Care Quality and Safety Commission), Public submission, AWF.650.00110.0001 at 0005 [11].

⁶⁶⁰ Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001 at 0038; see also Transcript, Kathleen Eagar, 14 October 2019 at T5792.17–25.

⁶⁶¹ Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0038.

703. The implementation in mid-2024 of the next part of the proposed increase will see all facilities staffed to a minimum that equates to four stars in the CMS system. Only 15.5% of homes are currently staffed to this level. This is fewer than one in five. The University of Wollongong report estimates that 'the additional staffing time required for all facilities with 3 stars or lower to achieve 4 stars is 78 minutes (47.0%) in total including 14 minutes (43.8%) of Registered Nurse time'.⁶⁶² This translates to an across the board increase in staffing of 37.2% in total care staffing.⁶⁶³ We accept that the sector needs some time to prepare for these significant increases and therefore propose that four star staffing be achieved in two steps. This is a significant change from what we proposed in February in response to the concerns raised in a number of submissions in reply.
704. Finally, in response to concerns about possible inflexibility, we have included an exemption mechanism that will apply in circumstances where providers can demonstrate a genuine case of need to the satisfaction of the Australian Aged Care Commission. There are four categories of exemption to cover cases of genuine difficulty meeting the requirements because of staff shortages and cases where the mix of residents may not necessitate the full time presence of a registered nurse. Any exemption must be time limited and the need for an ongoing exemption should be reviewed by the Australian Aged Care Commission. Where there is a persistent difficulty meeting the standard in a given area, the Australian Aged Care Commission, in its system governor role, should address any underlying structural impediments through the workplace planning agency we propose in recommendation 39.

The home care workforce

705. In an earlier part of these submissions we proposed that the desire of older people to receive aged care services in their own homes should be matched by the aged care system to a far greater extent than is presently the case. We are concerned to ensure that the *quality* of those services is high and that the people receiving services are safe. To achieve this, an adequate number of trained care workers will be needed.
706. Aged care workers providing care to older people in their own homes face challenges that differ from those faced by their counterparts in residential aged care. They work alone, usually without supervision. They work in an environment over which they, and the approved providers who send them to work, have little control. Approved providers, and the regulator, may have limited or no visibility over the services provided.

⁶⁶² Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0026.

⁶⁶³ Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle, tab 148, AHS.0001.0001.0001 at 0039.

Who are the home care workers?

707. According to the 2016 Aged Care Workforce Survey, an estimated 130,263 workers made up the 'home care and home support workforce'.⁶⁶⁴ An estimated 86,463 worked in direct care roles.⁶⁶⁵ Significantly, the total home care workforce *fell* significantly between 2012 and 2016. In 2012, the total workforce consisted of 149,801 and the direct care workforce was 93,359. In percentage terms, there were reductions of 13% and 7% respectively.
708. The reduction in Full Time Employment (FTE) numbers were even more significant than the headcount figures suggest. Between 2012 and 2016, there was a 19% reduction in the FTE home care workforce.⁶⁶⁶ As the Survey concludes, 'the sector is undergoing considerable structural change and this is reflected in the way labour is used both in numbers but also in the differential use of direct and non-direct care employees'.⁶⁶⁷ Further, there has been 'an increase in the proportion of workers employed for fewer hours'.⁶⁶⁸
709. Community care workers made up 84% of the home care workforce, a proportion which had risen slightly since 2012 when it was 81%. The number of FTE home care and home support registered nurses *fell* by 29% between 2012 and 2016. This continued a pattern since 2007 that saw the proportion of the FTE home care workforce who are registered nurses fall from 13.2% to 10.5%, mirroring the trend in residential aged care.⁶⁶⁹
710. As is the case with the residential aged care sector, the home care workforce is predominantly female (89%).⁶⁷⁰

⁶⁶⁴ Australian Department of Health, *The Aged Care Workforce*, 2016, p 69 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2892).

⁶⁶⁵ Australian Department of Health, *The Aged Care Workforce*, 2016, p 70, 72 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2893, 2985); The survey describes the non-direct care workforce as made up of case managers/coordinators, management, administration and others.

⁶⁶⁶ Australian Department of Health, *The Aged Care Workforce*, 2016, p 70 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2893).

⁶⁶⁷ Australian Department of Health, *The Aged Care Workforce*, 2016, p 69 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2892).

⁶⁶⁸ Australian Department of Health, *The Aged Care Workforce*, 2016, p 70 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2893).

⁶⁶⁹ Australian Department of Health, *The Aged Care Workforce*, 2016, p 70 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2893); As to the trend in residential care, see Submissions of Counsel Assisting the Royal Commission, Workforce, 21 February 2020, RCD.0012.0061.0001 at 0009–0012 [42]–[57].

⁶⁷⁰ Australian Department of Health, *The Aged Care Workforce*, 2016, p 74 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2897).

Mode of engagement

Direct employment

711. There is a body of evidence pointing to the need for policies and practices to drive a 'virtuous circle', where good employment, attractive wages and working conditions, supportive management and an empowering work culture, collaborative teams, high quality and relevant education and training, and high job satisfaction among care workers underpin high quality, person-centred care.⁶⁷¹
712. The recently released *Report of the Inquiry into the Victorian On-Demand Workforce* reveals that between 2014 and 2018, the number of 'independent contractors' in health and social care increased by 29%, from 70,700 in 2014 to 91,700 in 2018, compared with a 19% overall increase in that workforce.⁶⁷² Online platforms are playing a role in this trend.
713. The modes of engagement of the home care workforce have changed in recent years. The 2016 Aged Care Workforce Survey reported that the proportion employed under permanent part-time arrangements increased from 62% in 2012 to 75% in 2016. Surprisingly, there was a corresponding decrease in workers on 'casual and contract arrangements' from 27% to 14%.⁶⁷³ A Full Bench of the Fair Work Commission referred to the 2016 Survey in its 2019 review of the *Aged Care Award* and noted that 'as the data relates to both casuals *and* contract workers the proportion of employees who are casuals is likely to be less than 10 per cent'.⁶⁷⁴ This was described by the Fair Work Commission as a 'low utilisation of casual employees'.⁶⁷⁵
714. During Sydney Hearing 4, witnesses were asked whether the mode of engagement of home care workers is relevant to the quality of care they provide.
715. Peter Scutt, Founder and Chief Executive Officer of Mable Technologies Pty Ltd (Mable) explained that Mable is 'a platform that facilitates engagement between care workers who have put a profile on Mable and third parties who want to engage those workers'.⁶⁷⁶ Historically the third parties have been individual recipients of care but more recently, and partly because of the needs of approved providers responding to the COVID-19

⁶⁷¹ See, for example, G Meagher et al, *Meeting the social and economic support needs of older people using aged care services*, 2019.

⁶⁷² Victorian Government, *Report of the Inquiry into the Victorian On-Demand Workforce*, 2020, p 36 (Table 2); Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 23, RCD.9999.0361.0062 at 0107.

⁶⁷³ Australian Department of Health, *The Aged Care Workforce*, 2016, p 74 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2897).

⁶⁷⁴ *4 yearly review of modern awards – Award stage – Group 4 – Aged Care Award 2010 – Substantive claims* [2019] FWCFB 5078 at [151].

⁶⁷⁵ *4 yearly review of modern awards – Award stage – Group 4 – Aged Care Award 2010 – Substantive claims* [2019] FWCFB 5078 at [152].

⁶⁷⁶ Transcript, Sydney Hearing 4, Peter Scutt, 31 August 2020 at T8881.20–23.

pandemic, they have included approved providers.⁶⁷⁷ Mr Scutt explained that Mable is not the employer of the care workers on its platform. He described the care workers as ‘customers of the platform’.⁶⁷⁸ He said that where there is an approved provider involved, the provider is responsible for complying with the aged care quality standards.⁶⁷⁹

716. Mr Scutt was asked how the approved provider in that scenario would be able to ensure that the Quality Standards are met by that worker, given that the worker is under no obligation to comply with a direction given by the provider and may not even be known to the provider. Mr Scutt referred in his reply to the police checks and screening of the users of its platform carried out by Mable and the access that approved providers have to shift notes and incident reporting on the platform.⁶⁸⁰ However, he accepted that ‘the provider doesn’t direct the worker’. Further, Mable does not direct the worker because the ‘workers are independent contractors in most cases providing services directly to their clients’.⁶⁸¹
717. Mable’s website advertises that one of the benefits of its services is lower administrative costs.⁶⁸² Lower administration overheads means that more hours of direct care may be purchased with a given sum of money provided by the Government. While this is superficially attractive, the question we ask is: what is the cost in terms of the quality of that care? If the lower administrative costs mean less training and support for the care worker, this may mean that the quality of care is compromised. We do not ask that such a finding be made in the case of Mable or any other provider because the evidence does not support it. But we do note it as a matter of concern that will need to be monitored carefully by the Australian Aged Care Commission.
718. Ms Jessica Timmins, Head of Service of Hireup Pty Ltd (Hireup), a registered National Disability Insurance Scheme provider, explained that Hireup is also ‘an online platform that connects people with a disability with support workers’.⁶⁸³ It does not provide aged care services.⁶⁸⁴ In contrast to Mable, Hireup employs its support workers as casual employees.⁶⁸⁵ Ms Timmins explained that the decision to adopt this structure was a significant one for the business because the ‘duty of care that’s created when you are an employment model can lead to higher quality support outcomes for people with disability’.

⁶⁷⁷ Transcript, Sydney Hearing 4, Peter Scutt, 31 August 2020 at T8881.31–35.

⁶⁷⁸ Transcript, Sydney Hearing 4, Peter Scutt, 31 August 2020 at T8885.17–21.

⁶⁷⁹ Transcript, Sydney Hearing 4, Peter Scutt, 31 August 2020 at T8885.43–44.

⁶⁸⁰ Transcript, Sydney Hearing 4, Peter Scutt, 31 August 2020 at T8886.21–44

⁶⁸¹ Transcript, Sydney Hearing 4, Peter Scutt, 31 August 2020 at T8887.4–6.

⁶⁸² Mable Technologies Pty Ltd, *Pricing*, <https://mable.com.au/pricing>, viewed 14 October 2020.

⁶⁸³ Transcript, Sydney Hearing 4, Jessica Timmins, 31 August 2020 at T8867.44–47.

⁶⁸⁴ Transcript, Sydney Hearing 4, Jessica Timmins, 31 August 2020 at T8870.35–38.

⁶⁸⁵ Transcript, Sydney Hearing 4, Jessica Timmins, 31 August 2020 at T8868.34

She added that Hireup ‘wanted support workers to feel part of our team and committed to those same quality outcomes’.⁶⁸⁶

719. This evidence was supported by Ms Jaclyn Attridge, Head of Operations of Uniting Care and by Mr Ahilan St George, Director and Co-Founder of Vitality Club, which provide home care services through both the Commonwealth Home Support Program and the Home Care Package program.⁶⁸⁷ Ms Attridge explained that, from UnitingCare Australia’s perspective, ‘in terms of monitoring and checking quality of care, that is far simpler when you’re employing the staff directly’. This is because, as she explained it, the employees ‘are aware of your policies and your training programs’.⁶⁸⁸ Mr St George added that ‘direct employment is significantly easier to control’ because it is ‘easier to train and ensure quality and in terms of incident reporting, complaints management’.⁶⁸⁹ He added that, by contrast, it is very difficult to get subcontractors to ‘deliver a model of care as opposed to just a service’.⁶⁹⁰ We consider that this is important evidence from the ‘coalface’.

720. This evidence was echoed by that of Dr Jim Stanford, an economist and Director of the Centre of Future Work, who has conducted extensive research into the National Disability Insurance Scheme workforce. Dr Stanford was referred to the claims by Ms Timmins and Mr Scutt that their platforms facilitated consumer choice. Dr Stanford referred to research into the National Disability Insurance Scheme workforce which demonstrates that even where there are employment relationships between providers and care workers, there are risks about ‘how we ensure the quality and qualifications of service providers, how the time of workers is organised to ensure they have sufficient time to perform the duties that they’d been contracted to do..’.⁶⁹¹

721. An example of this research is a report which examined the implications of the National Disability Insurance Scheme individualised funding model on the quality of the working lives of disability workers and quality of care they are able to provide.⁶⁹² The report identified ‘job instability, inadequate training, and unfair and often dangerous work arrangements’. It concluded that, in addition to undermining both the quality of work for disability support workers and the quality of support for National Disability Insurance Scheme clients, ‘these problems are also clearly making it even harder, to recruit a

⁶⁸⁶ Transcript, Sydney Hearing 4, Jessica Timmins, 31 August 2020 at T8872.11–16.

⁶⁸⁷ Transcript, Sydney Hearing 4, Jaclyn Attridge and Ahilan St George, 31 August 2020 at T8843.7–14

⁶⁸⁸ Transcript, Sydney Hearing 4, Jaclyn Attridge, 31 August 2020 at T8860.10–14.

⁶⁸⁹ Transcript, Sydney Hearing 4, Ahilan St George, 31 August 2020 at T8861.32–35.

⁶⁹⁰ Transcript, Sydney Hearing 4, Jim Stanford, 1 September 2020 at T8861.37–38.

⁶⁹¹ Transcript, Sydney Hearing 4, Jim Stanford, 1 September 2020 at T8968.5–8.

⁶⁹² D Baines et al, *Prearity and Job Stability on the Frontlines of the NDIS*, 2019 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 38, RCD.9999.0630.0008).

motivated, high quality workforce to this rapidly-growing workforce'.⁶⁹³ There are important lessons in this experience for the aged care system. Aged care needs more workers but not at the expense of quality and skill.

722. During Sydney Hearing 4, we tested with witnesses a proposition that 'Providers should be required to deliver a set percentage of their care hours through the care workers they employ directly'. While there was support for the idea that high quality care was more likely to be delivered by employees rather than by contractors, there was little support for a legal requirement in these terms. For example, Professor Andrew Stewart described it as 'too arbitrary an approach'.⁶⁹⁴
723. Professor Stewart did however support what he described as a 'general rule', subject to exceptions, that 'workers who are performing services on behalf of providers, whether they are engaged directly or not, should be employees...'.⁶⁹⁵ Such an approach could be justified, he considered, because it was 'far more compatible with achievement of objectives relating to achievement of quality standards in relation to care'. The reason for this is that 'an employee is necessarily somebody who can be closely directed in the work they do'.⁶⁹⁶
724. We agree with this but submit that, rather than any such 'general rule' which would be too uncertain and difficult to enforce, the best way to encourage approved providers, and contractors engaged by approved providers, to employ care workers rather than engage them through platforms⁶⁹⁷ or other non-employment modes of engagement, is by means of the statutory general duty which we proposed earlier in these submissions.⁶⁹⁸ Because approved providers will be required to comply with this duty whether they directly employ the care workers or not, it is likely that they will find it easier to comply with their obligations to provide high quality and safe care if they are legally able to direct the way in which the care work is performed. Such a legal capacity to direct is part of the control exercisable in an employment relationship.
725. To adapt the evidence of Mr St George of home care provider Vitality Club, it is easier to deliver a model of care through employed care workers. Employees are required contractually to comply with any lawful and reasonable directions they are given about the performance of their work.⁶⁹⁹ If a provider directs an employed care worker to provide

⁶⁹³ D Baines et al, *Precarity and Job Stability on the Frontlines of the NDIS*, 2019, p 33 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 38, RCD.9999.0630.0008 at 0040).

⁶⁹⁴ Transcript, Sydney Hearing 4, Andrew Stewart, 1 September 2020 at T8975.14–15.

⁶⁹⁵ Transcript, Sydney Hearing 4, Andrew Stewart, 1 September 2020 at T8975.14–21.

⁶⁹⁶ Transcript, Sydney Hearing 4, Andrew Stewart, 1 September 2020 at T8975.31–36.

⁶⁹⁷ We accept that, as discussed above, some such care workers (such as those working for organisations like Hireup Pty Ltd) are also employees.

⁶⁹⁸ See recommendation 22: A general duty to provide high quality and safe care.

⁶⁹⁹ A Stewart, *Stewart's Employment Law*, 2018, pp 281–282.

care through a relationship-based model of care for example, the employee is required to do so. Where the care worker is engaged by an older person directly via a platform, this is necessarily more difficult for the provider if not impossible.

726. In the submissions we make about provider governance below, we propose an obligation on a nominated member of the governing body of each provider to attest annually on behalf of the members of the governing body that they have satisfied themselves that the approved provider has in place the structures, systems and processes to deliver safe and high quality care.⁷⁰⁰ Approved providers may conclude that to meet this requirement, one of the 'structures, systems and processes' that would contribute to the delivery of high quality and safe care would be the direct employment of those who are providing the care.

Administration of a register of personal care workers

727. Our February proposal that personal care workers be registered received widespread support. At that time, we stated that staff of the Royal Commission were examining the preferred mechanism for administering a registration scheme for personal care workers. We have settled upon the Australian Health Practitioner Regulation Agency.
728. The Australian Health Practitioner Regulation Agency was established as a result of an intergovernmental agreement in 2008 and oversees a system to ensure that the members of health professions act in a manner that promotes public safety.⁷⁰¹ The Australian Health Practitioner Regulation Agency is the national organisation responsible for implementing the National Registration and Accreditation Scheme (the National Scheme).⁷⁰²
729. The National Scheme establishes National Boards for each registered health profession which, supported by the Australian Health Practitioner Regulation Agency, regulate each individual registered health profession.⁷⁰³ It is through that regulatory system that we can all have confidence in our health professionals. To protect the recipients of aged care services, we propose that personal care workers be subject to this National Scheme.

⁷⁰⁰ See recommendation 53: New governance standard.

⁷⁰¹ Council of Australian Governments, *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions*, 2008.

⁷⁰² The Australian Health Practitioner Regulation Agency was established by section 23 of the Health Practitioner Regulation National Law as contained in the Schedule to the *Health Practitioner Regulation National Law Act 2009*.

⁷⁰³ The National Law and National Boards are separately enacted in each state and territory: *Health Practitioner Regulation National Law (Queensland)*, *Health Practitioner Regulation National Law (NSW) No 86a (NSW)*, *Health Practitioner Regulation National Law (Victoria) Act 2009 (Vic)*, *Health Practitioner Regulation National Law (ACT) Act 2010 (ACT)*, *Health Practitioner Regulation (National Uniform Legislation) Act 2010 (NT)*, *Health Practitioner Regulation National Law (Tasmania) Act 2010 (Tas)*, *Health Practitioner Regulation National Law (South Australia) Act 2010 (SA)*, *Health Practitioner Regulation National Law (WA) Act 2010 (WA)*.

730. We have considered what is required for a new occupation be introduced to the National Scheme. We have also considered the benefits of the National Scheme for older Australians and for the aged care workforce. On balance, we consider that the occupation of 'aged care personal care worker' is likely to meet the requirements for the National Scheme.

731. Under the intergovernmental agreement, a new occupation may only be introduced where:

- a. an unregulated profession is assessed against six criteria
- b. registration is supported by a majority of jurisdictions, and
- c. it can be demonstrated that the occupation's practice presents a serious risk to public health and safety which could be minimised by regulation.⁷⁰⁴

The six criteria are:

- a. is it appropriate for health ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another ministry?
- b. do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
- c. do the existing regulatory or other mechanisms fail to address health and safety issues?
- d. is regulation possible to implement for the occupation in question?
- e. is regulation practical to implement for the occupation in question?
- f. do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?⁷⁰⁵

732. The Council of Australian Governments' Health Council consults and assesses submissions addressing these criteria. Of particular relevance is that when assessing an occupation against the second criterion (significant risk of harm posed by an occupation), the COAG Health Council refers to 13 risk sub-categories.⁷⁰⁶

733. The evidence in this Royal Commission suggests that the usual daily work of a personal care worker in aged care may entail at least the following four sub-categories of risk:

⁷⁰⁴ Council of Australian Governments, *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions – Attachment B*, 2008, [1.3].

⁷⁰⁵ Council of Australian Governments, *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions – Attachment B*, 2008, pp 23-24; Exhibit 22-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 [27].

⁷⁰⁶ Exhibit 22-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 at 0006-0007 [28]-[29].

treatment commonly occurs without others present; patients commonly required to disrobe; supplying substances for ingestion; and putting an instrument, hand or finger into a body cavity.

734. The Australian Health Practitioner Regulation Agency and the 15 National Boards work together to deliver the National Registration and Accreditation Scheme, which is designed to meet a number of key objectives aimed at protecting the public.
735. Section 38(1) of the National Law requires each National Board to develop registration standards for the profession it regulates. These standards set out what requirements applicants must meet to become registered and remain registered.⁷⁰⁷ After 'wide-ranging consultations' the standards must be approved by the Council of Australian Government Health Council under section 12 and published on the relevant National Board's website in order to take effect.⁷⁰⁸ Registration standards must cover:
- a. professional indemnity insurance requirements for practitioners
 - b. criminal history of registration applicants, practitioners, and students, including the matters to be considered in deciding whether an individual's criminal history is relevant to the practice of the relevant profession
 - c. continuing professional development (CPD) requirements for practitioners
 - d. English-language-skills requirements for registration in the relevant profession (if any)
 - e. requirements for registration applicants about the nature, extent, period and recency of any experience practising in the relevant profession.⁷⁰⁹
736. Each National Board may then also develop codes of conduct and guidelines for professions under section 39 of the National Law. Scope of practice is not directly regulated under the National Scheme but will vary according to:
- a. educational qualifications
 - b. clinical experience
 - c. context of practice, for example, rural clinic or an urban hospital
 - d. relevant legislation

⁷⁰⁷ Exhibit 22-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 at 0009 [41]–[42].

⁷⁰⁸ Exhibit 29-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 at 0009 [44]–[46].

⁷⁰⁹ Exhibit 22-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 at 0009 [48]; *Health Practitioner Regulation National Law*, s 38(1).

- e. employers requiring particular qualifications or experience.⁷¹⁰
737. Acting outside a practitioner's scope of practice may in some circumstances constitute misconduct.⁷¹¹
738. We submit that registration standards, a code of conduct and scopes of practice informed by regulation will assist to define, professionalise and improve the quality of the aged care personal care worker workforce.
739. To ensure that graduates are provided with the knowledge, skills and professional attributes to practise safely, National Boards have responsibility for accreditation standards and accreditation of programs of study relevant to the qualifications of professions. This accreditation function can be performed directly by a committee of the National Board or by an external accreditation entity.⁷¹²
740. Accreditation standards are used to determine whether a program of study will provide a qualification appropriate for registration as a practitioner of a profession. Completion of an accredited program of study is mandatory for registration.⁷¹³
741. We submit that nationally accredited programs of study will enable employers of aged care personal care workers and the community generally to have greater confidence in the skills and qualification of the workforce.

Recommendation 48: National personal care worker registration scheme

- 48.1. By 1 July 2022, the Australian Health Practitioner Regulation Agency should establish a National Board and a registration scheme for personal care workers, with the following key features:
- a. a mandatory minimum qualification
 - b. ongoing training and continuing professional development requirements
 - c. minimum levels of English language proficiency
 - d. criminal history screening requirements
 - e. a code of conduct and power for the registering body to investigate complaints into breaches of the Code of Conduct.

⁷¹⁰ Exhibit 22-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 at 0011 [62]–[63].

⁷¹¹ Exhibit 22-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 at 0011 [62]–[63].

⁷¹² Exhibit 22-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 at 0012 [71].

⁷¹³ Exhibit 22-19, Final Hearing, Statement of Martin Fletcher, WIT.0425.0001.0001 at 0012 [74]–[77].

48.2. For existing aged care workers who do not meet the mandatory minimum qualification requirements, there should be transitional arrangements that allow them to apply to the National Board for registration based on their experience and prior learning.

Recommendation 49: Mandatory minimum qualification for personal care workers

49.1. A Certificate III should be the mandatory minimum qualification required for personal care workers performing paid work in aged care. The proposed Personal Care Worker National Board should establish an accreditation authority to:

- a. develop and review accreditation standards for the mandatory minimum qualification
- b. assess programs of study and education providers against the standards, and
- c. provide advice to the National Board on accreditation functions.

49.2. The National Board should approve the accredited program of study, and review the need for personal care workers in home care to have specialised skills or competencies.

Part 3.7 Informal carers

742. The future aged care program should ensure that the family and friends who provide care to older people are supported to look after their own health and wellbeing.
743. The Royal Commission's Terms of Reference mandate inquiry into what can be done to strengthen the system of aged care services by the Australian Government, the aged care industry, families and the wider community, as well as ensuring that there is improved engagement with families and carers on care related matters, and the need for close partnerships with carers.⁷¹⁴
744. As noted, it is the express preference of older people to stay in their own homes for as long as possible, and correspondingly, to receive aged care and support in their own homes and not in a residential aged care setting. Because of this, in addition to formal aged care services received by older people, many family members and friends undertake significant carer-related responsibilities. In these submissions, we refer to those family members and friends as 'informal carers'.
745. Informal carers carry out their role to ensure the preference of older people to stay at home can be met. Informal carers frequently continue to provide personal care and support if the older person for whom they have been caring enters residential aged care. By that time, the informal carer has often also assumed an advocacy role for their loved one as well.
746. The needs of older people are not static and will generally increase over time or otherwise fluctuate. Accordingly, throughout their experience of caring for a loved one, informal carers need to develop new skills continually to manage the physical and emotional toll of supporting their loved one to live at home. In the event of an older person moving into residential aged care, their informal carer(s) will need to develop new skills and ways to support this transition.
747. The value of informal carers to the sustainability of the aged care system is difficult to overstate and yet, their work is largely invisible. In economic terms alone, the contribution of those providing unpaid care in Australia is enormous. The replacement value of unpaid care across the total carer population in 2020 has been estimated to be nearly \$80

⁷¹⁴ Letters Patent, 6 December 2018, as amended on 13 September 2019 and 25 June 2020, paragraphs (d), (e) and (j).

billion.⁷¹⁵ This figure is significantly up from the corresponding 2015 estimate of \$60.3 billion per year.⁷¹⁶

748. Recent data from the Australian Bureau of Statistics indicates that there were 2.65 million carers in 2018. Of those, 861,000 were primary carers and 428,000, or nearly 50%, provided care to people over the age of 65.⁷¹⁷ And of course, these figures may be an underestimate, as not everyone providing care identifies as a 'carer'.
749. The Royal Commission received a wide range of evidence and material that being an informal carer for an ageing family member or friend can bring great personal rewards and satisfaction.⁷¹⁸ It is often a choice many people willingly make.⁷¹⁹ However, the caring role can often lead to significant detrimental effects on the health and wellbeing of the carer. The employment of informal carers is also frequently impacted on by the carer role.⁷²⁰ These impacts can leave the carer burdened and with other aspects of their life compromised, including family responsibilities and their wider emotional needs. The financial position and career development of the carer can also be compromised. This has long-term consequences for the financial security of carers, including on their ability to retire. There is evidence that informal carers do not feel supported.⁷²¹ This can affect the carer's ability to care, which in turn impacts on the sustainability of the caring relationship and the quality of care that the older person receives.
750. There was evidence that the current aged care system provides reactive, inadequate and piecemeal support to family and friends and that it does so when the strain on a caring relationship reaches crisis point.⁷²²

⁷¹⁵ Deloitte Access Economics, *The Economic Value of Informal Care in 2020*, 2020, p 16, <https://apo.org.au/sites/default/files/resource-files/2020-07/apo-nid307225.pdf>, viewed 17 September 2020.

⁷¹⁶ Deloitte Access Economics, *The Economic Value of Informal Care in Australia in 2015*, 2015, p iii, <https://www2.deloitte.com/au/en/pages/economics/articles/economic-value-informal-care-Australia-2015.html>, viewed 8 October 2020.

⁷¹⁷ Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia: Summary of Findings, 2018*, Table 40.1 (Catalogue 4430.0), <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0>, viewed 7 July 2020.

⁷¹⁸ Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3988.33–38, Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3982.43–47; T3983.1–3, Transcript, Mildura Hearing, Bonny Dietrich, 30 July 2019 at, 3967.1–8, Transcript, Mildura Hearing, Don Laity, 30 July 2019 at T3967.12–13

⁷¹⁹ Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3982.43–47; T3845.22–23, Transcript, Mildura Hearing, Joan Rosenthal, 29 July 2019 at T3900.19–22.

⁷²⁰ Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3988.42–48, T3989.1–8.26–34, 36–40, Transcript, Mildura Hearing, Meredith Gresham, 30 July 2019 at T4013.19–33; T4024.42–47.

⁷²¹ Transcript, Mildura Hearing, Danijela Hlis, 31 July 2019 at T4067.11–12; Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3852.44–45.

⁷²² Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3995.9-11; Transcript, Mildura Hearing, Elaine Gregory, 29 July 2019 at T3852.44–45; Transcript, Mildura Hearing, Dorothy Holt, 29 July 2019 at T3865.15–20.

751. What can be done then, to support informal carers in our aged care system?
752. We submit that a preventative approach which identifies and values the role of informal carers is required. An approach which, having identified the informal carer, then equips informal carers with skills at an early stage in their caring role. We submit that this must be supported by access to regular and flexible high quality respite.
753. The evidence was that there is great value in a shared space where carers come together, such as the Mildura Carer's Hub and the Home and Community Care centre in Bidyandanga, approximately 200 kilometres north of Broome.⁷²³ Services that have been shown to improve the wellbeing of family and friends who care for older people include: respite and breaks from caring; a supportive general practitioner; counselling; advice and information; practical home support; and support from family and friends. In particular, respite has been shown to improve the emotional wellbeing and physical health of informal carers, provide time for people with caring responsibilities to look after themselves, as well promoting enhanced autonomy and independence, and providing a period of enhanced 'freedom' or 'choice'—the time to take a break.⁷²⁴
754. Accessing support services early on in the caring role is critical to supporting the wellbeing of the informal carer and to increase the sustainability of the caring relationship.⁷²⁵
755. Support services that have been identified as helpful for those providing care to older people include training and resilience to build capacity and manage stress levels. Building capacity through education and training may also include developing skills in administering medicines, manual handling, and accessing and using aids and medical devices.⁷²⁶ Psychosocial interventions such as counselling, behavioural management and participation in support groups is reported to reduce stress by changing beliefs about responsibilities, as well as enabling carers to recognise their own needs for support and understanding.⁷²⁷
756. There are currently three main challenges associated with supporting informal carers to engage with relevant support services. First, there is no formal mechanism to link carers

⁷²³ Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3997.34–3998.7; Exhibit 7-2, Mildura Hearing, Witness Statement of Elaine Gregory, WIT.0315.0001.0001 at 0004 [29]; Exhibit 4-2, Broome Hearing, Statement of Faye Dean, WIT.1142.0001.0001 at 0004 [28]–[29]; Exhibit 7-4, Mildura Hearing, Statement of Rosemary Cameron, WIT.0309.0001.0001 at 0021–0022 [126]–[134].

⁷²⁴ M Hamilton et al, *Transitioning Australian Respite*, 2016, p 12.

⁷²⁵ P Singh et al, 'Dementia care: Intersecting informal family care and formal care systems', *Journal of Ageing Research*, 2014, p 3 [5].

⁷²⁶ K Eagar et al, *Effective Caring: a synthesis of the international evidence on carer needs and interventions*, 2007, p 23.

⁷²⁷ M Vernooij-Dassen et al, 'Cognitive reframing for carers of people with dementia', *Cochrane Database of Systematic Reviews*, 2011, Vol 11.

to the informal carer support services as they take on a caring role. Rather, the system relies on a carer self-identifying as a 'carer' and knowing where to go for support. This means that despite the positive outcomes associated with informal carer support services, timely engagement with services is often unlikely to occur. Secondly, assessment for eligibility for aged care services does not adequately consider the needs of the informal carer beyond the sustainability of their caring role. Thirdly, informal carers are required to navigate up to three government systems, which are complex and fragmented. We submit that the Royal Commissioners should make recommendations to address each of these challenges.

757. In our submission, informal carers should be identified, and appropriate support put in place, when the older person for whom they care is being assessed for aged care services. The needs of a person receiving aged care will evolve, as will the role of family and friends. Not all informal carer relationships may be readily apparent at the stage of initial assessment. It is important that care finders⁷²⁸ have an ongoing role in relation to the identification of informal carers. This is an important first step in ensuring carers' needs are assessed and met. It is part of a suite of reforms necessary to ensure that informal carers who provide care and support to older Australians will have access to timely, skilled and well-coordinated support that helps them to continue in their caring role, as well as supporting their health and wellbeing generally.

Volunteers

Recommendation 50: Informal carers and assisting them to receive support

- 50.1. The Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should improve services and support for informal carers by:
- a. linking My Aged Care and the Carer Gateway by 1 July 2022, to enable the sharing of information to enable respite available through My Aged Care and support services available on the Carer Gateway to be identified jointly and to be provided in a co-ordinated manner
 - b. on and from 1 July 2022:
 - i. enabling direct referral and information sharing for informal carers between My Aged Care, care finders, assessment services and the Carer Gateway

⁷²⁸ See recommendation 10: Care finders to support navigation of aged care.

- ii. providing accurate and up-to-date information on My Aged Care about the range of supports locally available to informal carers, including training, education, counselling, income support, and access to the Carers Hub network (once established)
- c. on and from 1 July 2023:
 - i. requiring My Aged Care, care finders and assessment services to identify informal carers when assessing a person for aged care
 - ii. enabling care finders to refer informal carers to assessment services for assessment for and access to formal respite care
 - iii. supporting and funding a community-based Carers Hub network.

Recommendation 51: Volunteers and Aged Care Volunteer Visitors Scheme

51.1. From 1 July 2021, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should promote volunteers and volunteering in aged care to support older people to live a meaningful and dignified life and supplement the support and care provided to them through the aged care system, whether in their own home or in a residential care home, by:

- a. increasing the funding to the Volunteer Grants under the Families and Communities Program – Volunteer Grants Activity in 2021–22 to support organisations and community groups to recruit, train and support volunteers who provide assistance to older people
- b. requiring, as a condition of approval and continuing approval of all approved providers, that all aged care services, which use volunteers to deliver in-house co-ordinated and supervised volunteer programs, must:
 - i. assign the role of volunteer coordination to a designated staff member
 - ii. provide induction training to volunteers and regular ongoing training, to volunteers in caring for and supporting older people, complaints management and the reporting of abuse and neglect
 - iii. retain evidence of provision of such training

- c. providing additional funding, and expanding the Community Visitor Scheme and changing its name to the Aged Care Volunteer Visitors Scheme, to provide extended support for older people receiving aged care who are at risk of social isolation.

758. Along with informal carers, volunteers are an integral part of the aged care system. Data reveals that the majority of volunteers in residential aged care facilities and in home care undertake social activity support assistance as well as planned group activity assistance and companionship.⁷²⁹ Other types of work carried out by volunteers include assistance with domestic activity, respite care, home maintenance, gardening, transport, shopping and appointments and meal preparation. These data are consistent with evidence given in the course of public hearings and with public submissions.⁷³⁰
759. The 2016 National Aged Care Workforce Census and Survey reported that 83% of residential facilities and 51% of home care and home support outlets utilise volunteer staff.⁷³¹ We anticipate that there may be overlap between people who identify as carers and those who identify as volunteers.
760. The 2016 survey reported that a total of 23,537 volunteers provided 114,847 hours of service to residential aged care facilities in 2016 in a designated fortnight.⁷³² Home care and home support outlets engaged a total of 44,879 volunteers who provided 206,531 hours of service in the designated fortnight.⁷³³ In a public submission to the Royal Commission, Meals on Wheels Australia has suggested that the numbers of people volunteering in aged care may in fact be much higher than the survey results suggest. Meals on Wheels Australia alone has approximately 76,000 registered active volunteers across Australia.⁷³⁴

⁷²⁹ Australian Department of Health, *The Aged Care Workforce*, 2016, p 65, 131 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2888, 2954).

⁷³⁰ Meals on Wheels Australia, Public submission, AWF.650.00070.0001 at 0003; Transcript, Mudgee Hearing, Julian Krieg, 6 November 2019, T6508.35-45; Exhibit-14-17, Canberra Hearing, Statement of Hamish MacLeod, WIT.1309.0001.0001 at 0005 [36].

⁷³¹ Australian Department of Health, *The Aged Care Workforce*, 2016, p 129 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2952).

⁷³² Australian Department of Health, *The Aged Care Workforce*, 2016, p 64 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2887).

⁷³³ Australian Department of Health, *The Aged Care Workforce*, 2016, p 129 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 89, CTH.0001.1001.2805 at 2954).

⁷³⁴ 'The 68,000 volunteers reported as working in a community based aged care setting were reported for a fortnight period. Data reporting on volunteers was optional for some service providers. We believe that this is not an accurate representation of how many volunteers are actually working in this area and constitute a significant part of the aged care workforce. Meals on Wheels Australia members alone have approx 76,000 registered active volunteers across Australia...': Meals on Wheels Australia, Public submission, AWF.650.00070.0001 at 0001_0003.

761. The aged care Community Visitors Scheme is a permanent Australian Government scheme that encourages and relies on volunteers. The Community Visitors Scheme arranges visits by volunteers to older people who use aged care services to provide companionship and friendship. This service is free to users and has been funded by the Australian Government since 1992.⁷³⁵
762. The Community Visitors Scheme provides funding to organisations known as ‘auspices’ to recruit, train and support volunteers, conduct police checks, match volunteers to older people receiving aged care, and support relationships that form between volunteers and the people they visit.⁷³⁶ The auspices are not typically approved providers. Community visitors are not advocates, and there is a separately funded National Aged Care Advocacy Program.⁷³⁷
763. In August 2016, the Australian Department of Health engaged the consulting firm Australian Healthcare Associates to review the Community Visitors Scheme. The review identified a range of areas for improvement with the Scheme, while noting that it ‘is seen as a long-running and highly successful scheme that brings substantial benefits to both visitors and consumer alike’.⁷³⁸ The review identified lack of awareness as a key barrier to full use of the scheme.
764. What can be done to bring awareness to volunteering in the aged care system? What can be done to support those volunteering in aged care? We submit a twin approach to supporting volunteers in the aged care system. First, we submit that the existing Community Visitor Scheme in aged care should be equipped to provide extended support for older people receiving aged care who are at risk of social isolation. We submit there is a need to promote the work of this scheme and attract and build an increased volunteer base.
765. Secondly, we submit that approved providers of aged care should support volunteers in the work that they do. We submit that approved providers ought to do so through appropriate supervision, induction and training. Approved providers should support volunteers to understand what they can do, and to whom they should address any concerns if they witness or suspect neglect or abuse of an older people receiving aged care. We submit that this approach should be scalable to the size and location of a given approved provider and should not create an excessive burden on smaller providers.

⁷³⁵ Australian Department of Health, *Community Visitors Scheme National Guidelines*, 2019.

⁷³⁶ Department of Health, *Community Visitors Scheme*, 2020, <https://www.health.gov.au/initiatives-and-programs/community-visitors-scheme-cvs>, viewed 7 July 2020.

⁷³⁷ Recommendation 7: Enhanced individual advocacy.

⁷³⁸ Australian Department of Health, *Review of the Community Visitor Scheme Final Report*, 2017, p 4.

766. Various official visitor schemes, also known as community visitor schemes, exist in all States and Territories and have operated in Australia since the late 1800s, when they were introduced to have an oversight function in respect of mental health facilities.⁷³⁹ Official visitors, or community visitors, are typically tasked with oversight and monitoring of conditions in institutional settings. In this respect, they have a safeguarding role and therefore, a different role and function to volunteers in aged care, including the Aged Care Community Visitors Scheme. There is no official visitors scheme that has a safeguarding role in the aged care system. The New South Wales Ageing and Disability Commissioner, Mr Robert Fitzgerald AM, and Ms Katherine McKenzie, Director of Operations at the New South Wales Ageing and Disability Commissioner, raised the possibility of an official visitors scheme in aged care which took a hybrid approach to an official visitors scheme which included both social connection and safeguarding measures.⁷⁴⁰ We are conscious that an official visitors scheme in aged care would be a departure from the nature of the current community visitors scheme. The current community visitors scheme is based on social connection rather than oversight and safety. We submit that it is essential to preserve, and enhance the existing community visitors scheme as a means to maintain the social connection of older people. For these reasons, we do not propose a recommendation for an official visitors scheme.

Carer's leave

767. There are currently no provisions in the National Employment Standards under the *Fair Work Act 2009* (Cth) for an employee to take extended unpaid leave for the purpose of caring for an elderly family member or friend.⁷⁴¹ The Royal Commission has heard evidence that flexibility in work arrangements has the potential relieve the impact of carer burden earlier described.⁷⁴² Accepting the impact of caring responsibilities on the informal carer's work and career development, and the consequent long term financial impact this has on an informal carers retirement savings and income, to which these submissions have earlier referred, we submit that there is a good case for evaluating the costs and benefits of a change in the National Employment Standards that would allow for an employee to take leave from their employment to care for an elderly family member or friend, and to consider the appropriate scope of any such change.⁷⁴³

⁷³⁹ WestWood Spice, *Community Visitor Schemes Review*, 2018, p 17.

⁷⁴⁰ Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 73, WIT.0786.0001.0001 at 0004.

⁷⁴¹ The National Employment Standards are set out in Part 2.2 of the *Fair Work Act 2009* (Cth) and set minimum standards for the employment of most Australian employees. The minimum standards relate to 10 matters including maximum weekly hours and different types of leave including annual leave, sick leave and personal/carer's leave.

⁷⁴² Transcript, Mildura Hearing, Catherine Thomson, 30 July 2019 at T3989.44–46; T3990.1–15, 20–24

⁷⁴³ Transcript, Mildura Hearing, Meredith Gresham, 30 July 2019 at T4024.33–39; Transcript, Mildura Hearing, Nicole Dunn, 30 July 2019 at T3979.3–6.

768. Professor Andrew Stewart gave evidence in Sydney Hearing 4 that the *Fair Work Act 2009* (Cth) could be amended to extend an entitlement to leave to care for an elderly family member, on the same basis that employees are currently entitled to leave to care for a new born or newly adopted child.⁷⁴⁴ A change of this kind would have economy-wide impacts and would require careful evaluation.
769. With the increase to the ageing population and preference for older people to remain living at home, the role of informal carers is likely to be even more important in the years to come than is currently the case.
770. The evidence in this Royal Commission highlighted the value of informal carers in the aged care system, as well as the toll and impact that caring can have on the carer. Investigation of the merits of an entitlement to leave to care for our elderly is justified as a potential additional measure to support informal carers to continue to care for their loved ones. A change to the National Employment Standards to support carers in this manner ought to be fully investigated by the Australian Government. We submit that there ought to be an investigation into an amendment of the National Employment Standards under Part 2-2 of the *Fair Work Act 2009* (Cth) to provide for an additional entitlement to unpaid carer's leave for an employee to care for an elderly family member or friend. This investigation should examine the social and economic impacts of such an amendment and should consider:
- a. a new National Employment Standard providing for up to two years unpaid carer's leave to provide care or support to a member of the employee's family or a member of their household who requires care or support because they are frail and aged
 - b. an entitlement to leave only where:
 - i. the employee has, or will have, completed at least 12 months of continuous service with the employer immediately before commencing the period of unpaid leave
 - ii. the employee has or will have, the primary responsibility for the care and support of the older person
 - iii. the employee has or will have, a right to return to the employee's pre-leave position. If that position no longer exists, the employee should return to an available position for which the employee is qualified and suited nearest in status and pay to the pre-unpaid carer's leave position.
771. We submit that the results of this investigation should be made public by 30 June 2022.

⁷⁴⁴ Transcript, Sydney Hearing 4, Andrew Stewart, 1 September 2020 at T8984.29–38.

Part 3.8 Provider governance

772. Without good governance, aged care providers are less likely to deliver high quality care. Evidence before the Royal Commission has shown that the level of substandard care is unacceptably high in the aged care sector.⁷⁴⁵ It is improbable that, if all aged care providers had good governance arrangements in place, this level of substandard care would exist. The evidence emphasises the need for aged care providers to have robust governance arrangements focused on delivering safe and high quality care.⁷⁴⁶
773. Governance arrangements provide for the systems by which an organisation is controlled and operates, and the mechanisms by which the organisation, and its people, are held to account.⁷⁴⁷ They involve everyone at an organisation. They are set by the leaders of an organisation and, in particular, the governing body. They are implemented by executive leaders and workers who report to those executive leaders.
774. Governance arrangements reflect and promote the culture of an organisation. An aged care provider's most important objective should be to enhance the wellbeing of older people by providing them with safe and high quality care. Governance arrangements for aged care providers should include systems to achieve this primary objective.
775. At present, aged care legislation requires that, for an aged care provider to be approved under aged care legislation, the provider must be incorporated.⁷⁴⁸ An approved provider is therefore subject to governance requirements in any legislation under which it is incorporated as well as additional governance requirements in existing aged care legislation.⁷⁴⁹ Under aged care legislation, an approved provider of residential care, home care or short-term restorative care must comply with Standard 8 (organisational governance) in the Aged Care Quality Standards set out in Schedule 2 to the *Quality of Care Principles 2014* (Cth).⁷⁵⁰

⁷⁴⁵ In relation to the nature, extent and systematic causes of substandard care, see Part 2 above.

⁷⁴⁶ Governance arrangements are expressly mentioned in the Royal Commission's Terms of Reference. See Letters Patent dated 6 December 2018, subparagraph (i)(x). Provider governance is relevant to other parts of the Terms of Reference, including, in particular, paragraph (g).

⁷⁴⁷ Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 1, RCD.9999.0260.0001 at 0005.

⁷⁴⁸ Unless the provider is a State or Territory, an authority of a State or Territory, or a local government authority. See *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 63D, 63F.

⁷⁴⁹ Aged care providers are incorporated under the *Corporations Act 2001* (Cth) or *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth) or state and territory incorporated associations legislation or other special state and territory legislation. A large majority of those corporate aged care providers are incorporated under the Corporations Act. Providers registered with the Australian Charities and Not-for-profits Commission must meet governance standards set out in the *Australian Charities and Not-for-profits Commission Regulation 2013* (Cth) made under the *Australian Charities and Not-for-profits Commission Act 2012* (Cth).

⁷⁵⁰ *Aged Care Act 1997* (Cth), ss 54-1 and 54-2; *Quality of Care Principles 2014* (Cth), ss 17 and 18. In addition, an approved provider of residential care that holds refundable accommodation

776. The existing requirements have not provided, on a consistent basis, sufficiently strong governance and leadership of aged care providers. Changes are needed to improve providers' care governance and corporate governance, to strengthen the integrity and sustainability of the system as a whole, and to sharpen the focus on delivering high quality aged care services.
777. Governing bodies of aged care providers should be comprised of members whose integrity, skills and independence enable them to act, first and foremost, in the best interests of the people receiving that care. Evidence before the Royal Commission has shown that, for some providers, the members of their governing bodies have not met this mark.⁷⁵¹
778. In particular, that evidence has demonstrated a lack of adequate clinical governance expertise on the boards of some providers.⁷⁵² Each governing body should have a care governance committee, to ensure that quality of care is considered at the highest level of the organisation.⁷⁵³ The chair of the care governance committee should be a member of the governing body with appropriate experience in care provision. The focus on quality of care should cascade from the governing body through executive leadership to all staff.
779. People receiving aged care, their relatives and staff have told the Royal Commission that their complaints and feedback to aged care providers have often not been heeded or acted on.⁷⁵⁴ Providers should have stronger systems in place to ensure that complaints and other feedback from people in their care and staff are considered by the governing body and used to shape policies and practices.
780. There is also a lack of transparency and accountability about what providers are doing and how well it is being done.⁷⁵⁵ Good quality comparative information about aged care

⁷⁵¹ deposits, accommodation bonds or entry contributions must comply with the Governance Standard set out in Division 4 of Part 5 of the *Fees and Payments Principles 2014 (No. 2)* (Cth). Transcript, Cairns Hearing, Petronella Neeleman, 15 July 2019 at T3584.1–20; Exhibit 6-17, Darwin Hearing, Statement of Paul Cohen, WIT.0258.0001.0001 at 0038–0044 [208]–[209]; Exhibit 13-5, Hobart Hearing, Statement of Jo-Anne Hardy, WIT.0496.0001.0001 at 0009–0010 [36]–[41].

⁷⁵² Transcript, Darwin Hearing, Paul Cohen, 10 July 2019 at T3161.43–3162.6; T3168.32–3169.43; Transcript, Darwin Hearing, Donato Smarrelli, 10 July 2019 at T3179.21–3180.9; Transcript, Cairns Hearing, Petronella Neeleman, 15 July 2019 at T3581.42–3582.22; T3584.1–20; T3592.10–44.

⁷⁵³ See, for example: Transcript, Hobart Hearing, Penny Webster, 15 November 2019 at T7116.25–31; Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 201, 206 and 207; Exhibit 13-20, Hobart Hearing, Bupa South Hobart Tender Bundle, tab 163, BPA.060.002.5503.

⁷⁵⁴ Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, WIT.0006.0001.0001 at 0008 [31]; Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, WIT.0003.0001.0001 at 0008 [10]; Transcript, Adelaide Hearing 1, Matthew Richter, 20 February 2019 at T526.10–23; Exhibit 8-36, Brisbane Hearing, Statement of Beverley Johnson, WIT.0332.0001.0001 at 0009 [51]–[52].

⁷⁵⁵ See, for example: John Simpson, public submission AWF.001.02459 at 0002; Transcript, Brisbane Hearing, Professor Ron Paterson ONZM, 7 August 2019 at T4602.38–44; Exhibit 1-60, Adelaide Hearing 1, Statement of Gerard Hayes, WIT.0019.0001.0001 at 0013 [69(g)].

services is not available publicly.⁷⁵⁶ There should be greater transparency about the operations of aged care providers – they should be required to provide an annual report on various matters for publication on the internet. On the new Act coming into effect, that report should be provided to the Australian Aged Care Commission. Before then, it should be provided to the Secretary of the Australian Department of Health. Ready availability of this information would enable public scrutiny and accountability, and would encourage providers to strengthen their performance.

Recommendation 52: Legislative amendments to improve provider governance

52.1. By 1 January 2022, the *Aged Care Act 1997* (Cth) should be amended to require that:

- a. the governing body of an approved provider providing personal care services must have a majority of independent non-executive members (unless the provider has applied to the Aged Care Quality and Safety Commissioner for an exemption and the exemption has been granted)
- b. the constitution of an approved provider must not authorise a member of the governing body to act other than in the best interests of the provider
- c. an applicant for approval to provide aged care services must notify the Aged Care Quality and Safety Commissioner of its key personnel, and an approved provider must notify the Commissioner of any change to key personnel within ten business days of the change
- d. a 'fit and proper person' test (replacing the 'disqualified individual' test) applies to key personnel
- e. an approved provider must provide an annual report to the Secretary of the Australian Department of Health containing information to be made publicly available through My Aged Care.

52.2. By 1 January 2022, the *Freedom of Information Act 1982* (Cth) should be amended to remove from Schedule 3 of that Act references to provisions in the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth), thereby ensuring that the exemption in section 38 of the Freedom of Information Act does not apply to 'protected information' under

⁷⁵⁶ Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Professor Ron Paterson ONZM, RCD.9999.0143.0001 at 0003 [28].

aged care legislation merely on the grounds that it is information that relates to the affairs of:

- a. an approved provider
- b. an applicant for a grant under Chapter 5 of the Aged Care Act
- c. a service provider of a Commonwealth-funded aged care service, or
- d. an applicant for approval under section 63B of the Aged Care Quality and Safety Commission Act.

52.3. The new Act should contain provisions reflecting both the amendments to the Aged Care Act and the system governance arrangements provided for in that new Act. Under the new Act, the system governor and quality regulator will be the Australian Aged Care Commission. The government functions in subparagraphs 52.1.a., c. and e. above will be undertaken by the Australian Aged Care Commission.

Independent members on the governing body of an approved provider

781. Contemporary good governance practice in Australia is to have, where possible, a majority of members on an organisation's governing body who are independent.⁷⁵⁷ An independent member of an organisation's governing body is one who is free of any interest or relationship that might influence, or might reasonably be perceived to influence, the capacity to bring an independent judgment to bear on issues before the governing body and to act in the best interests of the organisation as a whole. An executive employed by the organisation cannot be an independent member of its governing body.

782. This good governance practice should apply to aged care providers providing personal care services.⁷⁵⁸ The dire consequences for people receiving poor personal care warrant independent input into and scrutiny of decisions that are likely to have a systemic effect on the provision of that care.

⁷⁵⁷ See, for example: Transcript, Hobart Hearing, Catherine Maxwell, 15 November 2019 at T7164.45–7165.29; Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 2, RCD.9999.0478.0001 at 0002–0003 [10]; Australian Institute of Company Directors, *Role of non-executive directors – Board composition*, 2016, p 1, <http://aicd.companydirectors.com.au/resources/director-tools/practical-tools-for-directors/board-composition>, viewed 29 June 2020; ASX Corporate Governance Council, *Corporate Governance Principles and Recommendations*, 2019, p 13.

⁷⁵⁸ Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 2, RCD.9999.0478.0001 at 0002–0003 [10]; Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 4, RCD.9999.0512.0009 at 0010 [9].

783. Aged care legislation should require that the majority of members of an approved provider's governing body must be independent. The legislation should permit an approved provider to apply to the regulator for an exemption from this general requirement in limited circumstances. For instance, the legislation might only permit an application to be made by an approved provider falling below a particular size threshold.
784. An approved provider applying for an exemption should indicate why the provider cannot meet the requirement, and should set out alternative arrangements in place to ensure independent scrutiny of strategic decisions affecting the safety and quality of services. At a minimum these arrangements should include at least one independent governing body member. They might also include, for example, regular audits of decisions of the governing body by a third party. An exemption should only be capable of being granted for a fixed period of up to, say, three years.
785. An approved provider failing to meet the independence requirements for governing body membership should be obliged to give the regulator an 'if not, why not' explanation about what has in fact occurred and why, and what remedial action has been taken. The regulator should have powers to take further regulatory action if it is not satisfied with that explanation. Examples of those powers are referred to in submissions made below on regulation.

Governing body members acting in the best interests of the approved provider

786. Members of an organisation's governing body have a duty to act in good faith in the best interests of the organisation and for a proper purpose.⁷⁵⁹ However, s 187 of the *Corporations Act 2001* (Cth) permits a director, in certain circumstances, to discharge the duty to act in the best interests of a wholly-owned subsidiary company by acting in the best interests of its holding company. In particular, the director may do so if the constitution of the subsidiary company expressly authorises the director to act in the best interests of the holding company.
787. Directors of a wholly-owned subsidiary that is an approved provider should not be permitted by law to give priority to the interests of a holding company that does not have any responsibilities under aged care legislation. Aged care legislation should specify that the constitution of an approved provider may not authorise a member of its governing body to act in the best interests of an entity other than that approved provider. Such a statutory provision should apply to all approved providers, whether or not they are wholly-owned subsidiaries.

⁷⁵⁹ *Corporations Act 2001* (Cth), ss 181–184.

Notification of key personnel and of changes to key personnel

788. For the sake of transparency and accountability, the people responsible for the governance and management of approved providers should be clearly identifiable. They should be identified to the aged care regulator on an ongoing basis and as a matter of course. At present, aged care legislation does not require that to occur.⁷⁶⁰
789. Aged care legislation defines the key personnel of an entity as:
- a. a member of the group of people responsible for the executive decisions of the entity, including directors or members of the entity's governing body;
 - b. any other person who has authority or responsibility for, or significant influence over, planning, directing or controlling the activities of the entity;
 - c. for an entity conducting an aged care service:
 - i. any person who is responsible for the nursing services provided by the aged care service and who holds a recognised qualification in nursing; and
 - ii. any person who is responsible for the day-to-day operations of an aged care service; and
 - d. for an entity proposing to conduct an aged care service:
 - i. any person who is likely to be responsible for the nursing services to be provided by the service and who holds a recognised qualification in nursing; and
 - ii. any person who is likely to be responsible for the day-to-day operations of the service.⁷⁶¹
790. There are advantages of a definition in these terms. People who have 'authority or responsibility for, or significant influence over, planning, directing or controlling the activities of the organisation' may include directors of a holding company of a subsidiary approved provider.⁷⁶² Such people would include the key personnel of a corporate entity engaged to manage the day-to-day operations of an aged care service, as well as people

⁷⁶⁰ Aged care legislation currently only requires an approved provider to notify the Aged Care Quality and Safety Commissioner of 'a change of circumstances that materially affects the approved provider's suitability to be a provider of aged care services'. See *Aged Care Act 1997* (Cth), s 9-1(1). The Commissioner has issued guidance to the aged care sector on the interpretation of this provision, listing a change to key personnel as one of a number of examples of material changes that should be notified to the regulator—noting, however, that these are 'examples only and approved providers should consider each situation individually'. See Aged Care Quality and Safety Commission, *Notifying material changes for approved providers*, Australian Government, 2018, <https://www.agedcarequality.gov.au/providers/notifying-material-changes-approved-providers>, viewed 10 August 2020.

⁷⁶¹ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 8B.

⁷⁶² *Australian Securities and Investments Commission v King* (2020) 376 ALR 1, [52]–[59].

who are not a director of an approved provider but in accordance with whose instructions or wishes the directors are accustomed to act.⁷⁶³

791. Before 2016, aged care legislation expressly required that providers notify the regulator of any change to the provider's key personnel. In 2016, that requirement was removed by what was then referred to as a 'red tape reduction' measure.⁷⁶⁴
792. Aged care legislation currently only requires an approved provider to notify the regulator of 'a change of circumstances that materially affects the approved provider's suitability to be a provider of aged care services'.⁷⁶⁵ The Aged Care Quality and Safety Commissioner has issued guidance to the aged care sector on the interpretation of this provision, listing a change to key personnel as one of a number of examples of material changes that should be notified to the regulator – but noting also that these examples are 'examples only and approved providers should consider each situation individually'.⁷⁶⁶
793. There is also no express statutory requirement that, on applying for approval as an approved provider, an entity must inform the regulator of its key personnel. Instead, information on key personnel is sought in the application form approved by the Aged Care Quality and Safety Commissioner.⁷⁶⁷
794. Aged care legislation should impose obligations on approved providers to notify the regulator of key personnel and changes to key personnel. In the absence of express obligations of this kind, the regulator is less likely to know who is controlling or directing the activities of approved providers.
795. If, despite the existence of obligations of this kind, the regulator becomes aware, through monitoring or regulatory action, of a person who may be one of an approved provider's key personnel but who has not been identified to the regulator as such, the regulator will be able to exercise its powers to obtain information from the provider about the role of the individual and the person's fitness and propriety to undertake that role.⁷⁶⁸ If, after consideration of that information, the regulator finds that the person is a member of the provider's key personnel but is not a fit and proper person to be key personnel, the regulator would have power to take further regulatory action against the approved

⁷⁶³ See, for instance, *Corporations Act 2001* (Cth), s 9, definitions of 'director' (para (b)(ii)) and 'officer' (para (b)(iii)).

⁷⁶⁴ *Aged Care Act 1997* (Cth), s 9-1(1)(b) repealed by the *Budget Savings (Omnibus) Act 2016* (Cth).

⁷⁶⁵ *Aged Care Act 1997* (Cth), s 9-1(1).

⁷⁶⁶ Aged Care Quality and Safety Commission, *Notifying material changes for approved providers*, Australian Government, 2018, <https://www.agedcarequality.gov.au/providers/notifying-material-changes-approved-providers>, viewed 10 August 2020.

⁷⁶⁷ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63B(2); Aged Care Quality and Safety Commission, Application for approval to provide aged care - New applicant, <https://www.agedcarequality.gov.au/media/87218>, viewed 23 September 2020.

⁷⁶⁸ These powers are described in submissions on regulation below.

provider and the person, which action is also described in submissions below on regulation.

A 'fit and proper person' test for key personnel of an approved provider

796. Identification of the people comprising an approved provider's key personnel is vital to ensure that there is no uncertainty about which people must meet regulatory standards applicable to key personnel.
797. Under existing aged care legislation, regulatory standards applicable to key personnel are limited. The aged care regulator must not approve an entity as a provider of aged care if any of the entity's key personnel is a 'disqualified individual'.⁷⁶⁹ Having become an approved provider, the provider commits an offence if the provider recklessly permits a disqualified individual to be one of its key personnel.⁷⁷⁰ The disqualified individual also commits an offence.⁷⁷¹
798. The term 'disqualified individual' is defined in aged care legislation in a narrow and exhaustive way. A disqualified individual is a person who:
- a. has been convicted of an indictable offence;
 - b. is an insolvent under administration; or
 - c. has been certified by a registered medical practitioner as unable to perform his or her duties because of mental incapacity.⁷⁷²
799. No discretion attends the determination of a person's status as a disqualified individual. But the consequences of disqualified individual status are clearly significant. And the exhaustive, but confined, terms of the definition produces anomalies. Some people are able to remain involved in the provision of aged care services when they ought not to be, and others are prevented from involvement when they have a valuable contribution to make.
800. A wider, less rigid approach to key personnel is needed. An approved provider has responsibilities to deliver safe and high quality aged care services to older people. Its key personnel should be fit and proper to ensure that the provider discharges those responsibilities.⁷⁷³ Key personnel should be good at their jobs, competent and qualified, and they should also be of good character and reputation. Aged care regulation does

⁷⁶⁹ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63D(2)(c).

⁷⁷⁰ *Aged Care Act 1997* (Cth), s 10A-2(1).

⁷⁷¹ *Aged Care Act 1997* (Cth), s 10A-2(3).

⁷⁷² *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 7, 8A; *Aged Care Act 1997* (Cth), Schedule 1.

⁷⁷³ Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 2, RCD.9999.0478.0001 at 0006–0007 [15]; Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 4, RCD.9999.0512.0009 at 0013 [14]–[15]; Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 1, RCD.9999.0470.0001 at 0006–0007 [7].

not currently promote or achieve this end. Replacing the ‘disqualified individual’ test with a ‘fit and proper person’ test would improve the regulation of key personnel.

801. The expression ‘fit and proper person’ is commonly used in legislation that deals with eligibility to engage in a profession or to hold a position of responsibility. The High Court has observed that these ‘traditional words’ refer to a person’s honesty, knowledge and ability and that the purpose of the words ‘is to give the widest scope for judgment and indeed for rejection’.⁷⁷⁴
802. Statutory ‘fit and proper person’ tests usually set out a range of matters relevant to the suitability of a person to hold a particular position or undertake a particular role. In this regard, there are similarities in the services provided in the aged care and disability care sectors and some providers operate across both sectors. A fit and proper person test for key personnel of approved providers would require consideration of matters not dissimilar to the matters relevant to the suitability of key personnel of registered National Disability Insurance Scheme providers.⁷⁷⁵ For key personnel of approved providers, those ‘suitability matters’ should be specified in aged care legislation and would include matters relating to criminal offending, insolvency and other financial mismanagement, and adverse findings and decisions by courts, tribunals and government regulators.⁷⁷⁶
803. It would not fall to the aged care regulator to consider these suitability matters for each member of key personnel of every approved provider. Nor would the regulator have a positive obligation to determine whether each member of every approved provider’s key personnel is a fit and proper person. That would impose an onerous and unnecessary burden of the regulator’s resources.⁷⁷⁷ Moreover, an approved provider can and should undertake due diligence when engaging a person as one of its key personnel.⁷⁷⁸
804. To enable the aged care regulator to focus on the application of the fit and proper person test only in those cases that warrant the regulator’s attention and potential intervention, aged care legislation should require every provider to investigate, and report to the

⁷⁷⁴ *Hughes and Vale Pty Ltd v New South Wales* (1955) 93 CLR 127 at 156–157.

⁷⁷⁵ *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth), s 10.

⁷⁷⁶ The matters set out in s 10 of the *National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018* (Cth) do not include adverse findings or enforcement action by the Australian Health Practitioner Regulation Agency or whether the person has ever been disqualified from managing corporations under Part 6-5 of the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth).

⁷⁷⁷ Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 5, WIT.0780.0001.0001 at 0006 [29].

⁷⁷⁸ Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 4, RCD.9999.0512.0009 at 0013 [15].

regulator on, the existence or otherwise of suitability matters for key personnel. This should not impose an unreasonable burden on providers.⁷⁷⁹

805. Aged care legislation should require a provider to exercise due diligence in gathering information about the existence or otherwise of suitability matters for each of its key personnel, and subordinate legislation should set out the steps to be taken in that process. Those steps could include conducting various specified searches or inquiries.
806. Aged care legislation should also require that, for each member of a provider's key personnel, the provider must disclose to the regulator the existence of any suitability matters and attest to the regulator that:
- a. the provider has exercised due diligence in gathering information about the suitability matters for that person; and
 - b. either:
 - i. if the due diligence process does not reveal the existence of any suitability matter, the provider has no reason to believe that the person is not fit and proper to be one of its key personnel; or
 - ii. if that process reveals the existence of one or more suitability matters, the provider nevertheless considers that the person is fit and proper to be one of its key personnel.
807. A provider should have an opportunity to put information before the regulator on any reasons why, in spite of the existence of one or more suitability matters, the provider considers that the person is nonetheless fit and proper to be one of its key personnel. Natural justice would require the regulator to take that information into account.
808. The existence of one or more suitability matters would not necessarily establish that a person is not fit and proper. For example, the fact and circumstances of a person having been an insolvent under administration might have little bearing on the fitness and propriety to undertake a particular role as one of a provider's key personnel. Similarly, an old conviction that is not a 'spent' conviction might not affect a person's fitness and propriety in light of the age and other circumstances of the person at the time of offending, the time that has elapsed since the conviction, and evidence of the person's subsequent rehabilitation and good standing.⁷⁸⁰
809. Aged care legislation should provide that, if, after consideration of the information before it, the regulator is satisfied that a member of an approved provider's key personnel is not

⁷⁷⁹ Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 2, RCD.9999.0478.0001 at 0006 [14].

⁷⁸⁰ Statutory spent convictions schemes are set out in: Part VIIC of the *Crimes Act 1914* (Cth); *Criminal Records Act 1991* (NSW); *Spent Convictions Act 1988* (WA).

a fit and proper person, the regulator would be able to exercise a range of regulatory powers in respect of the provider and the member of key personnel.⁷⁸¹ Also, and as is the case currently, the regulator should be able to apply to the Federal Court for a remedial order if an 'unacceptable key personnel situation' is thought to exist because a member of a provider's key personnel is not a fit and proper person.⁷⁸²

810. An analogous process of due diligence, disclosure and attestation would apply in respect of the key personnel of an entity applying for approval as an approved provider. The applicant would have to exercise due diligence in gathering information about the existence or otherwise of suitability matters for each of its key personnel, disclose to the regulator the existence of any suitability matters for the person, and make an attestation about his or her fitness and propriety. Aged care legislation should require that the regulator must not grant approval to a provider if the regulator is satisfied that one or more of the provider's key personnel is not a fit and proper person.⁷⁸³
811. The due diligence, disclosure and attestation process should be undertaken on a regular and ongoing basis.⁷⁸⁴ Aged care legislation should require that it occur:
- a. at the time of applying for approval as an aged care provider;
 - b. at the time of notifying the regulator of a change in key personnel;
 - c. within 10 days of becoming aware of any change of circumstances giving rise to the existence of one or more suitability matters for key personnel; and
 - d. for the preceding year, in any annual reporting to government.⁷⁸⁵

Public annual reporting to government by every approved provider

812. Accountability and transparency are critical features of good governance.⁷⁸⁶ They are particularly important in the case of approved providers which receive most of their funding from taxpayers and provide care to vulnerable people who are often unable to speak for themselves. Approved providers should be required to provide ready access to information about their operations, to enable proper scrutiny. To that end, aged care legislation should require that every approved provider must give to the Secretary of the

⁷⁸¹ Merits review before the Administrative Appeals Tribunal would be available in respect of decisions involving the exercise of those regulatory powers. Those powers are described in submissions on regulation.

⁷⁸² *Aged Care Act 1997* (Cth), s 10A-3.

⁷⁸³ Merits review before the Administrative Appeals Tribunal would be available in respect of such a decision.

⁷⁸⁴ Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 1, RCD.99999.0470.0001 at 0007.

⁷⁸⁵ This annual reporting is distinct from the public annual reporting described in the immediately following paragraphs below. Although annual reporting on suitability of key personnel could occur at the same time as other annual reporting, information on suitability of key personnel would not be made public on a website.

⁷⁸⁶ Australian Institute of Company Directors, *Not-for-Profit Governance Principles*, 2019, p 74.

Australian Department of Health,⁷⁸⁷ for publication on a website, an annual report that includes:

- a. financial reports, including profit and loss and balance sheet information;
- b. details of the provider's related-party transactions⁷⁸⁸
- c. the names and positions of all key personnel
- d. any attestation by the governing body of the kind described in paragraphs 840 to 841 below
- e. information on staffing levels, qualifications, hours worked, employment status, and turnover⁷⁸⁹
- f. information on service capacity and utilisation and turnover of people receiving aged care services, and
- g. information on the number, type, and outcome of complaints.⁷⁹⁰

813. While some of this information, such as financial reports and names of directors, is available in respect of some providers,⁷⁹¹ that totality of this information is not readily and publicly available, in one place, in respect of all providers. It should be.

814. One useful comparison is the reporting requirements for Australian charities. The *Australian Charities and Not-for-profits Commission Act 2012* (Cth) provides for the Australian Charities and Not-for-profits Register, which contains information about current and former registered entities.⁷⁹² The Commissioner of the Australian Charities and Not-for-profits Commission is required to maintain the register and it must be available for public inspection on the internet.⁷⁹³ The legislation specifies a variety of

⁷⁸⁷ Or, in future, the Australian Aged Care Commission as the body that assumes the role of system governor. See the submissions on system design above.

⁷⁸⁸ The term 'related party' is not defined in aged care legislation but the term 'related body corporate' is defined in s 50 of the *Corporations Act 2001* (Cth). The concepts of a 'related party' and a 'related party transaction' are, however, defined in relevant accounting standards. See Australian Accounting Standards Board, *AASB 124 Related Party Disclosures*, https://www.aasb.gov.au/admin/file/content105/c9/AASB124_07-15.pdf, viewed 8 October 2020, paragraph 9.

⁷⁸⁹ Exhibit 1-60, Adelaide Hearing 1, Statement of Gerard Hayes, WIT.0019.0001.0001 at 0013 [69(g)]; Exhibit 1-45, Adelaide Hearing 1, Statement of Patricia Sparrow, WIT.0014.0001.0001 at 0013 [83]; Transcript, Adelaide Hearing 1, Patricia Sparrow, 19 February 2019 at T431.44–46.

⁷⁹⁰ Transcript, Adelaide Hearing 1, Glenys Beauchamp, 18 February 2019 at T308.44-46; Transcript, Adelaide Hearing 1, Ian Yates, 11 February 2019 at T56.15–17; Exhibit 3-70, Sydney Hearing 1, Statement of Professor Joseph Ibrahim, WIT.0115.0001.0001 at 0012 [69]–[70]. Other publicly available information will include star ratings for approved providers and their services.

⁷⁹¹ *Accountability Principles 2014* (Cth), Part 4, Division 2; *Fees and Payments Principles (No 2) 2014* (Cth), Part 5, Division 5. Financial information for some kinds of aged care providers is also available from other sources, such as the Australian Securities Exchange, the Australian Charities and Not-for-profits Commission Act and the Australian Securities and Investments Commission.

⁷⁹² *Australian Charities and Not-for-profits Commission Act 2012* (Cth), Part 2-2, Division 40.

⁷⁹³ *Australian Charities and Not-for-profits Commission Act 2012* (Cth), ss 40-5(1) and (4).

information that must be made available on the register, including the entity's name, contact details, and governing rules, the name and position of each director or trustee, and financial reports and any audit or review reports given by the entity to the Commissioner.⁷⁹⁴

815. Another comparison is reporting under the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth), which requires the Australian Prudential Regulation Agency to publish an annual report on the operations of each private health insurer, including profit and loss and balance sheet information.⁷⁹⁵

Increased access to documents about affairs of approved providers

816. Secrecy provisions in aged care legislation restrict disclosure of 'protected information'.⁷⁹⁶ In broad terms, protected information is information that: was acquired under or for the purposes of the relevant aged care legislation; and either is personal information (as defined in the *Privacy Act 1988* (Cth)) or relates to the affairs of an approved provider or an applicant for approval as an aged care provider.⁷⁹⁷

817. These provisions do not prevent disclosure of protected information if that disclosure is authorised under another Act, such as the *Freedom of Information Act 1982* (Cth). The Freedom of Information Act provides for a general right of access to documents, other than 'exempt documents' or 'conditionally exempt documents', held by Australian Government agencies.⁷⁹⁸ If access to an exempt document is requested, there is no obligation to grant that request.⁷⁹⁹ If access to a conditionally exempt document is requested, access must be granted unless it would, on balance, be contrary to the public interest.⁸⁰⁰

818. Various kinds of documents relating to approved providers could fall within one or more classes of exempt or conditionally exempt documents under the Freedom of Information Act. For example:

- a. under s 47, a document is an exempt document if its disclosure would disclose: trade secrets; or any other information having a commercial value that would be, or could reasonably be expected to be, destroyed or diminished if the information were disclosed; and

⁷⁹⁴ *Australian Charities and Not-for-profits Commission Act 2012* (Cth), s 40-5(1).

⁷⁹⁵ *Private Health Insurance (Prudential Supervision) Act 2015* (Cth), s 167.

⁷⁹⁶ *Aged Care Act 1997* (Cth), Div 86; *Aged Care Quality and Safety Commission Act 2018* (Cth), Part 7, Div 4.

⁷⁹⁷ *Aged Care Act 1997* (Cth), s 86-1; *Aged Care Quality and Safety Commission Act 2018* (Cth), s 60(2).

⁷⁹⁸ *Freedom of Information Act 1982* (Cth), ss 3, 3A, 11 and 11A.

⁷⁹⁹ *Freedom of Information Act 1982* (Cth), s 11A(4).

⁸⁰⁰ *Freedom of Information Act 1982* (Cth), s 11A(5).

- b. under s 47G, a document is conditionally exempt if its disclosure would disclose information concerning the business, commercial or financial affairs of an entity and that disclosure could reasonably be expected to:
 - i. unreasonably affect that entity in respect of its lawful business, commercial or financial affairs; or
 - ii. prejudice the future supply of information to the Australian government.
819. In respect of a request for access to any document containing information about the business, commercial or financial affairs of an entity, no decision can be made on the request until the entity has had an opportunity to make submissions in support of a contention that the document is: exempt under s 47; or conditionally exempt under s 47G and access to the document would, on balance, be contrary to the public interest: see s 27.⁸⁰¹
820. In addition to the classes of exempt documents in ss 47 and 47G, s 38 of the Freedom of Information Act provides that a document is an exempt document if disclosure of the document, or information in it, is prohibited under a provision of another Act and the provision is listed in Schedule 3 to the Freedom of Information Act. At present, the secrecy provisions in aged care legislation are listed in Schedule 3 to the Freedom of Information Act. Insofar as documents containing 'protected information' are prohibited from disclosure under those secrecy provisions, they are exempt documents.
821. The combined effect of ss 27, 47 and 47G of the Freedom of Information Act strikes the right balance between approved providers' interests in non-disclosure of commercially sensitive information and the public interest in disclosure of information about the affairs of providers. The additional exemption under s 38 tips that balance too far in favour of unjustifiable non-disclosure.
822. The evidence of a number of witnesses before the Royal Commission made good this point.⁸⁰² By way of example, witnesses said that government agencies would refuse a complainant's request for access to an approved provider's written response to the complainant's complaint about the provider because the response contained 'protected information' relating to the affairs of the provider.
823. For these reasons, Schedule 3 of the Freedom of Information Act should be amended to remove the references to aged care legislation.

⁸⁰¹ This applies only where it appears to the decision-maker that the entity might reasonably wish to make such a contention: *Freedom of Information Act 1982* (Cth), s 27(1)(b).

⁸⁰² Transcript, Adelaide Hearing 1, Ian Yates, 11 February 2019 at T56.8–18; Transcript, Brisbane Hearing, Shona Reid, 9 August 2019 at T4764.10–18; T4765.23–43; Exhibit 21-28, Sydney Hearing 5, Provider Governance Tender Bundle, tab 3, RCD.9999.0512.0001 at 0007 [43].

Recommendation 53: New governance standard

53.1. Any governance standard for aged care providers developed by the Australian Commission on Safety and Quality in Health and Aged Care should require every approved provider to:

- a. have members of the governing body who possess between them the mix of skills, experience and knowledge of governance responsibilities, including care governance, required to provide governance over the structures, systems and processes for ensuring the safety and high quality of the care delivered by the provider
- b. have a care governance committee, chaired by a non-executive member with appropriate experience in care provision, to monitor and ensure accountability for the quality of care provided, including clinical care, personal care and services, and supports for daily living
- c. allocate resources and implement mechanisms to support regular feedback from and engagement with people receiving aged care, their representatives, and staff to obtain their views on the quality and safety of the services that are delivered and the way in which they are delivered or could be improved
- d. have a system for receiving and dealing with complaints, including regular reports to the governing body about complaints and containing, among other things, an analysis of the patterns of and underlying reasons for complaints
- e. have effective risk management practices covering care risks as well as financial and other enterprise risks, and give particular consideration to ensuring continuity of care in the event of default by contractors or subcontractors
- f. have a nominated member of the governing body:
 - i. attest annually on behalf of the members of the governing body that they have satisfied themselves that the provider has in place the structures, systems and processes to deliver safe and high quality care, and
 - ii. if such an attestation cannot be given, explain the inability to do so and how it will be remedied.

824. As outlined above, the Australian Commission on Safety and Quality in Health and Aged Care should assume responsibility for setting and reviewing quality and safety standards in the new aged care system.⁸⁰³ One of the matters which we have submitted that the Minister for Aged Care should refer to the Australian Commission on Safety and Quality in Health and Aged Care for urgent ad hoc review is a new governance standard.⁸⁰⁴ Whether the Australian Commission on Safety and Quality in Health and Aged Care conducts such a review and how it might do so are ultimately matters for that independent authority to determine. However, any review directed to a new governance standard should, in our submission, involve consideration of the following matters.

Skills mix of members of an approved provider's governing body

825. The business of an aged care provider is the provision of care to older people who often have complex health care needs. A provider's governing body should include people with experience and expertise in the provision of care.⁸⁰⁵ Without relevant experience and expertise, governing bodies are less able to interpret reports about delivery of care or see signs of potential problems with that care delivery.⁸⁰⁶

826. Aged care regulatory standards do not currently require that the governing body of an approved provider must include members with a range of specific skills relevant to the provision of quality and safe care.⁸⁰⁷

827. The governing body of an approved provider should review the skills of its members annually, identify any skills gaps and develop a plan and a timeframe for filling identified gaps by recruiting new members, if necessary, and developing the skills of existing members. Each member of the governing body should contribute to the annual skills review by identifying gaps in their own knowledge and skills relevant to the discharge of their corporate governance responsibilities.

828. Aged care standards should include a requirement in any governance standard that every approved provider must have members of the governing body who possess between them the mix of skills, experience and knowledge of governance responsibilities, including care governance, required to provide governance over the

⁸⁰³ See submissions on quality and safety above.

⁸⁰⁴ See submissions on quality and safety above.

⁸⁰⁵ See for example: Transcript, Hobart Hearing, Carolyn Cooper, 15 November 2019 at T7129.24–33; Transcript, Hobart Hearing, Ray Groom, 13 November 2019 at T6864.14–28; Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6864.32–43; Submission, AWF.001.04058.0001 at 00026.

⁸⁰⁶ See for example Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6864.32–43, T6867.9–13; Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6864.22–28; Transcript, Darwin Hearing, Donato Smarrelli, 10 July 2019 at T3179.27–3180.9.

⁸⁰⁷ This is different to governance arrangements for some local hospital networks. See *Health Services Act 1997* (NSW), ss 26(3)(a)–(e). In respect of an aged care provider's key personnel, see paragraphs 796 to 811 above. See also *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 63D(3) and (4).

structures, systems and processes for ensuring the safety and high quality of the care delivered by the provider. Any provider without that make-up of members on its governing body should be required to indicate how and by when it intends to remedy that deficiency.

829. Some other requirements for approved providers' governance arrangements which should be the subject of a new governance standard are as follows.
830. First, every governing body should be required to have a care governance committee, chaired by a non-executive member with appropriate experience in care provision, to monitor and ensure accountability for the quality of care provided, including clinical care, personal care and services, and supports for daily living. Such a requirement would be consistent with a recommendation already made by the Australian Government's Aged Care Workforce Strategy Taskforce in its 2018 report that every approved provider should establish an integrated care and clinical governance committee concerned with the provider's delivery of care.⁸⁰⁸
831. For such a requirement to be effective, the role of an approved provider's care governance committee must be understood not just by committee members but across the organisation.⁸⁰⁹ Care governance committee members must be well organised, knowledgeable and engaged if such a committee is to be effective and fulfil its purpose. The committee should have responsibility for ensuring that processes are established and maintained to record, monitor and report relevant information to the board in a systematic way, and that effective mechanisms are in place to take action, whether remedial or proactive or both, upon identification of issues.
832. Secondly, the governance standard should require each approved provider to:
- a. allocate resources and implement mechanisms to support regular feedback from and engagement with people receiving aged care, their representatives, and staff to obtain their views on the quality and safety of the services being delivered and ways of improving the delivery of those services; and
 - b. have a system for receiving and dealing with complaints, including regular reports to the governing body about complaints and containing, among other things, an analysis of the patterns of and underlying reasons for complaints.⁸¹⁰

⁸⁰⁸ Aged Care Workforce Strategy Taskforce, *A Matter of Care Australia's Aged Care Workforce Strategy*, 2018, pp 15, 50, 53, <https://www.health.gov.au/sites/default/files/a-matter-of-care-australia-s-aged-care-workforce-strategy.pdf>, viewed 12 August 2020.

⁸⁰⁹ See A Groves, D Thomson, D McKellar and N Procter, *The Oakden Report: The report of the Oakden Review*, 2017, pp 74–75.

⁸¹⁰ Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, WIT.0006.0001.0001 at 0008 [31]; Exhibit 1-11, Adelaide Hearing 1, Statement of Susan Elderton, WIT.0003.0001.0001 at 0008 [10]; Transcript, Adelaide Hearing 1, Matthew Richter, 20 February 2019 at T526.10–23.

833. People receiving aged care, their representatives and staff must have authentic opportunities to express their views on the quality and safety of the services that are delivered, and to affect the way in which services are delivered. They must also receive timely and satisfactory responses to their feedback. An approved provider should have processes to ensure systemic problems are identified and addressed.
834. Again, while the existing standards presently impose obligations on approved providers to engage with people receiving aged care and others in respect of quality and safety of services, they do not go far enough.⁸¹¹ They do not require the existence of a properly-resourced and fully-implemented feedback system. They do not include any express requirement for providers to engage with workers.⁸¹²
835. Much evidence has been given about the value of complaints for quality of service delivery in aged care.⁸¹³ Complaints have been described as ‘the canaries in the coal mine’.⁸¹⁴ Other evidence referred to complaints as ‘a wonderful thing in terms of quality improvement’.⁸¹⁵
836. The current legislative framework requires that approved providers have mechanisms in place for receiving and dealing with complaints.⁸¹⁶ However, evidence and information before the Royal Commission has suggested that providers often do not manage complaints well, and that in some cases complaints are discouraged.⁸¹⁷ At present, there is no express regulatory requirement that an approved provider’s governing body receive reports on complaints. That is a significant shortcoming. Every provider should implement arrangements to provide its governing body with regular reports on complaints, including an analysis of the patterns of, and underlying reasons for, complaints.⁸¹⁸

⁸¹¹ *Quality of Care Principles 2014* (Cth), Schedule 2, Standards 1(2)(a), 6, Standard 8(3)(a); Aged Care Quality and Safety Commission, *‘Care that is right for me’: A resource for working with aged care consumers*, 2020, p 14.

⁸¹² See *Quality of Care Principles 2014* (Cth), Schedule 2, Standard 8(3)(b).

⁸¹³ See, for example, Transcript, Brisbane Hearing, Graeme Head, 8 August 2019 at T4677.4–9.

⁸¹⁴ Transcript, Brisbane Hearing, Professor Ron Paterson, 7 August 2019 at T4589.44–4590.46.

⁸¹⁵ Transcript, Hobart Hearing, Bethia Wilson, 15 November 2019 at T7105.5–8.

⁸¹⁶ *Aged Care Act 1997* (Cth), s 56-4; *Quality of Care Principles 2014* (Cth), Schedule 2, Standards 6 and 8; *User Rights Principles 2014* (Cth), Schedule 1, item 2(12). See also Aged Care Quality and Safety Commission, *Better Practice Guide to Complaint Handling in Aged Care Services*, 2019, pp 10 and 12.

⁸¹⁷ See, for example: Exhibit 1-1, Adelaide Hearing 1, Statement of Barbara Spriggs, WIT.0025.0001.0001 at 0002 [12]; Exhibit 5-9, Perth Hearing, Statement of Noleen Hausler, WIT.1124.0001.0001 at 0009 [77]; Exhibit 13-22, Hobart Hearing, Statement of Elizabeth Monks, WIT.0558.0001.0001 at 0011 [4eii].

⁸¹⁸ Arrangements of this kind would reflect the clinical governance standard in the National Safety and Quality Health Service Standards developed by the Australian Commission on Safety and Quality in Health Care. See: Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (Second Edition), 2017, pp 7–8; Australian Commission on Safety and Quality in Health Care, *NSQHS Standards (Second Edition) User Guide for Governing Bodies*, 2019, pp 2, 7 and 23–24. See also: R Hislop, *Board governance in*

837. This could well form part of a provider's risk management strategy, which should also be another requirement of any governance standard. In that regard, every approved provider should have effective risk management practices covering care risks as well as financial and other enterprise risks, and should give particular consideration to ensuring continuity of care in the event of default by contractors or subcontractors or other exogenous events, such as bushfires or natural disasters.
838. The existing regulatory standard goes some way towards that end.⁸¹⁹ It does not, however, go far enough. Although it requires that every approved provider should have in place effective risk management systems and practices, it is silent about the way in which effective risk management is to be achieved and demonstrated. Guidance materials prepared by the Aged Care Quality and Safety Commission provide only limited guidance on the practical content of this risk management requirement.⁸²⁰
839. Risk management strategies should encompass the full range of risks involved in operating a business that provides care to vulnerable people, and not just financial risk. The events of this year, including bushfires and the COVID-19 pandemic, have brought the need for risk management strategies into sharp focus.⁸²¹ Risk management strategies should also include measures to identify emerging problems with organisational culture. Regulatory guidance, referred to below, could indicate how providers adopt contemporary risk management strategies.
840. Finally, the governance standard should include a requirement that a nominated member of the governing body must:
- a. attest annually, on behalf of the members of the governing body, that they have satisfied themselves that the approved provider has in place the structures, systems and processes to deliver safe and high quality care; and
 - b. if such an attestation cannot be given, explain the inability to do so and how it will be remedied.⁸²²
841. Governing bodies are too often unaware of, or unresponsive to, emerging and significant risks to the safety and wellbeing of older people receiving care from the provider.⁸²³

the aged care sector, Director Tools: Organisation, 2019, p 7; Exhibit 10-4, Melbourne Hearing 2, Statement of Mary Patetsos, WIT.0437.0001.0001 at 0008 [56].

⁸¹⁹ *Quality of Care Principles 2014* (Cth), Schedule 2, Standard 8(3)(d).

⁸²⁰ Aged Care Quality and Safety Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards*, 2019, pp 182 and 184.

⁸²¹ See, for example, Submission of RSL LifeCare, 31 July 2020, AWF.600.02120.0001.

⁸²² Transcript, Hobart Hearing, Raymond Groom, 13 November 2019 at T6876.21–22 and T6876.43; Transcript, Hobart Hearing, Stephen Shirley, 13 November 2019 at T6877.13–16; Transcript, Hobart Hearing, Cynthia Payne, 14 November 2019 at T7074.37–44.

⁸²³ See, for example, Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 2, pp 314 and 331.

Governing bodies should direct at least equal attention to their role and responsibility for ensuring the delivery of good care to older Australians as to other responsibilities, such as the financial performance of the provider.

842. The governance standard should require that governing bodies take steps to satisfy themselves, and attest – that is, state in writing – that the approved provider has in place the structures, systems and processes to deliver safe and high quality care.⁸²⁴

843. Such a requirement would mirror the requirement already introduced in standards developed by the Australian Commission on Safety and Quality in Health Care for health service organisations.⁸²⁵ In respect of the requirement to give that attestation, Professor Debora Picone AO, Chief Executive Officer of the Australian Commission on Safety and Quality in Health Care, gave evidence that:

This is mandated. It is compulsory. It has been one of our observations, that often in – when there have been failures, the boards will tell you they had no idea these problems were going on, which quite frankly I don't accept on any of the times I've been told that. So we wanted to make safety and quality as important as finance and as general performance. So we now require each member of the governing body to sign an attestation statement to say that they're satisfied that a whole range of issues are in place for safety and quality.⁸²⁶

844. While the regulatory standards specify what an approved provider must achieve, regulatory guidance specifies how these outcomes may be achieved.⁸²⁷ The Aged Care Quality and Safety Commission has published a document entitled *Guidance and Resources for Providers to support the Aged Care Quality Standards*. This document describes:

the intent of the Standards and expectations of performance, along with supporting information, and examples of evidence of compliance...[and] provides an indication of the matters that Aged Care Quality Assessors (quality assessors) consider in assessing compliance.⁸²⁸

845. These guidelines should exemplify good governance practices for the benefit of providers, service users and the wider public. They should demonstrate how compliance with the regulatory standards, including any new governance standard, may be achieved in accordance with contemporary best practice. To that end, they have to

⁸²⁴ Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0029 [144]; Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4778.6–12. See also Australian Commission on Safety and Quality in Health Care, *Fact Sheet 7: Governing Body Attestation Statement*, February 2019, p 1.

⁸²⁵ Australian Commission on Safety and Quality in Health Care, *Fact Sheet 7: Governing Body Attestation Statement*, February 2019, p 1. See also Australian Commission on Safety and Quality in Health Care, *Governing body attestation statement template*, 2019.

⁸²⁶ Transcript, Brisbane Hearing, Debora Picone, 9 August 2019 at T4778.6–12.

⁸²⁷ *Work Health and Safety Act 2011* (Cth), s 275.

⁸²⁸ Aged Care Quality and Safety Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards*, Australian Government, 2019, p 3, https://www.agedcarequality.gov.au/sites/default/files/media/Guidance_%26_Resource_V11.pdf, viewed 10 August 2019.

be reviewed regularly, and updated whenever necessary. They could form the basis of, at some point, a Code of Practice prepared by the regulator.

Recommendation 54: Program of assistance to improve governance arrangements

54.1. The Australian Government should establish an ongoing program commencing in the 2021–22 financial year to provide assistance to approved providers to improve their governance arrangements, including their care governance arrangements.

846. The governing bodies of approved providers vary significantly in their size, expertise and resources. Providers of all sizes and kinds and in all locations can struggle to implement good governance arrangements. In regional and remote areas, providers may face challenges in recruiting members for their governing bodies with the right skills and experience to deliver effective governance of an approved provider.
847. At present, there is Australian Government funding available to providers to improve their operations, including governance arrangements. These initiatives play a valuable role, but they are limited either by the range of providers that they target or the forms of assistance that they fund. The Australian Government should establish an ongoing program to provide assistance to approved providers to improve all aspects of their governance arrangements.
848. Among the formal and informal programs presently available to approved providers to help improve governance arrangements⁸²⁹ are the Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel Program,⁸³⁰ the Business Advisory Service⁸³¹ and the Business Improvement Fund.⁸³² While these programs appear to have produced useful results and be worthwhile, there is no evident need for three separate programs. The Australian Government should establish a single

⁸²⁹ In addition to these programs, providers may access relevant information and resources at no cost through a range of sources, including, for example, from the Australian Care Quality and Safety Commission. See, in this regard, Aged Care Quality and Safety Commission website, *Resource Library*, <https://www.agedcarequality.gov.au/resource-library>, viewed 3 June 2020.

⁸³⁰ Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0037 [144]–[146].

⁸³¹ Submissions of the Commonwealth in response to Submissions of Counsel Assisting, Mudgee Hearing, 4 December 2019, RCD.0012.0044.0002 at 0004–0005 [3.5]–[3.11]; PricewaterhouseCoopers, *Business advisory services for aged care providers*, <https://www.pwc.com.au/health/aged-care-advisory.html>, viewed 25 May 2020.

⁸³² Australian Department of Health, *Business Improvement Fund for residential care*, 2020, <https://www.health.gov.au/initiatives-and-programs/business-improvement-fund-for-residential-care>, viewed 25 May 2020.

ongoing program to provide practical assistance to approved providers to improve any aspect of their governance arrangements, including care governance arrangements.

849. There are presently around 3,000 approved providers of aged care services, but unification of the Commonwealth Home Support Programme and Home Care Packages could as much as double this number. Ongoing indexed annual funding of \$20 million would provide, on average, between \$50,000 and \$100,000 for providers seeking assistance on a rolling twenty year basis.
850. While the assistance should be made available to approved providers of all service types, it might be expected that the body administering the program would prioritise assistance to smaller providers with limited resources. Financially-viable providers with the capacity to obtain similar support through other channels should not receive assistance under this program in normal circumstances. The program should also make special provision to assist approved providers providing aged care services to Aboriginal and Torres Strait Islander people.
851. The body administering the program should also take into account the approved provider's record, capability and capacity to provide quality care. It will be important to ensure that the program does not facilitate undue recourse to and reliance on government intervention.⁸³³ It may therefore be appropriate for the body administering the program to adopt a general rule that providers can only receive assistance under the program twice unless exceptional circumstances exist.
852. The form of assistance offered to providers would be tailored according to the particular needs of each successful applicant. For example, the assistance could take the form of funding for an approved provider to engage an adviser for a certain period who would attend the service in person and offer practical guidance on a provider's governance processes. Such an adviser could be a person with equivalent skills to an eligible adviser appointed under the *Aged Care Quality and Safety Commission Act 2018* (Cth).

Part 3.9 Research and aged care data

853. Paragraph (f) of the Terms of Reference requires and authorises the Royal Commissioners to inquire into 'how best to deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure.'⁸³⁴

⁸³³ Transcript, Mudgee Hearing, David Hallinan, 6 November 2019 at T6566.1–14; Submissions of the Commonwealth in response to Submissions of Counsel Assisting, Mudgee Hearing, 4 December 2019, RCD.0012.0044.0002 at 0007 [3.18].

⁸³⁴ Letters Patent, 6 December 2019, as amended on 13 September 2019, paragraph (f)

854. Throughout the Royal Commission, witnesses have given evidence about aspects of innovation and technology in aged care, most notably in Adelaide Workshop 2.⁸³⁵ The Commissioners have also commissioned and published research about innovation in aged care.⁸³⁶
855. Research, innovation and technology are interrelated concepts. Research can provide an evidence base or highlight a need that might prompt innovation or the development of technology. Applied research can demonstrate the benefits, or otherwise, of innovation or technology. Research, innovation and technology require further attention to ensure the continuous improvement of aged care into the future. Technology may address an identified problem, but innovation may involve re-conceptualising the problem entirely and adopting new approaches.⁸³⁷
856. In this part, we make submissions about the role of research in delivering high quality and safe aged care services, and the importance of quality data for aged care research. We also make submissions about the innovative role data and data collection technology should play in aged care delivery and regulation, building on the submissions that we made to you during Adelaide Hearing 4.

Aged care research

857. The attention that aged care research receives by national research institutions is disproportionately low compared to the number of people accessing aged care services and the multitude of challenges facing the sector.⁸³⁸ There are structural limits in the way of researchers examining ageing and there is a lack of funding for aged care research.⁸³⁹
858. Australia has a number of academic and applied research and development bodies that focus on ageing and aged care. A number have given valuable evidence at the hearings and workshops. We see scope for their efforts to be better coordinated and funded to build the capacity of researchers and their aged care sector partners, and to provide the best outcomes for people who access aged care services.

⁸³⁵ See for example: Transcript, Adelaide Hearing 1, Craig Gear, 12 February 2020 at T140.45–141.7; Transcript, Adelaide Hearing 1, Edward Strivens, 12 February 2020 at T216.23–42; Transcript, Adelaide Hearing 1, Deborah Parker, 13 February 2020 at T238.37 – 239.20; Transcript, Adelaide Hearing 2, Tony Bartone, 20 February 2020 at T559.6 – 37; Transcript, Perth Hearing Dale Fisher, T2565.27 – 2566.9; Transcript, Darwin and Cairns Hearing, Natasha Chadwick, T3757.1 – 22; Transcript, Melbourne Hearing 2, David Panter, 10 October 2020 at T5650.27 – 5651.44; Transcript, Adelaide Workshop 2, 16 March 2020 at T7934 – 7961.

⁸³⁶ Flinders University, *Review of Innovative Models of Aged Care*, A research paper for the Royal Commission into Aged Care Quality and Safety, 2020.

⁸³⁷ For discussion see: Transcript, Adelaide Workshop 2, Daniella Greenwood, 16 March 2020 at T7955.6–39.

⁸³⁸ Transcript, Adelaide Workshop 2, Steven Wesselingh, 17 March 2020 at T8077.21-26; T8078.33-40.

⁸³⁹ Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020, T8079.38–T8080.4.

859. However, without significant investment in research and the development of a coherent and comprehensive evidence base, aged care policy will continue to be ‘kneejerk responses to try and solve problems when they become critical’.⁸⁴⁰

860. To contribute to a sustainable high quality and safe aged care system, we propose that a new Aged Care Research Council be established.

Funding and the National Health and Medical Research Council

861. There are four main sources of funding for aged care research in Australia: two dementia-specific funds, a health and medical research fund and another fund which covers every field of research other than health and medical research.⁸⁴¹ However, there is no dedicated funding source in Australia for research concerning aged care quality and safety.

862. Witnesses have explained that research, evaluation and quality assurance projects which explore the quality and safety of aged care models and practices do not attract much research funding.⁸⁴² Professor Steven Wesselingh, Chair of the National Health and Medical Research Council, said that while a large amount of money has been allocated to projects relevant to the health or clinical aspects of ageing, comparatively less is allocated to projects addressing issues of aged care quality and safety. He said:

In the last 10 years, in terms of aged care and the quality of aged care, NHMRC [National Health and Medical Research Council] has spent about \$86 million over 10 years. In contrast, in neurological disease we have spent \$1.8 billion. So working hard on neurological disease, that's all part of aged care, you know, Parkinson's disease, dementia, etcetera, so really good research. The actual questions about aged care quality and safety that you are addressing have received relatively little funding.⁸⁴³

863. The National Health and Medical Research Council is a peak funding body for medical research, and the peak peer review body in the country. Professor Wesselingh said that the National Health and Medical Research Council has tended to allocate funding on the basis of investigator-driven, rather than priority-driven, research.⁸⁴⁴

864. Associate Professor Briony Dow, Director of the National Ageing Research Institute, explained that in contrast, ‘co-design type work’ which is outcomes focused, is ‘not the type of research that lends itself to higher level academic publications’. She said that an unavoidable effect of adopting the co-design process with end users is that you do not have ultimate control over your research design. She also explained that if you are

⁸⁴⁰ Transcript, Adelaide Workshop 2, Alison Kitson, 17 March 2020, T8075.36–41.

⁸⁴¹ Dementia and Aged Care Services Fund, the Boosting Dementia Research Initiative, the Australian Research Council and the Medical Research Future Fund.

⁸⁴² Exhibit 6-22, Darwin Hearing, Statement of Johanna Westbrook, WIT0196.0001.0001 at 0003 [10]; 0016 [62].

⁸⁴³ Transcript, Adelaide Workshop 2, Steve Wesselingh, 17 March 2020 at T8077.17-22.

⁸⁴⁴ Transcript, Adelaide Workshop 2, Steve Wesselingh, 17 March 2020 at T8076.46-T8077.2.

researching for quality of care or quality of life outcomes, they are not capable of being flawlessly measured, as compared to, for example, blood pressure which is capable of objective measurement.⁸⁴⁵

865. Professor Alison Kitson, from the Caring Futures Institute at Flinders University, said that a broader view of what constitutes valuable research is needed. She suggested that research should be transdisciplinary to recognise that clinical interventions are not the only things that improve the quality of life.⁸⁴⁶
866. Professor Wesselingh suggested that what was needed was not a new funding body, nor a new peer review body, but a more strategic view of aged care research. He said that if there was a strategically directed initiative into issues around ageing and aged care, the National Health and Medical Research Committee would be able to take that on and achieve high quality outcomes.⁸⁴⁷ Some witnesses were unsure whether the National Health and Medical Research Council was best placed to administer the funding, with Dr Judy Lowthian, Head of Research at Bolton Clarke, noting that the peer review process was high quality, but not necessarily effective for aged care research.⁸⁴⁸
867. Given the particular needs of the aged care sector in terms of research, a new Aged Care Research Council is our recommended approach. The new Council should set the national research and development strategy and agenda for aged care and ageing related health conditions. The Aged Care Research Council will be able to encourage co-designed, applied and non-clinical ageing and aged care research.
868. The Aged Care Research Council should work with the National Health and Medical Research Council to facilitate the sharing and application of research outcomes with policy makers, research bodies, health care bodies, approved providers and the community. The new Aged Care Research Council should ensure that research into ageing-related health conditions is high on the national research agenda for the National Health and Medical Research Council.
869. We propose that the Aged Care Research Council will administer an aged care research fund with a budget, funded by a special appropriation, of 1.8% of the total government expenditure on aged care.

Translation of research into practice – applied research

870. Research activities relevant aged care services are of little value unless they lead to practical solutions that help to deliver high quality and safe care. According to Associate Professor Dow there is a great deal of evidence regarding models of care, appropriate

⁸⁴⁵ Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8080.4-27.

⁸⁴⁶ Transcript, Adelaide Workshop 2, Alison Kitson, 17 March 2020 at T8084.10-15.

⁸⁴⁷ Transcript, Adelaide Workshop 2, Steven Wesselingh, 17 March 2020 at T8076.43-8077.26.

⁸⁴⁸ Transcript, Adelaide Workshop 2, Judy Lowthian, 17 March 2020 at T8083.23-30.

care environments and workforce training needs relating to aged care. However, much of this evidence is either not known or not adopted by the aged care sector. Associate Professor Dow's opinion is that a centre devoted to translating this research into practice could contribute greatly to improving aged care in Australia.⁸⁴⁹

871. The 2018 report of the Aged Care Workforce Strategy Taskforce noted that, despite the number of existing research bodies and funding sources, the aged care sector is slow to adopt research. The Taskforce attributed this to the absence of a 'research translation pipeline' and said that this 'discourages government and private sector investment'.⁸⁵⁰
872. The Bolton Clarke Research Institute expressed a similar view.⁸⁵¹
873. Aged care research should focus on outcomes, with priorities driven by the aged care sector.⁸⁵² As Dr Robert Grenfell, of the Commonwealth Scientific and Industrial Research Organisation said, the research should be for actually solving the problems that need to be solved.⁸⁵³
874. Strategic Action 12 of the 2018 Taskforce report proposed the creation of an aged care Centre for Growth and Translational Research to accelerate research development and translation for the aged care sector.⁸⁵⁴ In 2019, the Australian Government committed \$34 million to establish the Centre.⁸⁵⁵ On 18 May 2020, it published a request for a proposal 'to co-design an effective operational model for the Centre for Growth and Translational Research'.⁸⁵⁶ After an open tender process, in October 2020, the Australian Government awarded a contract to Flinders University to establish the model for the Centre and set the research priorities for the first year of operation. The Australian Government intends to seek a consortia that will establish and operate the Centre from early 2021.⁸⁵⁷
875. The establishment of a Centre for Growth and Translational Research, like so much in aged care, has been too slow. An Aged Care Research Council with a broader focus as described in these submissions is needed to contribute to the delivery of high quality and

⁸⁴⁹ Exhibit 11-50, Melbourne Hearing 3, Statement of Frances Briony Dow, WIT.0509.0001.0001 at 0016 [55].

⁸⁵⁰ Exhibit 11-1, Melbourne Hearing 3, General Tender Bundle tab 205, A Matter of Care, Aged Care Workforce Strategy Report, ACW.9999.0001.0022 at 0113.

⁸⁵¹ Submission, Bolton Clarke Research Institute, AWF.001.05400.00_0001 at 0004-0005.

⁸⁵² Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8081.9-10.

⁸⁵³ Transcript, Adelaide Workshop 2, Rob Grenfell, 16 March 2020 at T7996.29-31.

⁸⁵⁴ Exhibit 11-1, Melbourne Hearing 3, general tender bundle tab 205, A Matter of Care, Aged Care Workforce Strategy Report, ACW.9999.0001.0022 at 0045.

⁸⁵⁵ Ministerial Submission from Department of Health to the Minister for Aged Care and Senior Australians and the Minister for Health, CTH.0001.1001.7729 at 7730. [To be tendered]

⁸⁵⁶ AusTenders, *Procurement of Services to Develop a Model: State 1, Aged Care Centre for Growth and Translational Research (CGTR), 2020*, <https://www.tenders.gov.au/Atm/ShowClosed/>, 20 October 2020.

⁸⁵⁷ <https://www.health.gov.au/ministers/senator-the-hon-richard-colbeck/media/aged-care-research-centre-to-draw-on-worlds-best-practice>, viewed 19 October 2020.

safe care for our future aged care system. If the Council is established, and other recommendations we propose are adopted such as the enhanced arrangements for workforce planning, it will be unnecessary to proceed with a separate Centre for Growth and Translational Research.

876. We consider it encouraging that the Australian Government recently indicated its support, in principle, for the establishment by it of a body with responsibility for aged care research.⁸⁵⁸

Co-design, collaboration and diversity

877. The Aged Care Research Council should consider the interests of 'service providers...clinicians, researchers, educators, government, consumer advocacy groups, community members and perhaps different funders like philanthropic or private donors'.⁸⁵⁹

878. Researchers should work collaboratively with existing research bodies, State and Territory Governments, local government, local training and education providers, pharmaceutical device developers and aged care providers. The Aged Care Research Council should work with health and aged care research translation bodies affiliated with the National Health and Medical Research Council to share research findings and information about innovation developments relevant to the aged care sector.

879. The Aged Care Research Council will assist in setting industry-driven priorities and priorities that are set by the needs of older people who will benefit from that research.⁸⁶⁰ It is important that the older person's voice is heard in determining priorities.⁸⁶¹

880. By prioritising research that involves co-design with older people, their families, aged care providers and the aged care workforce, the work of the Aged Care Research Council will help to develop a focus on care delivery that is personal and relationship based. Involving stakeholders right at the beginning is the most important factor for success.⁸⁶² Priorities need to be set by the end users, and then the role of researchers should be how to best carry out that research.⁸⁶³

⁸⁵⁸ Australian Government response to the Senate Community Affairs Committee report for the Inquiry into the effectiveness of the aged care quality assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practiced, June 2020. (<https://www.health.gov.au/sites/default/files/documents/2020/06/effectiveness-of-the-aged-care-quality-assessment-and-accreditation-framework.pdf> viewed 20 October 2020).

⁸⁵⁹ Transcript, Adelaide Workshop 2, Judy Lowthian, 17 March 2020 at T8083.18-19, 11-14.

⁸⁶⁰ Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020, T8080.31-36.

⁸⁶¹ Transcript, Adelaide 2 Workshop, Sue Gordon, 16 March 2020, T7951.1-7

⁸⁶² Transcript, Adelaide Workshop 2, Alison Kitson, 17 March 2020 at T8071.36-38.

⁸⁶³ Transcript, Adelaide Workshop 2, Briony Dow, 17 March 2020 at T8080.35-38.

Need for evaluation

881. A large scale review about innovative aged care models revealed that little work is done to evaluate their safety and effectiveness.⁸⁶⁴ This review identified a number of approaches to providing aged care for people in the community and in residential care, both in Australia and internationally. Most innovative models of care have not been rigorously evaluated, and evidence of their effectiveness at improving care recipients' outcomes is limited.⁸⁶⁵
882. The authors of a 2017 review of technological developments relevant to ageing and aged care noted that evaluations of technological interventions were generally of poor quality and that this limits understanding about their usefulness for older people.⁸⁶⁶
883. We submit that any research proposals must incorporate, and be funded for, rigorous evaluation.

Recommendation 55: Dedicated Research Council

55.1. By 1 July 2022, the Australian Government should establish and fund a dedicated Aged Care Research Council to:

- a. set the strategy and agenda for research and development into aged care and ageing related health conditions
- b. administer an aged care and ageing related health conditions research fund with an annual budget, funded by a special appropriation, of 1.8% of the total government expenditure on aged care
- c. conduct peer review of projects to determine funding allocations
- d. prioritise research that involves co-design with older people, their families and the aged care workforce
- e. facilitate networks between research bodies, academics, industry and government for research, technology pilots and innovation projects, and assist with the translation of research into practice to improve aged care in Australia

⁸⁶⁴ Flinders University, *Review of Innovative Models of Aged Care*, A research paper for the Royal Commission into Aged Care Quality and Safety, 2020.

⁸⁶⁵ SM Dyer et al, 'Review of Innovative Models of Aged Care: Report prepared for the Royal Commission into Aged Care Quality and Safety', 2019, Flinders University, p vi.

⁸⁶⁶ K Barnett et al, 'Developing a Technology Roadmap for the Australian Aged Care Sector: Literature Review', 2017, Medical Device Research Institute, Flinders University and Aged Care Industry Information Technology Council, p 14.

- f. work with the Australian Research Council, the National Health and Medical Research Council, and health and research networks to facilitate the sharing and application of research outcomes with policy makers, research bodies, health care bodies, approved providers and the community
- g. ensure that research into ageing-related health conditions is high on the national research agenda including for the Australian Research Council and the National Health and Medical Research Council.

Aged care data

884. In our submissions on future program redesign, at Adelaide Hearing 4 on 4 March 2020, we submitted that the Australian Government should implement a standardised data collection program designed on the principle of ‘collect once, use many times’.⁸⁶⁷ We submitted that care outcomes data, quality of life data and data on needs were required.⁸⁶⁸ The development and maintenance of new Quality Standards and Quality Indicators, as outlined earlier in these submissions will assist.

885. Of the 27 submissions received in response to our March submissions, those which addressed the topic of data collection and analysis were strongly supportive of the implementation of standardised data collection and the ‘collect once, use many times’ principle.⁸⁶⁹ SA Health and Opal Specialist Aged Care acknowledged that ‘good data collection is fundamental to setting a solid foundation for monitoring the performance of the system, its interfaces and to inform future reform’ and that ‘quality of life data should be collected and used to improve the quality of life of people in care’.⁸⁷⁰

886. The Australian Government acknowledged that improved data analysis may help improve understanding of older Australian’s access to health care, and that there are opportunities to collect more information and conduct more analysis across datasets, agencies and jurisdictions.⁸⁷¹ Other submissions highlighted barriers that currently exist

⁸⁶⁷ Submissions of Counsel Assisting, Adelaide Hearing 4, 4 March 2020, RCD.0012.0062.0001 at 0070.

⁸⁶⁸ Submissions of Counsel Assisting, Adelaide Hearing 4, 4 March 2020, RCD.0012.0062.0001 at 0070.

⁸⁶⁹ Submission of SA Health, Adelaide Hearing 4, AWF.665.00025.0002 at 0009; Submission of Opal Specialist Aged Care, Adelaide Hearing 4, 18 March 2020, AWF.665.00013.0001 at 0005; Submission of Australian Nursing and Midwifery Federation, Adelaide Hearing 4, AWF.665.00020.0001 at 0021.

⁸⁷⁰ Submission of SA Health, Adelaide Hearing 4, AWF.665.00025.0002 at 0009; Submission of Opal Specialist Aged Care, Adelaide Hearing 4, 18 March 2020, AWF.665.00013.0001 at 0005.

⁸⁷¹ Submission of the Commonwealth of Australia, Adelaide Hearing 4, 22 April 2020, AWF.00024.0002 at 0018 [3.82].

in achieving effective data collection, including a lack of interoperability across the whole health sector as current data is not consistently captured across jurisdictions.⁸⁷² Aged Care Crisis cautioned against placing reliance on 'self-reported data as it is commonly skewed'.⁸⁷³ It was submitted that data should be publicly reported to improve transparency and enable choice; and linkages between data sets and collection protocols should be strengthened to enable research and development into best practice and service improvement.⁸⁷⁴

887. Importantly, it was submitted that data collection and reporting are one element of an approved provider's 'cost of compliance' and that costs of data collection should be considered when addressing the future cost of provision of providing aged care services.⁸⁷⁵
888. We propose that centralising and harmonising the functions of aged care in the new Australian Aged Care Commission will go some way to achieving the 'collect once, use many times' goal. Ensuring Information and Communications Technology connectivity and interoperability of the Australian Aged Care Commission's data and data systems with those of organisations such as the Department of Health and the Australian Commission on Quality and Safety in Health and Aged Care will be vital. This principle should be actively pursued by the Australian Aged Care Commission as part of its system governance role
889. It is not enough that data simply exists within the system. A central pillar of an aged care system in which government, approved providers and most importantly the public can have confidence, is high quality, reliable, consistent, up-to-date, and accessible data. Data about aged care is vitally important to aged care research and innovation as it means that researchers have access to greater information than they otherwise would have were they to gather the data themselves. Data provides a head-start to any researcher and better access to and information about the aged care system is likely to

⁸⁷² Submission of Opal Specialist Aged Care, Adelaide Hearing 4, 18 March 2020, AWF.665.00013.0001 at 0005; Submission of Allied Health Professions Australia, Adelaide Hearing 4, March 2020 AWF.665.0023.0001 at 0010; Submission of SA Health, Adelaide Hearing 4, AWF.665.00025.0002 at 0010.

⁸⁷³ Submission of Aged Care Crisis, Adelaide Hearing 4, 18 March 2020, AWF.665.00018.0001 at 0023.

⁸⁷⁴ Submission of Opal Specialist Aged Care, Adelaide Hearing 4, 18 March 2020, AWF.665.00013.0001 at 0005; Submission of UnitingCare Australia, Adelaide Hearing 4, March 2020, AWF.665.00015.0001 at 0021.

⁸⁷⁵ Submission of UnitingCare Australia, Adelaide Hearing 4, March 2020, AWF.665.00015.0001 at 0021; Submission of City of Whittlesea, Adelaide Hearing 4, 24 March 2020, AWF.665.00021.0001 at 0002.

assist many researchers. Data and research based on reliable data are fundamental to informing policy development and the identification of need within the aged care system.

890. As evidence from the hearings and workshops of this Royal Commission shows, there are few datasets available to researchers about a person's experience of being in care.⁸⁷⁶ It can take years for researchers to access data even though it is collected annually. It can be costly to access data.⁸⁷⁷ The Department of Health has acknowledged that there are deficiencies in information sharing between the Department of Health and the Aged Care Quality and Safety Commission which can impact on the effective performance of their regulatory role.⁸⁷⁸ These deficiencies likely persist even after the transfer of compliance and approval functions to the Commission at the beginning of 2020. A lack of comprehensive knowledge about the system means the basis for aged care policy reform will be opaque in many respects.
891. We propose the development of an aged care national minimum dataset which will provide the essential data necessary for research and policy development in aged care.
892. Ms Louise York of the Australian Institute of Health and Welfare said that a minimum dataset should be the 'core number of data elements that are captured as a by-product of the activity that's going on for clinical or other transactional purposes'. She explained that the data should be useful for looking at both the individual service provider level and the system level, and said that a lot of that data is in the system at the moment however 'it just needs to be more timely and linked more regularly to get a better picture'.⁸⁷⁹
893. Ms York told us that 'there's great potential of linked up data to provide information about the risks that are being experienced [by people using aged care]'. She considered that hospitalisations, prescribing rates, complaints and accreditation status could be linked and would be 'much more valuable and meaningful if it could be risk adjusted for the profile of the people using those services' through regular assessment and assignment to classification levels. She explained 'that sort of information could conceivably be linked in to provide more information about the quality at the service level'.⁸⁸⁰ Associate Professor Maria Inacio of the Registry of Senior Australians agreed that compliance and accreditation information would be incredibly valuable in the future to understand [the] performance of facilities.⁸⁸¹

⁸⁷⁶ Transcript, Adelaide Workshop 2, Alison Kitson, 17 March 2020, T8084.23–26.

⁸⁷⁷ Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020, T7988.33–7989.5.

⁸⁷⁸ Submissions of the Commonwealth of Australia, Brisbane Hearing, Earle Haven Case Study, 4 September 2019, RCD.0012.0028.0024 at 0025 [2]; Exhibit 8-32, Brisbane Hearing, Statement of Amy Laffan, WIT.0282.0001.0001 at 0006–0007 at [37]–[41].

⁸⁷⁹ Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7981.1–7.

⁸⁸⁰ Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7977.43–45; T7982.36–43.

⁸⁸¹ Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7978.17–19.

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

work with clinicians, policy makers, academics, people involved, consumers, customers, older people and potentially the ICT sector, workforce, to work through... what they want to know, what’s already available and then how we would go through the painstaking work of working out how to actually isolate those core pieces of information that need to be collected to really get that regular measurement over time of what we’re trying to achieve.⁸⁸²

895. The Australian Institute of Health and Welfare currently collects and publishes national minimum datasets for the community services sector, the health sector and housing and homelessness services. The Institute should also perform this technical role for an aged care national minimum dataset.

896. Ms Louise York emphasised the importance of separating curation and governance.⁸⁸³ Dr Grenfell referred to ‘curation’ tasks as including linking data and making it available and searchable to users.⁸⁸⁴

897. Ms York stated that the Australian Institute of Health and Welfare does not currently have the resources to curate a mandatory aged care minimum dataset including existing datasets, workforce and quality of life. However, it has a model which can build on what it already does, and can scale that up to include additional data sources.⁸⁸⁵

898. To support this function it will need powers to collect the elements of the minimum dataset in a timely manner and sufficient funding to curate and publish the dataset. We consider that neither the collection nor the funding for the aged care minimum dataset should be the subject of discretionary decisions within government and should be made mandatory through legislative amendment and annual appropriation from the Budget.

899. Dr Grenfell proposed that while the Australian Institute of Health and Welfare should be responsible for data curation, data governance needed to sit with an independent entity.⁸⁸⁶ The new Australian Aged Care Commission should have the primary responsibility for governing and delivering quality and comprehensive aged care data. Control of such data means that the Commission can maintain control of the aged care system.

900. It is important that approved providers, aged care workers and consumers understand the value of data and are engaged in its collection. Associate Professor Maria Inacio of the Registry of Senior Australians explained that in order to collect enough information

⁸⁸² Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7987.26–35.

⁸⁸³ Transcript, Melbourne Workshop 2, Louise York, 16 March 2020 at T7999.20–26.

⁸⁸⁴ Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7979.37–39.

⁸⁸⁵ Transcript, Adelaide Workshop 2, Louise York, 16 March 2020 at T7999.43–44.

⁸⁸⁶ Transcript, Melbourne Workshop 2, Robert Grenfell, 16 March 2020 at T7996.17–27.

to understand what is happening and draw inferences about how to improve what's going to happen in the future, there has to be partnership between the regulators and the providers.⁸⁸⁷

901. Dr Rob Grenfell emphasised that there are multiple facets to a minimum dataset in terms of what each person engaged with the dataset may want from it and what the dataset actually delivers. For the client or the engaged participant, they have to understand what they will 'get from it by allowing their data to be collected'.⁸⁸⁸
902. The development of an aged care national minimum dataset will serve purposes beyond the immediate needs of the Australian Aged Care Commission. Other national minimum datasets established by National Agreement are governed by 'Managements Groups'.⁸⁸⁹ A similar management group chaired by the Australian Aged Care Commission should establish an aged care national minimum dataset. The management group should be comprised at a minimum of some of the relevant custodians of aged care data: the Australian Bureau of Statistics, the National Health and Medical Research Council and/or the Aged Care Research Council, and the Quality Standards and Quality Indicator setting body - the Australian Commission on Quality and Safety in Health and Aged Care. This management group should consult with stakeholders in aged care, including approved providers, people receiving care and researchers, to ensure that the aged care national minimum dataset is fit for purpose.
903. Ensuring the quality and consistency of data in the aged care national minimum dataset will require consistent definitions of terms. In the future, an important task for aged care data management is establishing a 'common language' for aged care data. Attention should be paid to the intersection between aged care and health care and the importance of common terms to enable the systems to communicate. This will require the standardisation of data throughout the aged care system while ensuring compatibility with the health care sector. The Australian Government announced the 'Aged Care Data Compare' project in June 2020 which is looking at this issue. The Australian Aged Care Commission should work with the Department of Health on the management of this project in the future.
904. Overall data management, planning and leadership must sit with the system governor, the new Australian Aged Care Commission. This will include overseeing the development of information and communication technologies (ICT) infrastructure to ensure the effective and secure use of data throughout the system, and considering

⁸⁸⁷ Transcript, Adelaide Workshop 2, Maria Inacio, 16 March 2020 at T7997.36-39.

⁸⁸⁸ Transcript, Adelaide Workshop 2, Robert Grenfell, 16 March 2020 at T7981.19-27.

⁸⁸⁹ See for example the National Health Information Agreement, 2013.

solutions or to reduce the administrative burden of data collection through the use of ICT and software solutions.

905. The Australian Institute of Health and Welfare should be given responsibility for the technical role of curation and publication of the aged care national minimum dataset consistent with its expertise and curation and publication of other national minimum datasets. This will involve collecting the data identified by the management group for inclusion from Australian Government and State and Territory data custodians and approved providers. The task will require the cleaning and linking of all the sources of data according to the dataset specifications and publishing the final data making it accessible to researchers and the general public at least annually or half-yearly. More regular publication of certain dataset elements may be appropriate in some cases.
906. The *Australian Institute of Health and Welfare Act 1987*, (Cth) and likely other Acts, will require legislative amendment, to ensure that the Australian Institute of Health and Welfare has the powers and responsibility to collect and publish this dataset regularly. This will require Australian Government support, particularly to arrange agreements with States and Territories for their data identified by the management group to be relevant to the aged care minimum dataset. Any provisions relating to protection or disclosure of data in the new Act will also need to be drafted with the importance of the aged care national minimum dataset in mind.
907. A further significant part of legislative amendment to support the dataset will involve ensuring that aged care data receive its due attention within the Australian Institute of Health and Welfare. This will include legislating an annual appropriation specific to aged care data sufficient for the curation and publication of an aged care national minimum dataset, publication of related data for public education, and meeting the further data needs of the Australian Aged Care Commission. It may be necessary to legislate internal governance arrangements including a dedicated Ethics Committee and/or other management committee to meet the increased work load and expectations.
908. Finally the role of the Australian Institute of Health and Welfare will involve the accreditation of software for use in the aged care system. The Institute already performs this role for the Specialist Homelessness Services Collection. The Institute will accredit aged care software systems for consistency with the aged care national minimum dataset to ensure that data collected from approved providers meets the data specifications of the aged care national minimum dataset. The Institute should perform the same function or fulfil a consultation role for government software systems.

Recommendation 56: Data governance and an aged care national minimum dataset

56.1. The Australian Government should establish the framework to enable the Australian Aged Care Commission to effectively take leadership of and responsibility for aged care data on and from 1 July 2023. This will require the Australian Government to:

- a. establish a 'management group' to develop an outcomes framework for an aged care national minimum dataset
- b. develop data sharing agreements, in accordance with any relevant legislation, and under agreements with the States and Territories, to support timely access to and linkage of data for the aged care national dataset and quality indicators
- c. ensure that legislative hurdles to the Australian Institute of Health and Welfare obtaining aged care national minimum dataset elements are removed and the collection is timely and mandatory
- d. ensure the Australian Institute of Health and Welfare Authority is funded to curate and regularly publish an aged care national minimum dataset through an unconditional annual appropriation from the Federal Budget adequate to perform the curation and publication of the dataset and publish aged care data for public education through the GEN website.

56.2. The Australian Aged Care Commission's aged care data functions will involve:

- a. chairing the 'management group' to develop an outcomes framework for an aged care national minimum dataset, including ensuring that relevant stakeholders are consulted
- b. overseeing the development of a common language and standardisation of aged care data, including consideration of interoperability with the health care sector
- c. facilitating the development of software for use by approved providers, to be accredited by the Australian Institute of Health and Welfare for collection of aged care national minimum dataset elements and quality indicator data and incorporating compliance with the Aged Care Quality Standards
- d. facilitating the development of software and ICT systems to enable automatic reporting by approved providers on mandatory reporting

obligations, quality indicators, prudential arrangements and other responsibilities

- e. establishing arrangements consistent with the 'collect once, use many times' principle, including:
 - i. ICT interoperability arrangements between the Australian Aged Care Commission and the Australian Commission on Safety and Quality in Health and Aged Care to enable the sharing of data relevant to the functions of both organisations
 - ii. ensuring administrative data relevant to approved providers, such as assessment data, is made available to providers, and
 - iii. ensuring a mechanism exists for approved providers to effectively and securely transfer information about a consumer when the consumer changes service providers.

56.3. The *Australian Institute of Health and Welfare Act 1987* (Cth), and other legislation as required, should be amended as necessary to achieve the objectives of this recommendation. This should include ensuring the Institute has the powers and responsibilities necessary to undertake the curation and publication of the aged care national minimum dataset.

56.4. The Australian Institute of Health and Welfare should accredit software used by approved providers and, where relevant, data custodians assessed as compatible with the dataset specifications of the aged care national minimum dataset.

Part 3.10 Aged care accommodation

909. Where people live affects how people live. Accommodation that is well designed to meet people's needs, both now and into the future, can improve their quality of life. But people's needs change over their lives. Ideally, people should plan ahead for those changes. Often they do not.
910. People's accommodation should, where possible, cater to their changing needs. Accommodation with accessible and dementia-friendly design features will remain more suitable for people as they experience the consequences of age-related conditions. If people live in accommodation conveniently located closer to shops and other amenities, they will be more capable of maintaining social engagement with a local community as they grow older.
911. By planning ahead, people give themselves the best chance of growing old at home and, if they so choose, dying there. Planning ahead means that a person experiencing a major life event, such as serious illness or injury, may not be compelled, at short notice and great emotional and financial cost, to leave a longstanding and cherished home and move into other accommodation. It means that a person may be able to receive aged care services at home.
912. The Royal Commission is authorised, by paragraph (c) of the Terms of Reference, to inquire into 'the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia, including ... in the context of changing demographics and preferences, particularly people's desire to remain living at home as they age'.⁸⁹⁰ That inquiry has extended to matters affecting but going beyond the delivery of aged care services.⁸⁹¹
913. As acknowledged in the Terms of Reference, most older people in Australia want to remain at home as they age.⁸⁹² Around 1.3 million people received aged care services last year. Around one in every six of those people lived in residential aged care. Most people received aged care services in their homes.⁸⁹³
914. Across Australia, there is a need to improve access to accommodation in which people can grow older and, as necessary, receive aged care services. That is so whether the accommodation is owner-occupied, privately rented, social and affordable housing, or

⁸⁹⁰ See Letters Patent dated 6 December 2018. See also paragraphs (b) and (f) of the Terms of Reference.

⁸⁹¹ See Letters Patent dated 6 December 2018, paragraph (g).

⁸⁹² Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 9, RCD.9999.0410.0253 at 0347; Exhibit 2-86, Adelaide Hearing 2, Statement of Hjalmar Swerissen, WIT.0085.0001.0001 at 0003 [14]; Exhibit 1-9, Adelaide Hearing 1, Statement of Paul Verstegee, WIT.0009.0001.0001 at 0005 [28]–[29].

⁸⁹³ Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 7, CTH.1000.0004.9017 at 9043.

residential aged care. Older people living in unsuitable housing face greater risk of falls, injury and immobility and the prospect of unanticipated entry into residential aged care.⁸⁹⁴

915. The majority of older people in Australia own their own homes or are paying them off.⁸⁹⁵ Barriers to adoption of innovative, well-designed housing models and downsizing should be reduced.⁸⁹⁶ It is likely that, in future, fewer older people will be home owners and more of them will be private renters with less ability to obtain home modifications.⁸⁹⁷ Measures to increase the supply of accessible private rental housing, such as government-funded occupancy supplements and planning concessions, should be explored.⁸⁹⁸ Some older people depend upon social and affordable housing, the supply of which has historically not met demand.⁸⁹⁹ The design of much existing social and affordable housing does not conform to accessibility standards.⁹⁰⁰ More investment in and construction of well-designed, age-appropriate social and affordable housing is required.⁹⁰¹ It will help to prevent people having to move into residential aged care prematurely to access accommodation suitable for their care needs.
916. Overall, there is a need for coordinated intergovernmental policy, planning and action relating to housing and accommodation for Australia's ageing population.⁹⁰² As a matter of priority, governments should work together to increase accessible housing, including private rental housing and social and affordable housing. Given the focus of the Terms

⁸⁹⁴ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 23b, RCD.9999.0408.0153 at 0186; Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8781.1–6.

⁸⁹⁵ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 9, RCD.9999.0410.0253 at 0348. See also Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 4 RCD.9999.0444.0001 at 0028.

⁸⁹⁶ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 5, RCD.9999.0398.0001 at 0003 and 0007; Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8744.10-32. See also National Ageing Research Institute, *Models of Integrated Care, Health and Housing – report prepared for the Royal Commission into Aged Care Quality and Safety*, July 2020, p viii.

⁸⁹⁷ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 26, RCD.9999.0398.0122 at 0218–0219; Transcript, Adelaide Workshop 1, David Panter, 11 February 2020 at T7759.46–7760.3.

⁸⁹⁸ See, for example: Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8750.4–8751.4; Transcript, Sydney Hearing 3, Peta Harwood, 14 August 2020 at T8748.36-42 and T8751.29–36; Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8751.41–45; Exhibit 19-4, Sydney Hearing 3, Statement of Natasha Bowers, RCD.9999.0441.0001 at 0002–0003 [13]–[14], 0010 [32]–[36] and 0012 [43].

⁸⁹⁹ Exhibit 19-5, Sydney Hearing 3, Statement of David Larmour, RCD.9999.0400.0001 at 0003; Transcript, Sydney Hearing 3, David Larmour, 14 August 2020 at T8760.13–8761.8. See also: Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8740.35–8741.2; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 9, RCD.9999.0410.0253 at 0306.

⁹⁰⁰ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 23b, RCD.9999.0408.00153 at 0193.

⁹⁰¹ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 23b, RCD.9999.0408.00153 at 0195, 0204–0205; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 24, RCD.9999.0409.0472 at 0607, 0674–0675; Transcript, Adelaide Hearing 1, Claerwen Little, 20 February 2019 at T493.1–8.

⁹⁰² Transcript, Sydney Hearing 3, Peta Harwood, 14 August 2020 at T8741.27–8742.1; Transcript, Sydney Hearing 3, Simon Schrapel, 14 August 2020 at T8740.15; Transcript, Sydney Hearing 3, Brendon Radford, 14 August 2020 at T8742.14.

of Reference on the delivery of aged care services, however, these general accommodation issues are not the subject of any particular proposed recommendations.

917. The proposed recommendations in the submissions below are specifically directed to design of residential aged care buildings. The design of those buildings must of course be accompanied by an effective model of care delivery to ensure safe and high quality care for aged care residents.⁹⁰³ Other submissions, including submissions on quality and safety of care and workforce and training, are relevant in this regard.
918. Principles of accessible and dementia-friendly design should now be the expected norm for new or substantially refurbished residential aged care buildings.⁹⁰⁴ Residential aged care services should also transition from institutional settings to smaller, lower density congregate living arrangements integrated in a local community.⁹⁰⁵

Recommendation 57: Improving the design of aged care accommodation

57.1. The Australian Government should guide the design of more appropriate residential aged care accommodation for older people by:

- a. developing and publishing by 1 July 2022 a comprehensive set of national aged care design principles and guidelines on accessible and dementia-friendly design for residential aged care, which should be:
 - i. capable of application to ‘small home’ models of accommodation as well as to enablement and respite accommodation settings
 - ii. amended from time to time as necessary to reflect contemporary best practice
- b. implementing by no later than 1 July 2023 a program to promote adoption of the National Aged Care Design Principles and Guidelines in design and construction of residential aged care buildings, which program should include:
 - i. industry education, including sharing of best practice models

⁹⁰³ Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8791.20–30; Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8792.26–36; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 39, WIT.1367.0002.0001 at 0011 [60]–[66]; Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0011 [57]–[58].

⁹⁰⁴ Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8786.36–45 and T8787.13–21.

⁹⁰⁵ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 28, RCD.9999.0409.0001 at 0280; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 29, RCD.9999.0410.0001 at 0008; Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8804.9–14; Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8796.20–24.

- ii. financial incentives, whether by increased accommodation supplements or capital grants or other measures or a combination of such measures, for residential aged care buildings that comply with the Guidelines
- c. advancing to the National Federation Reform Council by 1 July 2025 a proposal for amendments to Class 9c of the *National Construction Code* to require the adoption of accessible and dementia-friendly design standards for any new residential aged care buildings, or those proposed to be substantially refurbished, according to specifications informed by the National Aged Care Design Principles and Guidelines.

919. Accessible design guidelines, such as the Livable Housing Design Guidelines, provide useful guidance for design and construction of houses and apartments. However, they were not developed with residential aged care in mind and do not apply in that setting.⁹⁰⁶ They also do not refer to dementia-friendly design principles. Despite the existence of a number of dementia-friendly design resources in Australia, including guidance materials from Dementia Australia and Dementia Training Australia, there is no indication that any of them have been adopted nationally.⁹⁰⁷

920. There is a need for greater awareness and consistency of standards for accessible and dementia-friendly design in residential aged care. To that end, the Australian Government should develop and publish a comprehensive set of national aged care design principles and guidelines for residential aged care.⁹⁰⁸ The guidelines should be:

- a. capable of application to ‘small home’ models of accommodation as well as to enablement and respite accommodation settings; and
- b. amended from time to time as necessary to reflect contemporary best practice.

921. In developing the National Aged Care Design Principles and Guidelines, the Australian Government may, as considered appropriate, have regard to other existing resources in

⁹⁰⁶ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 21, RCD.9999.0408.0001 at 0015.

⁹⁰⁷ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 31, RCD.9999.0410.0094; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 32, RCD.9999.0410.0096.

⁹⁰⁸ See, for example: Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8791.7–18; Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8794.23–27; Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8792.22–26.

Australia and overseas.⁹⁰⁹ The National Aged Care Design Principles and Guidelines should permit some flexibility as to the way they might apply in different circumstances.⁹¹⁰

922. The National Aged Care Design Principles and Guidelines should be voluntary. The Australian Government should, however, publicise them and encourage their adoption and application by approved providers, builders, architects and others. The Australian Government should prepare and publicise sample best practice models to demonstrate what adoption and application of the National Aged Care Design Principles and Guidelines will look like.
923. Financial incentives, whether by increased accommodation supplements or capital grants or other measures, should be paid to approved providers which can demonstrate that their residential aged care buildings have adopted the National Aged Care Design Principles and Guidelines.⁹¹¹
924. If, however, accessible and dementia-friendly design principles remain voluntary for an indefinite time, there is a very real risk that their adoption and application will not be widespread. So much has been the fate of the Livable Housing Design Guidelines.⁹¹² The Australian Government should, at all times while promoting the National Aged Care Design Principles and Guidelines, inform approved providers and others that it intends to introduce new mandatory design standards for residential aged care by no earlier than 2025.
925. That should be done by the Australian Government advancing to the National Federation Reform Council by 1 July 2025 a proposal for amendments to Class 9c of the *National Construction Code* to require the adoption of accessible and dementia-friendly design standards for any new residential aged care buildings, or those proposed to be substantially refurbished, according to specifications informed by the National Aged Care Design Principles and Guidelines. That could occur by drafting specific requirements or by incorporating by reference certain measurable and clear-cut aspects of the National Aged Care Design Principles and Guidelines (as amended from time to time). Importantly, those standards, while mandatory, should still permit flexibility, individuality and innovation in design of residential aged care buildings.

⁹⁰⁹ Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8792.5–8; Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8792.42–8793.5.

⁹¹⁰ Transcript, Sydney Hearing 3, Robert Pahor, 14 August 2020 at T8791.7–18; Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8794.23–43; Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8792.26–36 and T8802.4–17.

⁹¹¹ See, for example: Exhibit 19-9, Sydney Hearing 3, Statement of Frank Weits, RCD.9999.0427.0001 at 0009 [37]; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 39, WIT.1367.0002.0001 at 0016 [91]–[95].

⁹¹² Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 5, RCD.9999.0398.0001 at 0008; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 23b, RCD.9999.0408.0153 at 0177.

Recommendation 58: Capital grants for ‘small home’ models of accommodation

- 58.1. The Australian Government should expand, with effect from 1 January 2022, the Rural, Regional and Other Special Needs Building Fund to provide additional capital grants for building or upgrading residential aged care facilities to provide small scale congregate living.
- 58.2. A majority of the people who receive, or who will receive, aged care at the premises to which any such grant relates should, within the meaning of section 7 of the *Grant Principles 2014* (Cth), be one or more of the following:
- a. supported residents, concessional residents or assisted residents
 - b. people with special needs
 - c. low-means care recipients
 - d. people who live in a location where there is a demonstrated need for additional residential care services
 - e. people who do not live in a major city.
- 58.3. A capital grants program for building or upgrading residential aged care facilities to provide small scale congregate living should continue after the introduction of the new Act.

926. At the Sydney Hearing 1, Mr Glenn Rees, Chairman of Alzheimer’s Disease International, described residential aged care in this country in the following terms:

Australia has a fairly institutional provision, it seems to me, of aged care, even though as a country we’ve probably known since nineteen – the early 1990s what good design looks like.⁹¹³

927. In broad terms, good design in residential aged care, particularly for people living with dementia, will usually involve less institutional settings and smaller, lower density congregate living arrangements.⁹¹⁴ Smaller, lower density congregate living arrangements promote better quality of life, particularly for people living with dementia.⁹¹⁵

⁹¹³ Transcript, Sydney Hearing 1, Glenn Rees, 13 May 2019 at T1552.9–12.

⁹¹⁴ See, for example: Transcript, Sydney Hearing 3, Frank Weits, 14 August 2020 at T8790.10–20; Transcript, Sydney Hearing 3, Stephen Cornelissen, 14 August 2020 at T8796.1–14; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 39, WIT.0778.0001.0001 at 0005–0006 [35]–[36].

⁹¹⁵ See, for example: Exhibit 3-45, Sydney Hearing 1, Statement of Tamar Krebs, WIT.0124.0001.0001 at 0004–0005 [22]–[23]; Exhibit 3-84, Sydney Hearing 1, Statement of Kate Swaffer, WIT.0127.0001.0001 at 0030 [229]; Exhibit 3-47, Sydney Hearing 1, Statement of Lucille O’Flaherty, WIT.0122.0001.0001 at 0002 [9]–[10]; Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 39, WIT.0778.0001.0001 at 0013–0014 [73]–[80].

928. The Australian Government should support the building or upgrading of residential aged care facilities to provide small scale congregate living of this kind. It should particularly do so when people who are living or will live in such facilities: have special needs; or are financially disadvantaged; or live in a rural or remote area or in an area needing additional residential aged care services.
929. The Rural, Regional and Other Special Needs Building Fund provides residential care grants under Part 5.1 of the *Aged Care Act 1997* (Cth) and Part 2 of the *Grant Principles 2014* (Cth). The 2018–19 Aged Care Approvals Round provided approximately \$60 million in capital grants for 28 residential aged care facilities.⁹¹⁶
930. Under s 7(2) of the *Grant Principles*, the main criterion for allocation of capital grants out of the Rural, Regional and Other Special Needs Building Fund is that:
- A majority of the care recipients who receive, or who will receive, the care to which the grant relates must be one or more of the following:
- (a) supported residents, concessional residents or assisted residents;
 - (b) people with special needs;
 - (c) low-means care recipients;
 - (d) people who live in a location where there is a demonstrated need for additional residential care services;
 - (e) people who do not live in a major city.
931. Under s 8(1) of the *Grant Principles*, the Secretary of the Australian Department of Health must, in determining the priority to be given to respective grant applications each year, have regard to certain matters, including ‘the extent to which the project will meet the needs of care recipients living with dementia’ and ‘whether the project will provide high quality accommodation for care recipients’.⁹¹⁷
932. The Australian Government should expand the Rural, Regional and Other Special Needs Building Fund to provide additional capital grants for building or upgrading residential aged care facilities to provide small scale congregate living. Alternatively, the Australian Government could establish a separate capital grants program specifically for projects of this kind catering mostly for residents within one or more of the disadvantaged groups described in s 7(2) of the *Grant Principles*.
933. One other way in which the Australian Government could provide financial support for a transition to small scale congregate living is the payment of a supplement to approved

⁹¹⁶ Australian Department of Health, *2018–19 Aged Care Approvals Round, 2020*, <https://www.health.gov.au/initiatives-and-programs/2018-19-aged-care-approvals-round-acar>, viewed 14 October 2020.

⁹¹⁷ *Grant Principles 2014* (Cth), ss 8 (1)(f)–(g); See also *Grant Principles 2014* (Cth), s 8(2)(a).

providers for every resident living in a building providing small scale congregate living.⁹¹⁸ Such a payment might be said to have the benefit of compensating for additional capital and labour costs associated with a small home model of care. However, it would not necessarily direct financial support to areas of greatest need and well-resourced approved providers may already intend to move to this model in any event.⁹¹⁹

⁹¹⁸ Exhibit 19-8, Sydney Hearing 3, Statement of Stephen Cornelissen, WIT.0777.0001.0001 at 0024 [117]. If such a supplement were to be considered, the Aged Care Pricing Authority could ascertain what the proper amount of such a supplement should be.

⁹¹⁹ Exhibit 19-1, Sydney Hearing 3, General Tender Bundle, tab 39, WIT.0778.0001.0001 at 0016 [92].

Part 3.11 Younger people in residential aged care

934. Aged care is not intended for younger people.⁹²⁰ Their needs are not the same as the needs of older people.⁹²¹ No younger person should have to live in residential aged care.⁹²² But too many younger people do, and too many have done so for too many years.⁹²³
935. This is recognised by the Australian Government. In its response to the Royal Commission's Interim Report, the Australian Government committed itself to ensure that, apart from in exceptional circumstances:
- a. no person under the age of 65 enters residential aged care from 2022;
 - b. no person under the age of 45 lives in residential aged care from 2022;
 - c. no person under the age of 65 lives in residential aged care from 2025.⁹²⁴
936. These commitments are commendable. They must be achieved and they must stay achieved. Stated intentions must translate to sustainable results. That has not happened in the past.
937. For decades, the Australian Government has accepted that younger people should not have to live in residential aged care, but younger people have still continued to find themselves living there. Past initiatives have not delivered, certainly not in any enduring and comprehensive way.⁹²⁵

⁹²⁰ The term 'younger people' is used here to mean people under the age of 65 years. It is acknowledged that some younger people in designated groups, including Aboriginal and Torres Strait Islander people, are otherwise eligible for aged care.

⁹²¹ See, for example: Exhibit 9-18, Melbourne Hearing 1, Statement of James Nutt, WIT.1237.0001.0001; Transcript, Melbourne Hearing 1, James Nutt, 11 September 2019 at T5153–5174; Exhibit 9-3, Melbourne Hearing 1, Statement of Lisa Corcoran, WIT.1240.0001.0001; Transcript, Melbourne Hearing 1, Lisa Corcoran, 9 September 2019 at T4818–4828; Exhibit 9-8, Melbourne Hearing 1, Statement of Neale Radley, WIT.1251.0001.0001; Transcript, Melbourne Hearing 1, Neale Radley, 10 September 2019 at T4966–4971.

⁹²² The Royal Commission's terms of reference authorise the Commissioners to inquire into 'how best to deliver aged care services to ... people with disabilities residing in aged care facilities, including younger people' (paragraph (b)) and any matter they believe is reasonably relevant to the inquiry (paragraph (g)).

⁹²³ As at 30 June 2011, there were 6,381 younger people living in residential aged care in Australia. See Australian Institute of Health and Welfare, Bulletin 103, April 2012, *Younger people with disability in residential aged care 2010–11*, p 6. As at 30 June 2020, there were 4,860 younger people living in residential aged care in Australia. See Australian Department of Health's response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3541 [4].

⁹²⁴ Australian Prime Minister's Media Release, *Response to Aged Care Royal Commission Interim Report*, 25 November 2019. See also Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, p 252.

⁹²⁵ See, for example: Australian Institute of Health and Welfare, *National evaluation of the Aged Care Innovative Pool Disability Aged Care Interface Pilot: final report*, 2006, pp 3, 11 and 19; Community Affairs Reference Committee, Australian Senate, *Adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual*

938. As at 30 June 2020, there were 4,860 younger people living in residential aged care in Australia.⁹²⁶ Of those 4,860 people, 3,978 were aged between 55 and 64 years old, 752 were aged between 45 and 54 years old, 110 were aged between 35 and 44 years old, and 20 were under 35 years old.⁹²⁷
939. To achieve its commitments, the Australian Government must work actively to ensure that *all* younger people who are living in residential aged care can find suitable alternative accommodation before 2025. Reduction of the number of younger people living in residential aged care, particularly those who are aged between 55 and 64 years old, should not depend on younger people turning 65 years old or dying while in residential aged care.
940. The National Disability Insurance Scheme presents a significant opportunity to stop younger people having to live in residential aged care. It is important to recognise, however, that the NDIS will not be the solution for everyone.⁹²⁸ A sizeable minority of younger people who live in, or are at risk of entering, residential aged care are ineligible to become NDIS participants.⁹²⁹
941. The Australian Government has clearly indicated its commitment to stopping younger people having to live in residential aged care.⁹³⁰ Its actions since the Royal Commission's Interim Report have delivered some encouraging early signs.⁹³¹ But there

disabilities in Australia, 2015, pp 10–11, 79 and 127; Exhibit 9-1, Melbourne Hearing 1, General Tender Bundle, tab 59, RCD.9999.0182.0538 at 0548. See also Australian Government, *Younger People in Residential Aged Care: Strategy 2020-25*, 30 September 2020, pp 6–7.

⁹²⁶ Australian Department of Health's response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3541 [4].

⁹²⁷ Australian Department of Health's response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3541 [4] and 3542 [6].

⁹²⁸ As at 30 June 2020, 3,741 younger people living in residential aged care were National Disability Insurance Scheme participants and 3,690 of those participants had an approved NDIS plan. See National Disability Insurance Agency's response to Notice to Give Information and Produce Documents NTG-0795 dated 27 August 2020, CTH.8000.0001.0342 at 0348.

⁹²⁹ Exhibit 9-1, Melbourne Hearing 1, General Tender Bundle, tab 28, RCD.9999.0177.0001 at 0015.

⁹³⁰ See, for example, Australian Government, *Younger People in Residential Aged Care: Strategy 2020-25*, 30 September 2020. See also: Australian Minister for the National Disability Insurance Scheme and Australian Minister for Aged Care and Senior Australians, Media Release, *New funding and support strategy for younger people living in aged care*, 30 September 2020; Australian Minister for the National Disability Insurance Scheme, Media Release, *Delivering the NDIS plan: New medium-term accommodation for NDIS participants*, 2 December 2019; Australian Prime Minister, Media Release, *Response to Aged Care Royal Commission Interim Report*, 25 November 2019.

⁹³¹ Between 30 December 2019 and 30 June 2020, the number of younger people in residential aged care reduced from 5,297 to 4,860. See Australian Department of Health's response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3541 [4].

have been false dawns before.⁹³² Fulfilment of the Government's commitment will require dedicated, continuing and systematic action.

Recommendation 59: No younger people in residential aged care

59.1. The Australian Government should immediately put in place the means to achieve, and to monitor and report on progress towards, the commitments announced by the Australian Prime Minister on 25 November 2019 to ensure that:

- a. no person under the age of 65 enters residential aged care from 1 January 2022
- b. no person under the age of 45 lives in residential aged care from 1 January 2022
- c. no person under the age of 65 lives in residential aged care from 1 January 2025

by:

- d. referring for assessment by the agency most appropriate for the assessment of the person concerned, such as the National Disability Insurance Agency (and not an Aged Care Assessment Team or Aged Care Assessment Service), any younger person who is at risk of entering residential aged care
- e. developing hospital discharge protocols with State and Territory Governments to prevent discharge into residential aged care of any younger person
- f. developing, funding and implementing with State and Territory Governments programs for short-term and long-term accommodation and care options for any younger person who is:
 - i. living in or at risk of entering residential aged care and
 - ii. not eligible to be a participant in the National Disability Insurance Scheme
- g. requiring the National Disability Insurance Agency to publish an annual Specialist Disability Accommodation National Plan setting out, among other things, priority locations and proposed responses to thin markets

⁹³² Australian Government, *Younger People in Residential Aged Care: Strategy 2020-25*, 30 September 2020, pp 6–7.

- h. providing directly for, where appropriate and necessary, accommodation in the Specialist Disability Accommodation market, particularly in thin or underdeveloped markets
- i. funding dedicated and individualised advocacy services for younger people who are living in or at risk of entering residential aged care
- j. collecting data on an ongoing basis, and publishing up-to-date collected data each quarter, on, for each State and Territory, the number of younger people living in residential aged care and, among other things
 - i. their age ranges
 - ii. the average length of time in residential aged care
 - iii. the numbers of admissions into and discharges from residential aged care, and
 - iv. the reasons for younger people exiting from residential aged care, such as death, turning 65 years old or moving into the community
- k. having the responsible Minister report to the Parliament every six months about progress towards achieving the announced commitments, and
- l. ensuring that a younger person will only ever live in residential aged care if it is in the demonstrable best interests of the particular person (and is independently certified to be such by someone with suitable skills, experience, training and knowledge of the person) in limited and exceptional circumstances such as, for instance, where:
 - i. the person will turn 65 years old within a short period of time, being no more than three months, after entering into residential aged care
 - ii. the person's close relatives over 65 years of age live in a residential aged care facility and the person would suffer serious hardship on being separated from those relatives
 - iii. an Aboriginal or Torres Strait Islander person between the age of 50 and 64 years old elects to live in residential aged care.

Information and accountability

942. Government, service planners, service providers and the community need access to improved information on all younger people living in or at risk of entering residential aged

care. In this regard, there has been a longstanding lack of sufficiently detailed and reliable information.⁹³³

943. Without access to and analysis of improved information about younger people in residential aged care, it will remain difficult to understand properly the reasons why they come to live in residential aged care and how they leave. Without that proper understanding, it is more difficult to achieve durable solutions.
944. Ongoing collection and quarterly publication of up-to-date information about younger people living in residential aged care will permit scrutiny by interested parties, including advocacy bodies such as Youngcare, Summer Foundation, and the Young People in Nursing Homes National Alliance.
945. Scrutiny of that information, as well as any claims of progress by the Australian Government, will promote accountability.⁹³⁴ Accountability should prompt strong and continued action with an emphasis on results. Biannual reporting to the Australian Parliament by the responsible Minister of State will deliver further enhanced public and political accountability. That reporting should explain the extent of progress towards achieving the Australian Government's commitments.
946. A lack of access to and analysis of information has also inhibited service providers' ability to assess where there is likely to be demand for their services from younger people who are living in, or at risk of entering, residential aged care.⁹³⁵ A lack of available information of this nature impedes planning for service delivery and commitment to capital investment.⁹³⁶ Availability of accurate and up-to-date information also enables the matching of prospective tenants with appropriate Specialist Disability Accommodation as it becomes available.

⁹³³ See, for example: Transcript, Melbourne Hearing 1, Vicki Rundle, 11 September 2019 at T5076.1–5077.25; Transcript, Melbourne Hearing 1, Peter Broadhead, 10 September 2019 at T5026.45–5027.11. See also Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, p 234. The Australian Government's decision in November 2019 to commission a survey of younger people in residential aged care was intended to address this deficiency in part. Due to the COVID-19 pandemic, that survey has not gone ahead in 2020 as planned.

⁹³⁴ Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5186.37–46 and T5198.1–10.

⁹³⁵ Exhibit 9-6, Melbourne Hearing 1, Statement of Nicholas Hartland, WIT.0374.0001.0001 at 0009 [44]; Exhibit 9-10, Melbourne Hearing 1, Statement of Vicki Rundle, WIT.0436.0001.0001 at 0003 [16].

⁹³⁶ Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5186.38–47 and T5201.24-36; Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5198.26–36.

Appropriate assessment to prevent entry into residential aged care

947. The gateway to aged care is the Aged Care Assessment Team. The role and expertise of an Aged Care Assessment Team is to determine a person's eligibility and appropriateness for aged care services, including residential aged care.
948. Involvement of an Aged Care Assessment Team makes entry into residential aged care more likely for a younger person. From 1 January 2019 to 31 December 2019, delegates rejected only 60 of the 1,231 Aged Care Assessment Team assessments recommending a younger person's entry into permanent residential aged care.⁹³⁷
949. Following the Royal Commission's Interim Report, the Australian Government introduced the Aged Care Assessment Supplementary Guidelines for Younger People in January 2020.⁹³⁸ The Supplementary Guidelines state that eligibility for the National Disability Insurance Scheme should be considered before considering access to aged care.⁹³⁹ They also state that:
- The most appropriate outcome for younger people with a disability is to access age-appropriate accommodation and supports (which will primarily be through the NDIS), rather than aged care services.
- Aged care should only be used as a last resort for younger people and only where there are no other care facilities or care services more appropriate to meet their need.⁹⁴⁰
950. On its face, this is a step in the right direction. In principle, the Supplementary Guidelines reflect s 6(1)(b) of the *Approval of Care Recipients Principles 2014* (Cth), which provides that a younger person is only eligible to receive residential aged care if 'there are no other care facilities or care services more appropriate to meet the person's needs'.⁹⁴¹
951. The likely impact of the Supplementary Guidelines is, however, questionable. The Supplementary Guidelines identify urgent circumstances in which a younger person can be assessed by an Aged Care Assessment Team for entry into residential aged care (before NDIS eligibility is considered). Those urgent circumstances include: upon discharge from hospital, when housing is insecure, when a carer's situation changes significantly, and in other situations of risk.⁹⁴²

⁹³⁷ Australian Department of Health's response to Notice to Give Information NTG-0760 dated 15 July 2020, CTH.1000.0004.9242 at 9250 [28]–[29].

⁹³⁸ Australian Department of Health, *Aged Care Assessment Supplementary Guidelines for Younger People (For purposes of Aged Care Assessment Teams)*, January 2020.

⁹³⁹ Australian Department of Health, *Aged Care Assessment Supplementary Guidelines for Younger People (For purposes of Aged Care Assessment Teams)*, January 2020, p 4.

⁹⁴⁰ Australian Department of Health, *Aged Care Assessment Supplementary Guidelines for Younger People (For purposes of Aged Care Assessment Teams)*, January 2020, p 6.

⁹⁴¹ Transcript, Melbourne Hearing 1, Nicholas Hartland, 10 September 2019 at T4918.4–31.

⁹⁴² Australian Department of Health, *Aged Care Assessment Supplementary Guidelines for Younger People (For purposes of Aged Care Assessment Teams)*, January 2020, pp 12 and 15–16.

952. Inclusion of ‘upon discharge from hospital’ in those urgent circumstances is significant. Most younger people entering residential aged care are assessed in hospital or admitted into residential aged care from such an inpatient setting.⁹⁴³ One Australian Government witness described hospital discharge into residential aged care as a ‘worn path’.⁹⁴⁴
953. Despite the introduction of the Supplementary Guidelines, dozens of younger people continue to enter residential aged care every month.⁹⁴⁵ As acknowledged by Dr Nicolas Hartland, the then First Assistant Secretary of the In Home Aged Care Division of the Australian Department of Health, in his evidence before the Royal Commission, Aged Care Assessment Team staff are not expected to have a deep understanding of the needs of younger people and appropriate options available to them.⁹⁴⁶
954. Assessments of younger people with significant care needs should be undertaken by assessors with relevant expertise and with knowledge of available service options. Ordinarily the National Disability Insurance Agency will be best placed to conduct those assessments, irrespective of eligibility for National Disability Insurance Scheme supports and, in particular, Specialist Disability Accommodation. National Disability Insurance Agency assessors are likely to have a greater understanding of age-appropriate alternatives, rather than defaulting to an aged care option.

Access to advocacy and improved pathways

955. Navigation of the interface between the health, aged care and disability services systems is complicated.⁹⁴⁷ The complexity is even more pronounced for younger people with a cognitive impairment or without a family advocate or struggling to come to terms with a newly acquired disability or illness. In his 2019 review of the *National Disability Insurance Scheme Act 2013* (Cth), Mr David Tune AO PSM rightly found that ‘additional support should be provided to assist people with disability to navigate the NDIS and its processes’.⁹⁴⁸

⁹⁴³ Exhibit 9-1, Melbourne Hearing 1, General Tender Bundle, tab 28, RCD.9999.0177.0001 at 0011; Transcript, Melbourne Hearing 1, Kym Peake, 13 September 2019 at T5226.17–20. The Australian Department of Health has stated an intention to review the urgent circumstances pathway. The nature and outcome of any review is not presently known. See Australian Department of Health’s response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3543–3544 [8(b)].

⁹⁴⁴ Transcript, Melbourne Hearing 1, Peter Broadhead, 10 September 2019 at T5003.38.

⁹⁴⁵ Australian Department of Health’s response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3541 [4] and 3543 [7].

⁹⁴⁶ Transcript, Melbourne Hearing 1, Nicholas Hartland, 9 September 2019 at T4895.27–28. See also Exhibit 9-22, Melbourne Hearing 1, Statement of Kym Peake, WIT.0420.0001.0001 at 0013 [78]–[79].

⁹⁴⁷ Exhibit 9-12, Melbourne Hearing 1, Statement of Carol and Kevin Littlely, WIT.1242.0001.0001 at 0005 [39].

⁹⁴⁸ David Tune, *Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee*, 2019, p 39.

956. Improved advocacy is essential. Its focus should be on knowing available options and alternatives, assisting people to make informed decisions, and reviewing regularly the suitability of care and accommodation being provided.⁹⁴⁹
957. The Australian Government has recently announced in its 2020–21 Budget that, over three years from 2020–21, the Australian Government will provide \$10.6 million in funding for a national network of ‘up to 40’ system coordinators to help younger people find age-appropriate accommodation and supports to allow them to live independently in the community.⁹⁵⁰ That is a worthwhile development.⁹⁵¹
958. However, the number of system coordinators or ‘wranglers’ would appear insufficient, particularly given that they are tasked with helping in excess of 4,500 younger people get out of residential aged care and over 1,000 younger people avoid entering residential aged care.⁹⁵² It is also not clear what will happen after 2024. There should be ongoing funding for system coordinators after 2024 and, even if the Australian Government meets its commitments, after 2025 to help younger people avoid entering residential aged care in future.
959. It is otherwise not clear what, if any, advocacy role the system coordinators will play for younger people living in residential aged care. It is presently unclear how independent they are intended to be. Independent advocacy and supported decision-making are particularly important for younger people with a cognitive disability or early onset dementia. The Australian Government should ensure that resources are made available to support such an independent advocacy role.
960. It otherwise remains to be seen how the network of system coordinators will in fact work to achieve the Australian Government’s commitments. They will need to have skills in and knowledge about the health system to identify and locate younger people in hospital who are at risk of entering residential aged care and to prevent their discharge into

⁹⁴⁹ Transcript, Melbourne Hearing 1, Ben Gauntlett, 11 September 2019 at T5151.6–36.

⁹⁵⁰ Australian Government, *Budget Measures Budget Paper No 2 2020–21*, p 91; Australian Government, *Portfolio Budget Statement 2020–21, Budget Related Paper No 1.7, Health Portfolio*, p 121; Australian Minister for the National Disability Insurance Scheme and Australian Minister for Aged Care and Senior Australians, Media Release, *New funding and support strategy for younger people living in aged care*, 30 September 2020; Australian Minister for Health, *Budget 2020–21: Record health and aged care investment under Australia’s COVID-19 pandemic plan*, 6 October 2020.

⁹⁵¹ For evidence about the need for advocacy, see: Exhibit 9-12, Melbourne Hearing 1, Statement of Carol Littley and Kevin Littley, WIT.1242.0001.0001 at 11 [99]; Transcript, Melbourne Hearing 1, Luke Bo’sher, 13 September 2019 at T5191.18–26; Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5189.25–42; Transcript, Melbourne Hearing 1, Shane Jamieson, 13 September 2019 at T5188.20–36.

⁹⁵² See Australian Department of Health’s response to Notice to Give Information and Produce Documents NTG-0794 dated 2 September 2020, CTH.1000.0006.3540 at 3541 [4].

residential aged care.⁹⁵³ The system coordinators will also need to form local and in-depth relationships with contacts and counterparts in the health system.⁹⁵⁴ In order to reduce the risk of younger people in hospital being discharged into residential aged care, the system coordinators will have to ensure early engagement and planning for future accommodation and care needs.⁹⁵⁵ In that regard, they might well consider the evidence given to the Royal Commission by compensable scheme representatives from State Governments about the important role of planners and coordinators in their own schemes.⁹⁵⁶

961. The need for close interaction between the system coordinators on the one hand and contacts and counterparts in the health system on the other highlights the need for the Australian Government and State and Territory Governments to work together. Given their responsibility for hospital and subacute health care services, State and Territory Governments play a critical role in reducing the number of younger people in residential aged care.⁹⁵⁷ The Australian Government must make sure that it involves State and Territory Governments in measures to achieve its commitments. In particular, they should work together to develop hospital discharge protocols to prevent discharge of younger people into residential aged care. The Australian Government should otherwise establish a structured and ongoing mechanism for collaboration with its State and Territory counterparts.

Limited exceptions

962. There are likely to be some, albeit very limited, circumstances in which a younger person might enter residential aged care. Where this is suitable and appropriate, the person must be afforded every opportunity to have access to and choice of the services that they require.

963. Released on 30 September 2020, the Australian Government's *Younger People in Residential Aged Care: Strategy 2020-2025* states that the following principles will guide decisions about the circumstances in which a younger person may enter or remain in residential aged care:

⁹⁵³ Exhibit 9-19, Melbourne Hearing 1, Statement of Bronwyn Morkham, WIT.0372.0001.0001 at 0013 [48]–[51].

⁹⁵⁴ Transcript, Melbourne Hearing 1, Tamara Tomic, 11 September 2019 at T5133.17–44; Transcript, Melbourne Hearing 1, Liz Cairns, 11 September 2019 at T5138.45–5139.9; Transcript, Melbourne Hearing 1, Deborah Hoffman, 11 September 2019 at T5137.3–11.

⁹⁵⁵ Transcript, Melbourne Hearing 1, Liz Cairns, 11 September 2019 at T5131.33–44; Transcript, Melbourne Hearing 1, Tamara Tomic, 11 September 2019 at T5133.5–10.

⁹⁵⁶ Transcript, Melbourne Hearing 1, Liz Cairns, 11 September 2019 at T5134.36–47; Transcript, Melbourne Hearing 1, Tamara Tomic, 11 September 2019 at T5136.34–39; Transcript, Melbourne Hearing 1, Suzanne Lulham, 11 September 2019 at T5135.40–44.

⁹⁵⁷ See, for example, Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019 at T4973.34–40.

- younger people should be supported to exercise choice and control about where they live;
- strict eligibility conditions will need to be met for a younger person to enter residential aged care;
- each younger person's unique circumstances and goals should always be considered;
- education and support for younger people, and education within health and social supports, is critical to their informed choice;
- a younger person's accommodation and support preferences may change over time; and
- appropriate decision-making mechanisms must be in place to ensure relevant information and advice is considered and there is accountability in decisions.⁹⁵⁸

964. In general, these principles are appropriate. It is vital that a person has choice, aided by informed and supported decision-making, and coupled with a clear understanding of the options and alternatives available. To enable that choice, there must be access to services that are needed, irrespective of the 'system' that provides those services. Regular review, recognising changes in circumstances and service availability, is also essential.

965. The Australian Government's *Younger People in Residential Aged Care: Strategy 2020-2025* refers to some exceptional circumstances in which a younger person might enter into residential aged care, including that:

- a. the accommodation, for reasons such as remoteness, cultural, community or family considerations, or a specialist support model, is considered to be the most appropriate option for the younger person; and
- b. the younger person is an Aboriginal and/or Torres Strait Islander person who is aged between 50 and 64 years old.

966. Merely living outside of a capital city does not constitute exceptional circumstances justifying the placement of a younger person in residential aged care. That said, it is possible to conceive of specific situations that might warrant consideration of exceptional circumstances provisions. For example, an adult with a disability whose caregiver parent enters residential aged care might wish to join the parent in order to preserve the family relationship. Similarly, a person with a specific cultural connection to a residential aged care facility might have a strong preference to reside there. An Aboriginal and/or Torres Strait Islander person, who is aged between 50 and 64 years old and therefore eligible

⁹⁵⁸ Australian Government, *Younger People in Residential Aged Care: Strategy 2020-25*, 30 September 2020, pp 9–10.

for aged care services, might elect to live in a residential aged care facility because of its location or connection to community.⁹⁵⁹

967. Safeguards will, however, be required to ensure that exceptions do not become the rule. Overall, a younger person should only ever live in residential aged care if:

- a. it is in that person's demonstrable best interests; and
- b. that has been independently certified by someone with suitable skills, experience, training and knowledge of the person.

968. When exceptional circumstances exist and a younger person is permitted to enter residential aged care, they should receive any additional support for which they are eligible. This includes specific health services and other supports from the National Disability Insurance Scheme.⁹⁶⁰ These additional services and supports may prove critical for a younger person to maintain independent living skills and social connections, and to enhance the person's opportunities to return to living in the community.

969. Finally, no younger person living in residential aged care should be forgotten. All younger people in residential aged care should have their circumstances reviewed regularly and at least every six months. They should be able to make informed decisions about their place of residence. They should receive information about alternative care and accommodation options, without having to hunt for it.⁹⁶¹

Transitional accommodation and care

970. Appropriate accommodation enables people with disability to live as independently as possible. But modifying existing accommodation or building new accommodation can take time.⁹⁶² Without appropriate accommodation and the right levels of care in place, the risk of placement in residential aged care is heightened, particularly when someone is being urgently discharged from hospital.⁹⁶³

971. Mr Luke Bo'sher, former Chief Executive Officer of the Summer Foundation, summed up the challenge for people who are ready to leave hospital but do not have suitable accommodation:

This week we've heard examples of ACAT assessments being approved in a matter of days, and we've heard what's a very common story about an SDA

⁹⁵⁹ See Part 3.5 Aged care for Aboriginal and Torres Strait Islander people.

⁹⁶⁰ See, for example: Exhibit 9-9, Melbourne Hearing 1, Statement of Robyn Spicer, WIT.1245.0001.0001 at 0007 [68]; Transcript, Melbourne Hearing 1, Robyn Spicer, 10 September 2019 at T4992.29–41.

⁹⁶¹ Transcript, Melbourne Hearing 1, Carol Littlely, 11 September 2019 at T5094.28–5095.26.

⁹⁶² Transcript, Melbourne Hearing 1, Shane Jamieson, 13 September 2019 at T5203.4–26; Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5203.36–5204.46.

⁹⁶³ Transcript, Melbourne Hearing 1, Kym Peake, 13 September 2019 at T5230.24–27; Exhibit 9-22, Melbourne Hearing 1, Statement of Kym Peake, WIT.0420.0001.0001 at 0005 [28]; Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5193.38–5194.11.

application taking six months to prepare. So we're talking – that's not even the approval process from the NDIA; that's just the point of submitting a form to apply. And what we've got is a system where inappropriate placements can be funded in two or three days but an appropriate good practice solution will take six months to apply for and then a number of months for the NDIA to make a decision and then a number of more months to transition into that place while it's stood up by a service provider.⁹⁶⁴

972. This and other evidence has highlighted the need for greater availability of interim or transitional accommodation for people who have completed an acute or subacute phase of care but have no suitable accommodation available to them on discharge from hospital.⁹⁶⁵ Interim or transitional accommodation could give a younger person critical time for modifications to be made to the person's existing home or for approval to be granted to the person for Assistive Technology or for Specialist Disability Accommodation and Supported Independent Living services to become available. Such accommodation could also provide a pathway for younger people out of residential aged care.⁹⁶⁶
973. Witnesses gave evidence about how the availability of accommodation alternative to residential aged care would have affected them. They explained how their lives would have been very different if, rather than entering residential aged care, they had been able to access appropriate accommodation at the end of their acute or rehabilitation stay. They spoke of how their years of living in residential aged care were punctuated by sadness, frustration and social disconnection.⁹⁶⁷ They should never have had to enter residential aged care in the first place.
974. The Australian Government's establishment of a Medium Term Accommodation service stream in the National Disability Insurance Scheme will have some positive impact and should be welcomed.⁹⁶⁸ However, if it is to prevent younger people entering residential aged care, it must be offered in a timely manner, in the right places and in adequate supply. Like Specialist Disability Accommodation, it must also be offered in conjunction with the appropriate levels of care.
975. Not every younger person living in or at risk of entering residential aged care will be eligible to access accommodation supports under National Disability Insurance Scheme. The Australian Government should therefore develop, fund and implement, with State and Territory Governments' cooperation and assistance, accommodation and care

⁹⁶⁴ Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5195.23–30.

⁹⁶⁵ Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5210.39–5211.14; Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5211.18–44.

⁹⁶⁶ Exhibit 9-19, Melbourne Hearing 1, Statement of Bronwyn Morkham, WIT.0372.0001.0001 at 0061 [305]–[308].

⁹⁶⁷ Exhibit 9-8, Melbourne Hearing 1, Statement of Neale Radley, WIT.1251.0001.0001 at 0003–0004 [26]; Exhibit 9-18, Melbourne Hearing 1, Statement of James Nutt, WIT.1237.0001.0001 at 0003 [21].

⁹⁶⁸ Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019 at T4981.5–6.

options for younger people who are ineligible for NDIS supports and who are living in or at risk of entering residential aged care.

Long-term accommodation and care

976. While the availability of interim or transitional accommodation is an important part of the solution, permanent accommodation is the endgame for younger people wanting to establish themselves and have confidence in their future. Specialist Disability Accommodation is a fundamental element of assistance available to younger people who live in, or at risk of entering, residential aged care and who are participants in the National Disability Insurance Scheme. Equally important for them are Supported Independent Living care and Assistive Technology, which are also available to NDIS participants.
977. As at 30 June 2020, only 550 of the 3,690 younger people living in residential aged care with an approved NDIS plan had provision in their plan for Specialist Disability Accommodation (including for some with Supported Independent Living), with another 27 having approval for Supported Independent Living alone.⁹⁶⁹ It is difficult to understand how a person would not qualify for Specialist Disability Accommodation if the person's needs justified living in residential aged care.⁹⁷⁰ If younger people living in residential aged care are NDIS participants and have not yet been assessed for provision of SDA and SIL, that must happen as a matter of urgent priority.⁹⁷¹
978. Without this support, or something similar for those younger people who are not eligible for assistance under the National Disability Insurance Scheme, the risk of admission to and long-term stay in residential aged care increases greatly.
979. In some areas, the supply of Specialist Disability Accommodation and other disability support services is limited and does not meet demand.⁹⁷² To address this problem, the Australian Government should develop a Specialist Disability Accommodation National Plan that puts forward strategies to build supply of Specialist Disability Accommodation or viable alternatives in these areas. The plan should set out, among other things, priority locations and proposed responses to thin markets. It should be updated annually.

⁹⁶⁹ See National Disability Insurance Agency's response to Notice to Give Information and Produce Documents NTG-0795 dated 27 August 2020, CTH.8000.0001.0342 at 0348.

⁹⁷⁰ Eligibility for residential aged care is reserved for people who have a condition of frailty or disability requiring continuing personal care and who are unable to live in the community without support. See *Approval of Care Recipients Principles 2014* (Cth), s 6. This includes medical, physical, cognitive, psychological and social factors that result in a loss of function. *National Disability Insurance Scheme Act 2013* (Cth), s 24 and *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020* (Cth), Part 2.

⁹⁷¹ In his 2019 review of the National Disability Insurance Scheme Act, Mr Tune rightly calls for the timing and coordination of eligibility and planning decisions to be improved. See David Tune, *Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee*, 2019, pp 93–95 [6.18]–[6.24] and 159–161 [10.14]–[10.22].

⁹⁷² Transcript, Melbourne Hearing 1, Vicki Rundle, 11 September 2019 at T5073.45–5074.2.

980. Of course, the mere existence of such a plan will not ensure adequate supply of appropriate accommodation and services. At present, the Specialist Disability Accommodation market is not responding quickly or broadly enough. A report from the Summer Foundation and Social Ventures Australia estimated in 2019 that the shortfall in Specialist Disability Accommodation, even when taking into account building underway, was around 9,000 places.⁹⁷³ A shortfall of this nature was flagged as early as 2011.⁹⁷⁴ Simply waiting for the market to respond and deliver the requisite accommodation options will not ensure that the Australian Government meets its commitments. As Mr Bo'sher observed, the wait for NDIS decision-making on Specialist Disability Accommodation supports and for housing approval is compounded by the time required for construction or modification of accommodation.⁹⁷⁵
981. New approaches to increase the supply of appropriate accommodation are required. Improvements to data collection and sharing, which are also the subject of the proposed recommendation,⁹⁷⁶ will assist in stimulating market activity by demonstrating the level and location of demand. The Australian Government should provide more comprehensive and detailed information on the current supply of and demand for Specialist Disability Accommodation.⁹⁷⁷
982. More will have to be done, however, particularly in the immediate future.⁹⁷⁸ Different thinking from all levels of government is needed to increase the supply of suitable accommodation for younger people living in or at risk of entering residential aged care.
983. The Australian and State and Territory Governments have the opportunity to foster innovation by directly commissioning Specialist Disability Accommodation developments or acting as a service provider in places where the market is unlikely to respond. The Australian and State and Territory Governments might, for example, offer grants to social housing providers to construct suitable accommodation. Local government planning functions could also stimulate the market. For example, local governments might permit additional units to be built as part of a development if a developer incorporates Specialist Disability Accommodation in the development application.
984. For younger people in residential aged care who are not eligible for the National Disability Insurance Scheme, the Australian Government will need, in collaboration with State and Territory Governments, to find innovative accommodation solutions. Social and

⁹⁷³ Exhibit 9-1, Melbourne Hearing 1, General Tender Bundle, tab 37, RCD.9999.0178.0029 at 0053.

⁹⁷⁴ Exhibit 9-1, Melbourne Hearing 1, General Tender Bundle, tab 146, CTH.0001.8000.0001 at 0009 [17].

⁹⁷⁵ Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5203.36–5204.46.

⁹⁷⁶ See paragraphs 942 to 946 above.

⁹⁷⁷ Transcript, Melbourne Hearing 1, Luke Bo'sher, 13 September 2019 at T5209.12–25.

⁹⁷⁸ Transcript, Melbourne Hearing 1, Vicki Rundle, 11 September 2019 at T5074.46–5075.23; Transcript, Melbourne Hearing 1, Bronwyn Morkham, 13 September 2019 at T5217.40–41.

community housing has the potential to deliver more accommodation for younger people at risk of entering residential aged care, particularly for those with psychosocial disabilities, those experiencing homelessness, and other younger people ineligible for the National Disability Insurance Scheme.

985. Even when suitable accommodation is available, it must be accompanied by the requisite care services and supports. Without those services and supports, a younger person may still be pushed into residential aged care.⁹⁷⁹
986. In this regard, an administrative agreement in June 2019 of the Disability Reform Council, which is responsible for overseeing the implementation of the National Disability Insurance Scheme, is to be welcomed. Among other things, the June 2019 agreement provided for access to funding for some disability-related health support services under the National Disability Insurance Scheme.⁹⁸⁰ That agreement should be the subject of more formal and enforceable recognition.⁹⁸¹
987. The June 2019 agreement did not extend to subacute rehabilitation and palliative care. Continued engagement between the Australian and State and Territory Governments must focus on the provision of adequate levels of care – acute, subacute and maintenance care – to minimise the risk of younger people being admitted to residential aged care unnecessarily.
988. In relation to palliative care, younger people entering residential aged care at the end of their lives form a significant but somewhat hidden subset of younger people in residential aged care.⁹⁸² Information received by the Royal Commission from the Australian Department of Health indicates that, during the period from 1 January 2015 to 31 December 2019, 1,402 younger people in residential aged care died within six months of admission.⁹⁸³ Over the past three years, an average of 292 younger people have been admitted annually to residential aged care with ‘cancer/tumour’ recorded as a health condition.⁹⁸⁴
989. Under current arrangements, people in these circumstances generally fall outside the scope of the National Disability Insurance Scheme, and residential aged care has become their hospice. A lack of palliative care services and an apparent inability to

⁹⁷⁹ Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019, T4956.29–39.

⁹⁸⁰ Council of Australian Governments Disability Reform Council, *Gold Coast–28 June 2019 Communiqué*.

⁹⁸¹ See, for example, David Tune, *Review of the National Disability Insurance Scheme Act 2013: Removing Red Tape and Implementing the NDIS Participant Service Guarantee*, 2019, p 38.

⁹⁸² Exhibit 9-1, Melbourne Hearing 1, General Tender Bundle, tab 28, RCD.9999.0177.0001 at 0023.

⁹⁸³ Australian Department of Health’s response to Notice to Give Information NTG-0760 dated 15 July 2020, CTH.1000.0004.9242 at 9251 [33].

⁹⁸⁴ Australian Department of Health’s response to Notice to Give Information NTG-0760 dated 15 July 2020, CTH.1000.0004.9242 at 9251 [31]–[32].

obtain assistance under the National Disability Insurance Scheme for disabling consequences of cancer and some other terminal conditions leave some younger people with no option other than to enter residential aged care. That should not continue. No younger person should be compelled to move into residential aged care because of insufficient palliative care services.⁹⁸⁵

⁹⁸⁵ Australian Department of Health, *Aged Care Assessment Supplementary Guidelines for Younger People (For purposes of Aged Care Assessment Teams)*, January 2020, p 11.

Part 3.12 Aged care for people with disability

990. By paragraph (b) of the Terms of Reference, the Royal Commission is authorised to inquire into ‘how best to deliver aged care services to ... people with disabilities residing in aged care facilities’.⁹⁸⁶ A matter reasonably relevant to that inquiry is how best to deliver aged care services to people with disabilities living in their homes.⁹⁸⁷ For the purposes of its inquiry, the Royal Commission is also required to have regard to, among other things, ‘the interface with other services accessed by people receiving aged care services, including ... disability services’.⁹⁸⁸
991. The establishment of the National Disability Insurance Scheme transformed the way in which disability services are provided in Australia. The NDIS is justifiably described on its website as ‘the most important social reform in Australia since the introduction of Medicare’.⁹⁸⁹ It has changed, for the better, the lives of hundreds of thousands of people with disability by providing them with the reasonable and necessary supports that they need to live an ordinary life.
992. The NDIS does not, however, provide those supports to people who acquire a disability after they turn 65 years old.⁹⁹⁰ Nor does it provide supports to people with disability, whenever acquired, who had already turned 65 years old when the NDIS came into operation in their local area.⁹⁹¹ That includes people with lifelong disabilities. Nor does the NDIS provide supports to people with disability who first receive aged care services, on a permanent basis, after turning 65.⁹⁹²
993. Despite the landmark contribution made by the NDIS to the lives of people with disability, many people with disability aged 65 and over are prevented from accessing the NDIS and obtaining the benefits of an individualised NDIS plan of supports.⁹⁹³ In Australia, there were, in 2018, 1.9 million people with disability who were aged 65 years old and

⁹⁸⁶ See Letters Patent dated 6 December 2018, paragraph (b).

⁹⁸⁷ See Letters Patent dated 6 December 2018, paragraphs (c)(i) and (g).

⁹⁸⁸ See Letters Patent dated 6 December 2018, paragraph (l).

⁹⁸⁹ National Disability Insurance Scheme, *Overview of the NDIS Operational Guideline – About the NDIS*, <https://www.ndis.gov.au/about-us/operational-guidelines/overview-ndis-operational-guideline/overview-ndis-operational-guideline-about-ndis>, viewed 16 October 2020.

⁹⁹⁰ *National Disability Insurance Scheme Act 2013* (Cth), s 22(1)(a).

⁹⁹¹ *National Disability Insurance Scheme (Becoming a Participant) Rules 2016* (Cth), paragraph 3.2 and Schedule A.

⁹⁹² Part 4 of the *Age Discrimination Act 2004* (Cth) makes it unlawful to discriminate against someone on the ground of age in respect of various specified matters, including the provision of goods, services and facilities. However, s 41 of the *Age Discrimination Act* states that Part 4 does not make unlawful anything done by a person in direct compliance with the *National Disability Insurance Scheme Act 2013* (Cth) or a regulation, rule or other instrument under that Act.

⁹⁹³ See *National Disability Insurance Scheme Act 2013* (Cth), s 22(1); Australian Institute of Health and Welfare, *People with disability in Australia 2019 – In brief*, 2019, p 6; Roger Beale, Public submission, AWF.600.02422.0001 at 0001.

over.⁹⁹⁴ However, a report by the Australian Institute of Health and Welfare in 2019 estimated that only around 15,000 people aged over 65 (compared to around 460,000 aged under 65) would have access to the NDIS and its benefits when the NDIS rollout was completed in 2020.⁹⁹⁵

994. The NDIS discriminates against older people on the basis of their age.⁹⁹⁶ In the absence of any relaxation or removal of the age requirements for the NDIS, which is not a matter within the Terms of Reference and is not therefore something for this Royal Commission's inquiry, other government programs must step up to provide analogous benefits for those people with disability aged 65 and over who cannot access the NDIS.

995. There are existing government programs that provide some disability services to those people. The main one is the Commonwealth Continuity of Support Programme.⁹⁹⁷ Eligibility for the Continuity of Support Programme is limited, however, to those people with disability who did not qualify for the NDIS and were 'an existing client of state-managed specialist disability services at the time the CoS Programme commences in their region'.⁹⁹⁸ The Continuity of Support Programme commenced on 1 December 2016 'in line with the NDIS' and was said to be available in all States and Territories by the end of June 2020.⁹⁹⁹

996. Programs of this kind have not consistently and comprehensively given people with disability access to the nature and extent of supports available to others under the NDIS.¹⁰⁰⁰ They should – particularly in the absence of any change to the discriminatory age requirements under the NDIS.

997. The Australian Government has recently announced in the 2020–21 Budget that the Australian Government will provide, over three years from 2020–21 to 2023–24, \$125.3

⁹⁹⁴ Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia: Summary of Findings*, <https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release>, viewed 16 October 2020.

⁹⁹⁵ Australian Institute of Health and Welfare, *People with disability in Australia 2019 – In brief*, 2019, p 6.

⁹⁹⁶ Transcript Adelaide Hearing 1, Paul Versteeg, 12 February 2019 at T166.1–10. Insofar as it does so by reference to the age of 65 years, it is completely arbitrary. For instance, people born on or after 1 January 1957 are only eligible to receive the age pension once they have turned 67 years old.

⁹⁹⁷ Australian Department of Health, *About the Commonwealth Continuity of Support Programme*, <https://www.health.gov.au/initiatives-and-programs/commonwealth-continuity-of-support-cos-programme/about-the-commonwealth-continuity-of-support-programme>, viewed 19 October 2020.

⁹⁹⁸ Australian Department of Health, *About the Commonwealth Continuity of Support Programme*, <https://www.health.gov.au/initiatives-and-programs/commonwealth-continuity-of-support-cos-programme/about-the-commonwealth-continuity-of-support-programme#who-is-eligible>, accessed 15 October 2020.

⁹⁹⁹ Australian Department of Health, *Home Support Program, Commonwealth Continuity of Support (CoS) Programme Guidelines Overview*, October 2017, p 5.

¹⁰⁰⁰ Roger Beale, Public submission, AWF.600.02422.0001 at 0001.

million for a new Disability Support for Older Australians Program to replace the Commonwealth Continuity of Support Programme.¹⁰⁰¹ The new program will commence on 1 July 2021. According to the Australian Government:

The Australian Government will continue to support vulnerable older Australians who cannot access the National Disability Insurance Scheme (NDIS).

...

Approximately 3,600 Australians currently use the CoS Programme. It is vital that they receive support that is comparable to people on the NDIS.¹⁰⁰²

998. It remains to be seen whether the new Disability Support for Older Australians Program will provide 'support that is comparable to people on the NDIS'. It is also presently unknown what will happen after 2024.
999. In any event, the new program will only be available to people who were receiving services under the Commonwealth Continuity of Support Programme.¹⁰⁰³ Those people, presently numbering around 3,600, are likely to represent only a fraction of the people with disability aged 65 and over who cannot access the NDIS.¹⁰⁰⁴ And the Continuity of Support Programme has been closed to new entrants since July 2020.¹⁰⁰⁵ The number of people receiving services under the new Disability Support for Older Australians Program will only diminish in future.
1000. It is likely that, as Australia's population ages, more older people with disability will have to access aged care to obtain the supports and services they need. That will particularly be so if they are not NDIS participants. And most of them are not at the moment. Also, if an NDIS participant receives aged care services, on a permanent basis, for the first time after turning 65, the person loses forever their ability to participate in the NDIS.¹⁰⁰⁶

¹⁰⁰¹ Australian Government Budget 2020–21, *Budget Measures Budget Paper No 2 2020–21*, p 90.

¹⁰⁰² Australian Department of Health, *Budget 2020–21 Aged Care – Commonwealth Disability Support for Older Australians*, <https://www.health.gov.au/sites/default/files/documents/2020/10/budget-2020-21-aged-care-commonwealth-disability-support-for-older-australians.pdf>, viewed at 15 October 2020.

¹⁰⁰³ The Australian Government has said that the people who will benefit from the new Disability Support for Older Australians Program are '[c]lose to 3,600 existing CoS clients'. See Australian Department of Health, *Budget 2020–21 Aged Care – Commonwealth Disability Support for Older Australians*, <https://www.health.gov.au/sites/default/files/documents/2020/10/budget-2020-21-aged-care-commonwealth-disability-support-for-older-australians.pdf>, viewed at 15 October 2020.

¹⁰⁰⁴ Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia: Summary of Findings 2018*, <https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/2018>, viewed 16 October 2020.

¹⁰⁰⁵ Australian Department of Social Services, *Disability and Carers*, <https://www.dss.gov.au/disability-and-carers/transitioning-to-the-ndis>, viewed 16 October 2020.

¹⁰⁰⁶ See s 29(1)(b) of the *National Disability Insurance Scheme Act 2013* (Cth).

1001. If older people with disability have to access aged care to obtain the supports and services they need, they should not have to accept something less than what others in similar circumstances can access under the NDIS.

Recommendation 60: Equity for people with disability receiving aged care

60.1. By 1 July 2024, every aged care recipient with a disability or disabilities, regardless of when acquired, should receive through the aged care program daily living supports and outcomes (including assistive technologies, aids and equipment) equivalent to those that would be available under the National Disability Insurance Scheme to a person with the same or substantially similar conditions.

1002. The disability services and aged care systems are different philosophically and operationally. Discrete Commonwealth legislation separately governs each program area. Each area has its own responsible Minister. Disability services and aged care are financed differently and each offers a different range of services. The National Disability Insurance Scheme is not means tested, while aged care services involve consumer contributions. Aged care services are rationed in the existing system, while the NDIS is not. There are strict age requirements for the NDIS, but not for aged care.

1003. The Royal Commission has received evidence and information about inconsistencies between the supports and services available under the NDIS and those available in the aged care system, including greater access in the NDIS to supported accommodation, aids, equipment and therapy.¹⁰⁰⁷ The schedule of supports available to participants in the NDIS is more comprehensive than what is presently available in aged care.¹⁰⁰⁸

1004. Despite these differences, older people with disability should not, as a matter of principle, experience disadvantage because they access supports and services from the aged care

¹⁰⁰⁷ Transcript, Adelaide Hearing 2, Lynda Henderson, 18 March 2019 at T690.6–16; Transcript, Adelaide Hearing 1, Ian Yates, 11 February 2019 at T59.24–29; Transcript, Adelaide Hearing 2, Paul Sadler, 18 March 2019 at T732.9–17. It is also noted that, at present: the highest level of government funding available to an aged care resident at 19 October 2020 is \$84,446.10 plus subsidies each year (if classified as ‘High High High’ for the Aged Care Funding Instrument) but, on average, individual care packages for an NDIS participant receiving Supported Independent Living care supports is about \$325,000 a year without any user contribution. See Australian Department of Health, *Aged Care Subsidies and Supplements New Rates of Daily Payments from 20 September 2020*, <https://www.health.gov.au/resources/publications/schedule-of-subsidies-and-supplements-for-aged-care>, viewed 19 October 2020, and National Disability Insurance Agency, *Annual Report 2019–20*, p 41, Figure 2.3.3I. See also Transcript, Melbourne Hearing 1, Michael Lye, 10 September 2019 at T4975.1–15.

¹⁰⁰⁸ National Disability Insurance Scheme, *Price Guide 2020–21*, 1 October 2020.

system instead of the disability services system. That accords with one object of the proposed new Act – that is, to provide for ‘a system of aged care based on a universal right to high quality, safe and timely support and care to assist older people to live an active, self-determined and meaningful life’.¹⁰⁰⁹

1005. The aged care program should provide people with disability receiving aged care with daily living supports and outcomes (including assistive technology, aids and equipment) equivalent to those that would be available under the NDIS to a person with the same or substantially similar conditions.

Recommendation 61: Annual reporting to Parliament by the Disability Discrimination Commissioner and the Age Discrimination Commissioner

61.1. By 1 July 2024, the Disability Discrimination Commissioner and the Age Discrimination Commissioner should be required, as part of the new National Disability Strategy, to report annually to the Parliament on the numbers of aged care recipients with disabilities who are 65 years old or older and their ability to access daily living supports and outcomes (including assistive technologies, aids and equipment) equivalent to those available under the National Disability Insurance Scheme.

1006. Australia’s 10-year National Disability Strategy ends in 2020.¹⁰¹⁰ The Australian Government is presently developing a new National Disability Strategy.

1007. The current 10-year Strategy emphasises the human rights of people with disability. Indeed, it is described by the Australian Government as the main way ‘Australia implements the United Nations Convention on the Rights of Persons with Disabilities’.¹⁰¹¹ Under the Strategy, the Australian Human Rights Commission has an important role in ensuring that the Strategy upholds the human rights of people with disability.¹⁰¹²

1008. That role should continue under the new Strategy. To that end, the Disability Discrimination Commissioner and the Age Discrimination Commissioner should be required, as part of the new National Disability Strategy, to report annually to the Parliament on the numbers and circumstances of all people with disability who are 65 years old or older and receiving aged care. In particular, they should report on the ability

¹⁰⁰⁹ See the submissions above on principles of the new aged care system.

¹⁰¹⁰ Australian Government, *National Disability Strategy 2010–2020*, 2011.

¹⁰¹¹ Australian Department of Social Services, *National Disability Strategy – Position Paper*, July 2020, p 3. See also Australian Government, *National Disability Strategy 2010–2020*, 2011, pp 3 and 9.

¹⁰¹² Australian Government, *National Disability Strategy 2010–2020*, 2011, p 67.

of those older people with disability to access through the aged care program daily living supports and outcomes (including assistive technologies, aids and equipment) equivalent to those available under the National Disability Insurance Scheme.

Part 3.13 Better access to health care

1009. People receiving aged care should have access to and receive high quality health care.
1010. Like all people in Australia, they should be able to see a general practitioner when they need to. That practitioner should be able to spend the time needed to deal with their health problems and to work with others, including allied health professionals, to provide coordinated care focused on reablement, maintenance and prevention.
1011. When aged care recipients' health problems are complex or acute, they should be able to access and receive specialist care. They should also be able to have their specific health care needs met, such as their oral and dental care needs, and their mental health care needs. They should be taking the right medications, and the fewest necessary.
1012. However, as detailed in Part 3 of these submissions, people receiving aged care are all too often missing out on getting proper access to adequate health care.
1013. The health care needs of people receiving aged care are, on average, more complex than those of the general population. Those complex needs regularly require a coordinated multidisciplinary response involving various people across both the health care and aged care systems. Higher levels of frailty and acuity also mean that it is difficult for some people receiving aged care, particularly those living in residential care, to travel to access health care services. There must be access to outreach health care services for people who need them.
1014. For these and other reasons, a breakdown in the relationship or meeting point or 'interface' between these two systems will be likely to have significant, and adverse, impacts on the health of people receiving aged care.¹⁰¹³ The respective roles of the health and aged care systems in delivering health care to people receiving aged care must be clearly defined, well understood, and effectively carried out.

Recommendation 62: A new primary care model to improve access

- 62.1. Commencing by no later than 1 January 2024, the Australian Government should implement a new voluntary primary care model for people receiving aged care.
- 62.2. The new primary care model would have the following characteristics:
- a. general practices may, if they choose, apply to the Australian Government to become accredited aged care general practices

¹⁰¹³ Interfaces between the aged care system and other systems, including the health care system, are a matter that this Royal Commission is required to have regard to when conducting its inquiry. See Letters Patent dated 6 December 2018, paragraph (j).

- b. the initial accreditation criteria would be:
 - i. accreditation with the Royal Australian College of General Practitioners
 - ii. participation in after-hours cooperative arrangements, and
 - iii. use of My Health Record
- c. over time, as aged care general practices mature, the accreditation requirements could be strengthened
- d. each accredited aged care general practice would enrol people receiving residential care or personal care at home who choose to be enrolled with that practice
- e. each accredited aged care general practice would receive an annual capitation payment for every enrolled person, based on the person's level of assessed need
- f. an accredited aged care general practice would agree with each enrolled person and the person's aged care provider on how care will be provided, including by any use of telehealth services and nurse practitioners
- g. the accredited aged care general practice would be required to:
 - i. meet the primary health care needs of each enrolled older person (including through any cooperative arrangements with other general practices to provide after-hours care if required)
 - ii. use My Health Record in conjunction with aged care providers
 - iii. initiate and take part in regular medication management reviews
 - iv. prepare an 'Aged Care Plan' (in collaboration with a geriatrician and the aged care provider and others) for each enrolled person
 - v. accept any person who wishes to enrol with it (subject to geography) to avoid practices accepting only patients with less complex care needs, and
 - vi. report on performance against a range of performance indicators, including immunisation rates and prescribing rates
- h. the capitation payment would be reduced by the value of benefits paid when an enrolled person sees a general practitioner in another practice.

62.3. The Australian Government should undertake a thorough evaluation of the new primary care model in 2030 and make appropriate adjustments to the model at that time.

1015. People receiving aged care should have better access to general practitioners. Australian Institute of Health and Welfare data suggests that almost everyone receiving aged care sees a general practitioner, and relatively often.¹⁰¹⁴ However, without data about the nature and extent of health care needs of aged care recipients, it cannot be concluded that the level of service provision actually meets those needs. And witnesses before the Royal Commission, whether residents, their families or staff, have regularly stated that it does not.¹⁰¹⁵ Primary health care practitioners are either not visiting people receiving aged care at their residences, or not visiting enough, or not spending adequate time with them to provide the care required.

1016. Part of the problem is the way general practitioners are funded. The existing fee-for-service remuneration model includes the following measures to facilitate access to general practitioners by people receiving aged care:

- a. rebates for attendances at residential aged care facilities for general practitioners applying under the Medicare Benefits Schedule, including a 'flag fall' rebate of \$56.75 in addition to a standard attendance rebate¹⁰¹⁶
- b. bulk billing incentives for primary health care services provided to people holding a concession card¹⁰¹⁷
- c. the General Practitioner Aged Care Access Incentive payment under the Practice Incentive Program.¹⁰¹⁸

1017. These measures have not proven to be sufficient for the type and amount of care needed by people receiving aged care.¹⁰¹⁹ Witnesses identified a number of problems with the

¹⁰¹⁴ Australian Institute of Health and Welfare, *Interfaces between the aged care and health systems in Australia—first results*, November 2019, p 6.

¹⁰¹⁵ Transcript, Canberra Hearing, Rhonda Payget, 13 December 2019 at T7593.35–7594.22; Transcript, Canberra Hearing, Rhonda McIntosh, 9 December 2019 at T7201.38–45; Transcript, Canberra Hearing, Judith Gardner, 11 December 2019 at T7421.39–42; Exhibit 14-7, Canberra Hearing, Supplementary Statement of Troye Wallett, WIT.0617.0002.0001 at 0002 [11]–[15]; Exhibit 14-1, Canberra Hearing, General Tender Bundle, tab 52, RCD.0011.0039.0001.

¹⁰¹⁶ Australian Department of Health, *Medicare Benefits Schedule Online*, Items 90001 and 90002.

¹⁰¹⁷ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0015 [65a].

¹⁰¹⁸ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0015 [65b].

¹⁰¹⁹ Exhibit 14-7, Canberra Hearing, Supplementary Statement of Troye Wallett, WIT.0617.0002.0001 at 0002 [11]–[15]; Exhibit 14-1, Canberra Hearing, General Tender Bundle, tab 52, RCD.0011.0039.0001; Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0005 [29].

type of care provided under the current fee-for-service model.¹⁰²⁰ Specifically, they told us it creates an incentive for:

- a. care that responds or reacts to an episode of ill-health, rather than encouraging care that proactively attempts to reduce the risk of ill-health
- b. care that is episodic, rather than based on an established long-term relationship
- c. care that is provided directly to the patient only, without communication with family and the aged care service, including contributing to clinical governance processes
- d. time limited consultations, which may not allow for the time needed to communicate effectively with people with reduced cognitive ability, and
- e. care delivered by general practitioners individually, rather than collaborating with other health practitioners as part of a multidisciplinary team.

1018. The current fee-for-service model has long been recognised as ‘in conflict with the proactive, coordinated and ongoing team based approaches that are needed to support the prevention and optimal management of chronic and complex conditions’.¹⁰²¹ This is particularly the case for the kind of complex care often needed by older people accessing aged care.

1019. The proposed new primary care model seeks to encourage the provision of holistic, coordinated and proactive health care for the growing complexity of aged care recipients’ needs. It is a capitation model with patient enrolment. The new model would include the following features:

- a. general practices would be apply to the Australian Government to become accredited aged care general practices
- b. each accredited aged care general practice would enrol people receiving residential care or personal care at home who choose to be enrolled with that practice
- c. each accredited aged care general practice would receive an annual capitation payment for every enrolled person, based on the person’s level of assessed need
- d. the accredited aged care general practice would be required:

¹⁰²⁰ Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7241.40–6242.35; Transcript, Canberra Hearing, Clare Skinner, 13 December 2019 at T7608.40–7609.6; Exhibit 14-33, Canberra Hearing, Statement of Clare Skinner, WIT.1302.0001.0001 at 0010 [51]–[52]; Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0006–0007 [41]–[42]; Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7510.9–18; Transcript, Canberra Hearing, Paresh Dawda, 9 December 2019 at T7239.19–23; Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7530.47–7531.8.

¹⁰²¹ Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Health Conditions*, December 2015, p 36.

- i. to meet the primary health care needs of each enrolled older person (including through any cooperative arrangements with other general practices to provide after-hours care if required)
 - ii. to use My Health Record in conjunction with aged care providers
 - iii. to initiate and take part in regular medication management reviews
 - iv. to prepare an 'Aged Care Plan' (in collaboration with a geriatrician and the aged care provider if there is one) for each enrolled person
 - v. to accept any person who wishes to enrol with it (subject to geography) to avoid practices accepting only patients with less complex care needs
 - vi. to report on performance against a range of performance indicators, including immunisation rates and prescribing rates
- e. the capitation payment would be reduced by the value of benefits paid when an enrolled person sees a general practitioner in another practice.

1020. This funding model is proposed for people receiving residential care or personal care at home. The existing fee-for-service model is better designed for the general population who have 'short-term' health care needs and can easily navigate the health care system and attend at a general practitioner's clinic.¹⁰²² That model is less suited to a population with highly complex and long-term health care needs, particularly people receiving residential aged care. A capitation model is better suited than the fee-for service model to the needs of people receiving aged care.¹⁰²³

1021. The Australian Government was intending to introduce a voluntary patient enrolment model for people with chronic conditions in July 2020, although this has been postponed.¹⁰²⁴ While this model would have adopted, at least in part, a form of capitation, it would not have gone far enough. The model would have remunerated general practitioners \$36 for each patient upon enrolment, and quarterly payments of \$30 thereafter. General practitioners would have still used the standard fee-for-service billing against MBS items for patient services.¹⁰²⁵

¹⁰²² Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7530.45–47.

¹⁰²³ Transcript, Canberra Hearing, Christopher McGowan, 12 December 2019 at T7530.45–7531.17; Exhibit 14-5, Canberra Hearing, Statement of Paresh Dawda, WIT.0618.0001.0001 at 0016–0017 [13.4a].

¹⁰²⁴ Royal Australian College of General Practitioners, *Voluntary patient enrolment initiative delayed*, 2020, <https://www1.racgp.org.au/newsgp/professional/voluntary-patient-enrolment-initiative-delayed>, viewed 13 October 2020; Australian Medical Association, 2020, *Voluntary patient enrolment delayed*, <https://ama.com.au/gp-network-news/voluntary-patient-enrolment-delayed>, viewed 13 October 2020.

¹⁰²⁵ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0061 [252]–[253].

1022. The extra capitated funding in this particular model was intended to compensate general practitioners for services that are currently not reimbursed through the fee-for-service funding model. These include services such as accessing repeat prescriptions; referrals without a face-to-face appointment; follow-up and monitoring via telephone and email; and inclusion of patients in recall and reminder systems for preventative health and chronic disease care.¹⁰²⁶ However, the additional payments appear to be too low.¹⁰²⁷ They are unlikely to be sufficient to promote a proactive preventative care model with regular rounds, reviews and comprehensive care plans. In essence, this model would have been a continuation of the fee-for-service status quo with some minor capitation payments added on.

1023. In the model we propose, the Australian Government should determine the amount of the annual capitation payments required to provide adequate incentives to general practitioners to meet the care needs of people receiving residential care or personal care at home. A tiered system for the payments should be established, with differing amounts depending on the level of care needs of the enrolled patients. The tiers would range from lower annual amounts for enrolled patients receiving lower levels of personal care at home up to the highest annual amount for enrolled patients receiving residential care. The amounts would be calculated by reference to the amount of primary health care services typically required by people receiving those respective levels of aged care. They would include a supplement to cover associated services, such as following up on referrals and diagnostic testing, liaison with other health professionals and aged care staff, and communication with family members.

1024. The specific provision for after-hours cooperative arrangements reflects the need of people receiving aged care for after-hours care, and the reality that it is not feasible for a single general practice to be available to enrolled patients 24 hours a day, seven days a week. Therefore, to provide for 24/7 coverage, accredited general practices would need to participate in cooperative arrangements with other general practices that provide after-hours care to enrolled patients. Where people receiving aged care access general practitioner services outside the accredited aged care general practice or the cooperative arrangement, the capitation funding for the accredited general practice would be reduced by an amount equal to the item billed under the Medicare Benefits Schedule. This approach would help drive continuity of care through a single general practice and

¹⁰²⁶ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0061–0062[253].

¹⁰²⁷ See, for example: Transcript, Canberra Hearing, Troye Wallett, 9 December 2019 at T7241.34–46; Exhibit 14-6, Canberra Hearing, Statement of Troye Wallett, WIT.0617.0001.0001 at 0006–0007 [30]–[36].

protect the Australian Government from paying for services twice: through both capitation and fee-for-service.

1025. It must be emphasised that participation in the new model, by general practices and the patients alike, would be voluntary. It would be a matter for a general practice if it wished to provide services to patients receiving aged care by the new model or by the existing fee-for-service model. A general practice's patients would not be obliged to enrol either. An aged care general practice could have two groups of patients receiving aged care, those funded under the new model and those funded under the traditional fee-for-service model.

1026. The new model would work towards maintaining standards of care, through the imposition of accreditation and ongoing requirements and accountability measures.

1027. Accountability measures feature in this model to mitigate against the risks of patient selectivity and underservicing. These accountability measures should be developed in consultation with the Australian Department of Health and professional bodies. They may include relevant measures from the Practice Incentives Program Quality Improvement Incentive including:

- a. 'proportion of patients with diabetes with a current HbA1c result'
- b. 'proportion of patients with a weight classification'
- c. 'proportion of patients aged 65 and over who were immunised against influenza'
- d. 'proportion of patients with diabetes with a blood pressure result'.¹⁰²⁸

1028. This proposed reform represents a significant change to the way in which primary health care is provided to people receiving aged care. If it is not to be introduced on a permanent basis, it should at least be trialled widely and for no less than six years. Any trial should be broad-based and should ensure that the existence of incentives to take up other funding models do not distort evaluation of the outcome of the trial.

Recommendation 63: Royal Australian College of General Practitioners' accreditation requirements

63.1. By 31 December 2021, the Royal Australian College of General Practitioners should amend its *Standards for general practices* to allow for accreditation of general practices which practise exclusively in providing primary health care to aged care recipients in residential aged care facilities and in their own homes.

¹⁰²⁸ Australian Department of Health, *Practice Incentives Program Quality Improvement Measures*, 2020.

1029. Innovative general practice business models geared towards providing general practice services to people receiving aged care in their own homes or in residential aged care facilities should be encouraged.
1030. Accreditation is important to ensure general practices provide safe care. They are also a trigger for adequate remuneration for work in aged care. At present, general practices need to be accredited against the *Standards for general practices* to be eligible for the additional funding available through the Australian Government's Practice Incentives Program.¹⁰²⁹ It is also proposed that accreditation against the Royal Australian College of General Practitioners' *Standards for general practices* should be a criterion for an aged care practice to participate in the new primary care model described above.
1031. In the Royal Australian College of General Practitioners' *Standards for general practices* (5th ed), GP Standard 2 requires that '[t]he scope of general practice is not limited by age, gender, body system, disease process, or service site'.¹⁰³⁰ GP Standard 5 sets out the physical standards that a general practice must meet and assumes the existence of a physical facility with equipment on site.¹⁰³¹ These requirements may have the practical effect of preventing innovative mobile general practices specialising in aged care from attaining accreditation. Those kinds of practices should not have to comply with these requirements in order to attain accreditation against the Royal Australian College of General Practitioners' Standards.
1032. The Royal Australian College of General Practitioners stated in 2019 that it intends to start work in 2020 to identify the requirements that mobile-type general practitioner services would need to meet for accreditation purposes.¹⁰³² That work should involve amendment of the Royal Australian College of General Practitioners' Standards to ensure that, for innovative mobile practices specialising in aged care, they are able to attain accreditation despite only providing services to people receiving aged care in residential aged care facilities or in their homes. That work should be completed by 31 December 2021.

Recommendation 64: Access to specialists and other health practitioners through Multidisciplinary Outreach Services

64.1. By 1 January 2022, the Australian and State and Territory Governments should introduce Local Hospital Network-led multidisciplinary outreach services.

¹⁰²⁹ Australian Government, *Practice Incentives Program guidelines*, September 2019.

¹⁰³⁰ Royal Australian College of General Practitioners, *Standards for general practices*, 5th edition, 2019, p 123.

¹⁰³¹ Royal Australian College of General Practitioners, *Standards for general practices*, 5th edition, 2019, p 150.

¹⁰³² Transcript, Canberra Hearing, Mark Morgan, 9 December 2019 at T7288.32–41.

- 64.2. These services should be funded through amendment of the National Health Reform Agreement, and all aged care recipients receiving residential care or personal care at home should have access based on clinical need.
- 64.3. The amended National Health Reform Agreement should include a recurrent and sustainable funding mechanism to stimulate outreach services. The level of funding should be based on underlying costs as determined by the Independent Hospital Pricing Authority.
- 64.4. The key features of the model should include:
- a. provision of services in a person's place of residence wherever possible
 - b. multidisciplinary teams, including nurse practitioners, allied health practitioners and pharmacists
 - c. access to a core group of relevant specialists, including geriatricians, psychogeriatricians and palliative care specialists
 - d. embedded escalation to other specialists (including endocrinologists, cardiologists, infectious disease specialists and wound specialists), who are already salaried within the hospital and assigned to the model for part of their work
 - e. 24 hour a day on-call services available to:
 - i. aged care recipients receiving residential care or personal care at home
 - ii. the families of those people receiving aged care, and
 - iii. staff of aged care services
 - f. proactive care and rehabilitation
 - g. a focus where feasible on skills transfer to staff working in aged care
 - h. a specific focus on palliative care outreach services
 - i. clinical governance arrangements involving Local Hospital Networks and relevant aged care and primary care providers.

1033. People receiving residential aged care and personal care at home are increasingly frail and have high rates of comorbidities.¹⁰³³ Older people living in residential aged care

¹⁰³³ M Inacio, C Lang, S Bray, R Visvanathan, C Whitehead, E Griffith, K Evans, M Corlis, S Wesselingh, 'Health Status and Health Care Trends of Individuals Accessing Australian Aged Care Programs Over a Decade: The Registry of Senior Australians (ROSA) Historical Cohort', *International Medicine Journal*, 2 May 2020.

have less access to health care provided by specialists than their peers in the community. People receiving aged care need improved access to multidisciplinary, specialist care.

1034. In 2016–17, 32% of people living in residential aged care facilities received a medical specialist consultation, funded pursuant to the Medicare Benefits Schedule, at least once. During the same period, 74% of older people receiving home support and 65% of older people receiving aged care at home had at least one medical specialist consultation funded under the MBS.¹⁰³⁴ We heard that some specialists do not visit residential aged care facilities and that sometimes people receiving aged care are being denied access to the State and Territory public health services they need, such as palliative care and sub-acute rehabilitation.¹⁰³⁵

1035. At the Canberra Hearing, Ms Glenys Beauchamp PSM, the then Secretary of the Australian Department of Health, acknowledged that Australian Institute of Health and Welfare data ‘would tend to suggest there may be an issue with access’ to specialist services for people living in residential aged care.¹⁰³⁶ She noted that poor access could be due to difficulties for older people with travelling to services, specialists not visiting them, as well as problems the general population experiences in accessing specialists (including lack of availability and costs).¹⁰³⁷

1036. To address this issue, Australian and State and Territory Governments should introduce Local Health Network-led multidisciplinary outreach services. These services should be accessible to all people receiving residential care or personal care at home, based on clinical need.

1037. To be effective, the multidisciplinary outreach services should, wherever possible, provide services in a person’s place of residence, building on hospital in the home as well as telehealth and other technology-based initiatives. Those services should be delivered by multidisciplinary teams, including nurse practitioners, allied health practitioners (such as, for example, speech pathologists, occupational therapists, physiotherapists), and pharmacists. There should be access to a core group of relevant specialists, including geriatricians, psychogeriatricians, and palliative care specialists,

¹⁰³⁴ Exhibit 14-1, Canberra Hearing, General Tender Bundle, Tab 66, Australian Institute for Health and Welfare Report, - Royal Commission Prepared Briefing, RCD.9999.0280.0003 at 0012 [5]. *[this figure relates to people over 50 – currently calculating figure for over 65. Otherwise need to change word in text to people over 50 not older people]*

¹⁰³⁵ Exhibit 14-17, Canberra Hearing, Statement of Hamish MacLeod, WIT.1309.0001.0001 at 0005 [32]; Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7460.7–11; Transcript, Canberra Hearing, Kristine Stevens, 9 December 2019 at T7228.24–7229.10.

¹⁰³⁶ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0039-0040 [162]–[164]; Exhibit 14-18, Canberra Hearing, Statement of Catherine Davis, WIT.1304.0001.0001 at 0008 [50]–[51]; Exhibit 5-32, Perth Hearing, Statement of Shannon Ruddock, WIT.1132.0001.0001 at 0006 [61]; 0011 [98]–[100]; 0012 [110]–0013 [115].

¹⁰³⁷ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0040-0043 [164]–[177].

with embedded escalation to other specialists (including endocrinologists, cardiologists, infectious disease specialists, wound specialists), who are already salaried within the hospital and assigned to the model for part of their work. 24/7 on-call services should be available. Performance measures and benchmarks should apply. There should be clinical governance arrangements involving Local Hospital Networks and relevant aged care and primary care providers.

1038. The multidisciplinary outreach services should be funded through the National Health Reform Agreement. There should be sufficient flexibility in funding to implement these services according to different models of care designed to meet the needs of the local population, variations in State and Territory health systems, and other service infrastructure. The National Health Reform Agreement should include a recurrent and sustainable funding mechanism to stimulate outreach services. The level of funding should be based on underlying costs as determined by the Independent Hospital Pricing Authority.

1039. Currently, most, if not all, State and Territories have some form of hospital-based outreach service into aged care facilities and older people's homes in some of their Local Hospital Networks.¹⁰³⁸ However, these services are not universally available, and some people in need miss out.

1040. These existing outreach programs are intended to improve older people's access to health care where they live, and to avoid unnecessary hospitalisations. For example:

- a. Clare Holland House's Palliative Aged Care Specialist team provides nurse practitioner-led care rounds in aged care facilities. These rounds include the provision of specialist palliative care; case conferencing with the resident and relatives, facility staff members, the treating general practitioner, and relevant health care providers, as well as working with the aged care facility staff to identify people who might benefit from palliative care planning.¹⁰³⁹
- b. Queensland Health's Comprehensive Aged Residents Emergency and Partners in Assessment Care and Treatment (CARE-PACT) provides care for people in

¹⁰³⁸ Exhibit 14-27, Canberra Hearing, Statement of Nigel Lyons, WIT.0568.0001.0001 at 0013–0014 [65] and 0014 [68]–[69]; Exhibit 14-28, Canberra Hearing, Statement of John Wakefield, WIT.0571.0001.0001 at 0008 [51]; 0043–0049; Exhibit 14-1, Canberra Hearing, General tender bundle, tab 71, WIT.0570.0002.0001 at 0018–0019; Exhibit 14-30, Canberra Hearing, Statement of Christopher McGowan, WIT.0566.0001.0001 at 0047 [259]–[261]; Exhibit 14-34, Canberra Hearing, Statement of Kathrine Morgan-Wicks, WIT.0569.0001.0001 at 0012–0013; Exhibit 14-35, Canberra Hearing, Statement of Maggie Jamieson, WIT.0567.0001.0001 at 0008 [24]; Exhibit 14-26, Canberra Hearing, Statement of Terry Symonds, WIT.0565.0001.0001 at 025 [157]–[160]; 033 [209]–[210]; 0041 [273]–[274]; Exhibit 14-37, Canberra Hearing, Statement of Michael De'Ath, WIT.0572.0001.0001 at 0012 [50]–[51]; 0017–0018 [87]; Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0003 [20].

¹⁰³⁹ Exhibit 14-22, Canberra Hearing, Statement of Nicole Johnston OAM, WIT.1315.0001.0001 at 0011 [68] and 0013 [78].

residential aged care who would otherwise be sent to a hospital emergency department.¹⁰⁴⁰

1041. Outreach services of this kind are multidisciplinary and cover a range of important services, including: aged care rounds, telephone triage, acute care in the residential aged care facility environment as an alternative to emergency department transfer, nursing assessments for people presenting to hospital, discharge planning, co-ordination and transitional communication, follow-up services within seven days of discharge, and specialist telehealth consultative services.

1042. People receiving aged care derive significant benefits from access to these outreach programs.¹⁰⁴¹ Many of the health professionals and State, Territory and Australian Government representatives who gave evidence at the Canberra Hearing supported, in principle, greater national consistency of access to multidisciplinary outreach services.¹⁰⁴² These programs can also achieve economic benefits, including savings to State and Territory Governments occasioned by reduced hospital admissions.¹⁰⁴³ However, outreach programs are not currently available to all Australians receiving aged care; coverage is patchy, haphazard, and subject to local funding restrictions and availability of local hospitals.¹⁰⁴⁴

1043. The benefits of the proposed model of outreach services would extend beyond mere hospital avoidance. Those outreach services would drive improved quality of health care for people receiving aged care more generally, including by increasing the capacity and knowledge of staff working at residential aged care facilities. Through the establishment of relationships between aged care providers and a multidisciplinary outreach team led by a Local Hospital Network, access would be provided to specialists and associated paraprofessionals to address care recipients' complex health issues outside the scope of primary care. In this way, the multidisciplinary outreach services would complement the proposed new primary health care model described at paragraphs 1015 to 1028 above.

¹⁰⁴⁰ Exhibit 14-13, Canberra Hearing, Statement of Terry Nash, WIT.1296.0001.0001 at 0002 [9].

¹⁰⁴¹ See for example: Exhibit 14-15, Canberra Hearing, Statement of Michael Montalto, WIT.0624.0001.0001 at 0006.

¹⁰⁴² See, for example, Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7275.29–33; Transcript, Canberra Hearing, Mark Morgan, 9 December 2019 at T7278.37–47; Transcript, Canberra Hearing, Michael De'ath, 13 December 2020 at T7632.32–39.

¹⁰⁴³ See, for example, Exhibit 14-1, Canberra Hearing, Canberra General Tender Bundle, tab 70, RCD.9999.0289.0001 at 0001; Exhibit 14-22, Canberra Hearing, Statement of Nikki Johnston, WIT.1315.0001.0001 at 0018 [98].

¹⁰⁴⁴ Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7280.19–28.

Recommendation 65: Increased access to Older Persons Mental Health Services

65.1. By 1 January 2022, the Australian and State and Territory Governments should:

- a. fund separately under the National Health Reform Agreement outreach services delivered by State and Territory Government older persons mental health services to aged care recipients receiving residential care or personal care at home
- b. introduce performance measures and benchmarks for these outreach services
- c. promulgate standardised service eligibility criteria for hospital, community based, and aged care older persons mental health services that do not exclude from eligibility for such services people with dementia.

1044. All State and Territory Governments, except the Northern Territory Government, provide a mental health service specifically for older people with severe and complex mental health conditions. In the main, these older persons mental health services are multidisciplinary, and include specialist, medical, nursing and allied health practitioners. They typically provide services to older people in hospitals and community settings and are delivered by Local Hospital Networks.

1045. People receiving residential aged care should have the same access to these older persons mental health services as their peers in the community. They experience severe and complex mental health conditions just as others do in the community. Some innovative models provide outreach services to people in residential aged care, including to people with dementia.¹⁰⁴⁵ However, the adequacy of delivery of older persons mental health services to people living in residential aged care varies.¹⁰⁴⁶

1046. Under-resourcing of these services is a major problem, forcing some services to prioritise clients.¹⁰⁴⁷ The Australian and State and Territory Governments jointly fund older persons mental health services through the National Health Reform Agreement. While

¹⁰⁴⁵ Exhibit 14-27, Canberra Hearing, Statement of Nigel Lyons, WIT.0568.0001.0001 at 0051–0052 [294]–[296]; Exhibit 14-28, Canberra Hearing, Statement of John Wakefield, WIT.0571.0001.0001 at 0039 [263]; Exhibit 14-30, Canberra Hearing, Statement of Christopher McGowan, WIT.0566.0001.0001 at 0045–0046 [248]–[252].

¹⁰⁴⁶ Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8121.23–29; Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen MacFarlane, WIT.0740.0001.0001 at 0005–006 [41] and [42]; Transcript, Melbourne Hearing 4, Stephen MacFarlane, 15 July 2020 at T8135.10–16.

¹⁰⁴⁷ Transcript, Melbourne Hearing 4, Stephen MacFarlane, 15 July 2020 at T8133.33–42; Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen MacFarlane, WIT.0740.0001.0001 at 0006 [49].

older persons mental health services should work closely with the proposed Local Health Network-led multidisciplinary outreach services described in paragraphs 1033 to 1043 above, there should be a specific stream of funding for older persons mental health services to ensure transparency about the use of resources and delivery of services specifically for mental health. The Royal Commission has heard evidence that State and Territory Governments have not previously had to account for how mental health funding has been allocated and have repurposed mental health funding into mainstream health care services.¹⁰⁴⁸

1047. The policy documents governing older persons mental health services in most States and Territories suggest that they provide services to people with severe behavioural or psychological symptoms associated with dementia. However, this does not always occur in practice.¹⁰⁴⁹

1048. While older persons mental health services are run by State and Territory Governments, the Australian Government funds a number of dementia-specific programs for people receiving aged care. These dementia-specific programs include the Dementia Behavioural Management Advisory Service and the Severe Behavioural Response Teams.¹⁰⁵⁰ The Australian Government is also in the process of establishing a Specialist Dementia Care Program which will provide specialist psycho-geriatric clinical in-reach services to the specialist dementia care units that sit within larger residential aged care facilities, and will aim to meet the needs of people living with very severe behavioural and psychological symptoms of dementia.¹⁰⁵¹

1049. Fragmentation between services can mean that people with dementia and psychiatric comorbidities, for whom there might be some debate about whether any given behaviour reflects dementia or a comorbidity, 'may often fall between the gaps' or be 'referred to multiple different services' until a service is provided.¹⁰⁵² Standardised eligibility criteria should ensure that an older person with mental health care needs is not prevented from accessing services from an older persons mental health service because the person is living with dementia. It would also address inconsistencies in eligibility criteria.

¹⁰⁴⁸ Exhibit 17-5, Melbourne Hearing 4, Statement of Stephen MacFarlane, WIT.0740.0001.0001 at 0006 [48]; Transcript, Melbourne Hearing 4, Stephen MacFarlane, 15 July 2020 at T8139.35-47.

¹⁰⁴⁹ Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8119.38-47

¹⁰⁵⁰ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0045 [186]-[187]; 0047 [197]; 0053 [212].

¹⁰⁵¹ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0047 [197].

¹⁰⁵² Transcript, Melbourne Hearing 4, Stephen MacFarlane, 15 July 2020 at T8136.16-31.

Recommendation 66: Establish a Senior Dental Benefits Scheme

66.1. The Australian Government should establish a new Senior Dental Benefits Scheme, commencing no later than 1 January 2023, which will:

- a. fund dental services to people who:
 - i. live in residential aged care, or
 - ii. live in the community and receive the age pension or qualify for the Commonwealth Seniors Health Card
- b. include benefits set at a level that minimises gap payments, and includes additional subsidies for outreach services provided to people who are unable to travel, with weightings for travel in remote areas
- c. provide benefits for services limited to treatment required to maintain a functional dentition (as defined by the World Health Organization) with a minimum of 20 teeth.

1050. Older people are far more likely to have poor oral health.¹⁰⁵³ Poor oral health has obvious adverse consequences, including social isolation, functional impairment, pain and discomfort, ill health and even death.¹⁰⁵⁴ It can affect a person's ability to speak, eat and socialise. It can contribute to serious health conditions, including tooth decay, aspiration pneumonia and mouth cancer. It is also linked with other chronic conditions, such as diabetes, respiratory diseases and cerebrovascular diseases.¹⁰⁵⁵ As people get older and increasingly frail, the ability to adhere to good oral health practices can decline rapidly.¹⁰⁵⁶

1051. Older people at home, people moving into residential aged care and people receiving residential aged care need improved access to the full range of dental services, including those provided by oral health practitioners, general and specialist dentists, and dental prosthetists. Older people with a low socio-economic status and people receiving

¹⁰⁵³ Australian Research Centre for Population Oral Health, *Australia's Oral Health National Study of Adult Oral Health 2017-18*, 2019, pp ix–exi; xiii; Australian Government, *National Oral Health Plan 2015-2024 Healthy Mouths, Healthy Lives*, p 65.

¹⁰⁵⁴ See, for example, Exhibit 6-49, Cairns Hearing, Statement of Adrienne Lewis, WIT.0246.0001.0001 at 0003–0005 [14]–[26]; Exhibit 3-51, Sydney Hearing, Statement of Peter Foltyn, WIT.0121.0001.0001 at 0004–0005 [27]–[28]; 0009–0010 [46]–[54]; Exhibit 17-14, Melbourne Hearing 4, Statement of Martin Dooland, RCD.9999.0313.0001 at 0002–0003; Australian Institute of Health and Welfare, *Oral Health and Dental Care in Australia*, 2020.

¹⁰⁵⁵ Exhibit 6-33, Darwin Hearing, Statement of Catherine Maloney, WIT.0198.0001.0001 at 0002 [6].

¹⁰⁵⁶ Exhibit 17-1, Melbourne Hearing 4, General Tender Bundle, tab 16, RCD.9999.0305.0001 at 0004 [29]; Exhibit 17-11, Melbourne Hearing 4, Statement of Kathleen Matthews, RCD.9999.0302.0001 at 0002 [3].

residential aged care are at particularly high risk of experiencing oral health problems.¹⁰⁵⁷
In addition, people often arrive in residential care with oral health problems.¹⁰⁵⁸

1052. As outlined above in submissions on program design, oral health practitioners should form part of the allied health teams available for people receiving residential care or personal care at home. Those practitioners should engage in a range of preventative treatments, including overseeing aged care residents' daily oral health management such as tooth brushing and denture cleaning. Nevertheless, even with the best preventative treatments, people receiving aged care will still need, from time to time, access to dental services from dentists and dental surgeons. The introduction of a Senior Dental Benefits Scheme is intended to ensure that oral health practitioners who conduct routine assessments in aged care will have a more readily available avenue for referral when necessary.

1053. To overcome the reduced mobility of many aged care recipients, dental services should, when needed, be provided to older people at their place of residence. Many dental health services can be delivered in residential aged care facilities or within the community. At a minimum, outreach dental services require a clean and well-lit area that has access to running water and capacity for portable equipment.¹⁰⁵⁹

1054. There are already some dental outreach services being delivered in aged care settings across Australia.¹⁰⁶⁰ As with other outreach programs, these dental outreach services are not consistently provided. Outreach dental services should be publicly funded under the proposed Senior Dental Benefits Scheme for people living in residential aged care. A large proportion of those people are likely to be eligible for public dental services.¹⁰⁶¹ However, public dental services are already at capacity, with long waiting lists. And private dental services need a financial incentive to off-set the lost costs of leaving their practices to conduct an outreach service.

¹⁰⁵⁷ Australian Government, *National Oral Health Plan 2015-2024 Healthy Mouths, Healthy Lives*, p 65.

¹⁰⁵⁸ Exhibit 17-14, Melbourne Hearing 4, Statement of Martin Dooland, RCD.9999.0313.0001 at 0002; Exhibit 14-30, Canberra Hearing, Statement of Christopher McGowan, WIT.0566.0001.0001 at 0006 [38]; Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon, RCD.9999.0299.0001 at 0003 [10].

¹⁰⁵⁹ Transcript, Melbourne Hearing 4, Martin Dooland, 16 July 2020 at T8220.6–14; Exhibit 17-11, Melbourne Hearing 4, Statement of Kathleen Matthews, RCD.9999.0302.0001 at 0004–0005 [8]; Exhibit 17-9, Melbourne Hearing 4, Statement of Janet Wallace, RCD.9999.0303.0001 at 0007 [6].

¹⁰⁶⁰ See, for example: Transcript, Melbourne Hearing 4, Kathleen Matthews, 16 July 2020 at T8183.23–8184.11; Exhibit 17-1, Melbourne Hearing 4, General tender bundle, tab 16, RCD.9999.0305.0001 at 0001 [3]; Transcript, Cairns Hearing, Adrienne Lewis, 16 July 2019 at T3678.29–32.

¹⁰⁶¹ Exhibit 17-10, Melbourne Hearing 4, Statement of Nicole Stormon, RCD.9999.0299.0001 at 0004 [15]; Australian Research Centre for Population Oral Health, *Australia's Oral Health National Study of Adult Oral Health 2017-18*, 2019, p 36; Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Sector*, 2020, p 31.

1055. The proposed Scheme would also provide comprehensive dental health care to older people who cannot afford to fund it themselves, before they have any need to access residential aged care services. The consequences of poor oral health can worsen people's overall health and functioning to the point that they need residential aged care earlier than they might otherwise.¹⁰⁶² Again, many of these people would already be eligible for adult public dental services but cannot access them due to excessive waiting lists.
1056. The proposed Senior Dental Benefits Scheme would provide national consistency, avoid waiting lists and provide ongoing systemic funding for dental services. Such a scheme would be a modified version of what was proposed by the Australian Dental Association in its 2019 Dental Health Plan.¹⁰⁶³
1057. The Senior Dental Benefits Scheme should not to be paid for by a reduction in funding for already overstretched public dental services. Ensuring funding is in addition to the already existing public dental services will redirect some demand for those services and may reduce the wait time for people under 65 years old who need those public dental services.
1058. The risks of excessive costs under the Senior Dental Benefits Scheme should be managed by limiting eligibility to aged care residents and older people who receive the age pension or qualify for a Commonwealth Seniors Card, and by limiting the scope of services provided under the scheme to those services necessary to maintain a functional dentition, that is, 20 or more teeth.

Recommendation 67: Short-term changes to the Medicare Benefits Schedule to improve access to medical and allied health services

67.1. The Australian Government should:

- a. create new Medicare Benefits Schedule items by 1 November 2021 to allow for a benefit to be paid for a comprehensive health assessment, whether conducted by a general practitioner or a nurse practitioner, when an aged care recipient begins to receive residential aged care or personal care at home and at six month intervals thereafter, or more frequently if there is a material change in a person's circumstances or health

¹⁰⁶² Exhibit 6-49, Cairns Hearing, Statement of Adrienne Lewis, WIT.0246.0001.0001 at 0003 [14]–[18]; 0006 [32]; S Duckett, M Cowgill and H Swerissen, *Filling the gap – A universal dental scheme for Australia*, p 3.

¹⁰⁶³ Australian Dental Association, *The Australian Dental Health Plan: Achieving Optimal Oral Health*, 2019.

- b. immediately amend the Medicare Benefits Schedule to allow benefits to be paid under the GP Mental Health Treatment items 2700 to 2717 to patients receiving these services within a residential aged care service
 - c. create new Medicare Benefits Schedule items by 1 November 2021 for:
 - i. a mental health assessment, and subsequent development of a treatment plan, by a general practitioner or psychiatrist, within two months of a person's entry into residential aged care
 - ii. three monthly re-assessments or reviews of a mental health assessment by a general practitioner, psychiatrist, or psychologist
 - d. create new Medicare Benefits Schedule items by 1 November 2021, with the value of the benefit aligned with recommended professional fees, for allied mental health practitioners providing services to people in residential aged care and:
 - i. the number of services for which a benefit is payable should be based on clinical advice
 - ii. these benefits should cease on 1 January 2023, when the aged care allied health funding arrangement is established
 - e. amend the General Practitioner Aged Care Access Incentive payment to:
 - i. increase the minimum annual number of services required by general practitioners to qualify for the payment and the amount of the corresponding payment
 - ii. introduce incremental increases to the amount of the payment for general practitioners who deliver more the minimum annual number of services
- and index these amounts on the same basis as Medicare Benefits Schedule general practitioner attendance items.

1059. The proposed improvements to access to primary health care, specialists and mental and dental health care will take time to develop and implement. They will not come into effect immediately. In the short term, other measures should be put in place as a matter of priority to improve poor access by aged care recipients to health care services. Some of those short-term measures will not be required once the longer-term improvements are introduced.

Comprehensive health assessments for people receiving aged care

1060. Currently, general practitioners and other medical practitioners can access Medicare benefits for comprehensive health assessments for a range of groups, including people living in residential care and people aged 75 years and over.¹⁰⁶⁴ This restricts older people who receive aged care in the community and who are aged between 65 and 74 from accessing subsidised comprehensive health assessments.
1061. Medicare should fund the aged care comprehensive health assessments whenever they are clinically required. The relevant items in the Medicare Benefits Schedule should also be made available to nurse practitioners.
1062. Currently, for those items relating to residents in aged care facilities, the Medicare Benefits Schedule requires that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care facility.¹⁰⁶⁵ However, claims against these item numbers are capped at once every 12 months and do not include exceptions for changing health circumstances. This means that, when an aged care resident experiences a significant change in health, even one requiring hospitalisation, the person would not be eligible for a Medicare-subsidised comprehensive health assessment if they had received such an assessment in the previous twelve months.
1063. Specific new MBS items should be introduced for aged care comprehensive health assessments, rather than amending existing MBS item numbers. The creation of new items specific to people receiving aged care will facilitate monitoring of the adoption and impact of the items.

Equal access to Medicare-subsidised mental health services

1064. People living in residential aged care should at a minimum have access to the same mental health services as people in the community. Poor mental health is a serious problem in aged care. Just under half of permanent aged care residents have a diagnosis of depression.¹⁰⁶⁶ That compares with the general rates of depression for people aged 75 years and over, which were 7% for males and 12% for females.¹⁰⁶⁷

¹⁰⁶⁴ Australian Department of Health, *Medicare Benefits Schedule Online*, Items 224, 227, 701, 703, 705 and 707.

¹⁰⁶⁵ Australian Department of Health, *Medicare Benefits Schedule Online*, Item 705.

¹⁰⁶⁶ Australian Institute of Health and Welfare, *People's care needs in permanent residential aged care: Factsheet 2018-19*, Australian Government, 2020, https://gen-agedcaredata.gov.au/www_ahwgen/media/Factsheets-for-2019%e2%80%932020-GEN-update/Peoples-care-needs-in-aged-care-factsheet.pdf, viewed 26 August 2020.

¹⁰⁶⁷ Australian Bureau of Statistics, *National Health Survey: First Results, 2017-18*, Australian Government, 2020, <https://www.abs.gov.au/AUSSTATS/ABS@.NSF/0/F6CE5715FE4AC1B1CA257AA30014C725?Opendocument>, viewed 28 January 2020.

Depression in older people is associated with a decline in overall wellbeing, daily functioning, independence and autonomy, as well as disability, suicidal ideation, and mortality.¹⁰⁶⁸ In the program design submissions above, it is proposed that aged care providers should employ or engage allied mental health practitioners. This will assist in maintaining the mental health of older people. However, at least until this measure is implemented, people should be able to access Medicare-subsidised mental health care.

1065. Under the Better Access Initiative, Medicare benefits are payable for general practitioners and psychiatrists to assess and diagnose someone with a mental illness and establish a mental health treatment plan. When a mental health treatment plan is in place, it allows referrals for:

- a. ten MBS-subsidised 'psychological services' per year (which include a broad range of allied mental health services provided by clinical psychologists, registered psychologists, social workers, occupational therapists, or general practitioners who have completed accredited mental health training), and
- b. ten MBS-subsidised separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies).

1066. However, aged care residents are not eligible for general practitioner mental health treatment plans under the Better Access Initiative.

1067. The consequences of lack of access to the Better Access program were apparent during the COVID-19 pandemic in 2020, when the Australian Government made a number of incremental expansions to the program.¹⁰⁶⁹ But to benefit from these expansions, people needed to be eligible for the Better Access Initiative. Aged care residents did not get that benefit. They should have. Any barriers to aged care residents using Medicare-subsidised services under the Better Access Initiative should be removed immediately.

1068. In 2018, the Australian Government attempted to bridge the gap in access to mental health services between the community and residential aged care by allocating \$82.5 million over four years to Primary Health Networks to commission psychological services for people living in residential aged care.¹⁰⁷⁰ So far, this program has not produced sufficient access to mental health services – it is not clear that that situation will change.¹⁰⁷¹

¹⁰⁶⁸ National Ageing Research Institute, *Mental Health of Older Adults: A National Ageing Research Institute Position Paper*, 2019, p 2.

¹⁰⁶⁹ Australian Department of Health, *Looking after your mental health during coronavirus (COVID-19) restrictions*, 2020.

¹⁰⁷⁰ Department of Health, Portfolio Budget Statements 2018-19, Budget Relates Paper No. 1.9, 2018, p 66.

¹⁰⁷¹ Exhibit 17-1, Melbourne Hearing 4, General Tender Bundle, tab 31, CTH.1000.0004.9254; Transcript, Melbourne Hearing 4, Sunil Bhar, 15 July 2020 at T8163.9–27; Transcript, Melbourne

1069. Entry into residential care and the institutionalised environment will itself often contribute to mental health issues.¹⁰⁷² Not only is entering residential care a major life event, but it is often associated with the death of a spouse or other carer, or a major debilitating injury or illness.
1070. People entering or living in residential aged care are not systematically assessed for mental health conditions.¹⁰⁷³ The care people receive is primarily determined by the aged care provider and the care plan that staff members develop with the resident. It is dependent on residential aged care staff identifying when people have mental health needs and seeking an assessment. Aged care staff are not well equipped to undertake that task.¹⁰⁷⁴
1071. The mental health assessment and treatment process in aged care requires significant improvements. Given the high rates of mental illness in residential aged care, new Medicare Benefits Schedules items should be introduced to:
- a. support mental health assessments – and development of a mental health treatment plan, when required – for all older people within two months of entry to residential aged care, or at any subsequent time if a resident or their care provider seeks an assessment;¹⁰⁷⁵ and
 - b. support regular three-monthly reviews of treatment plans.
1072. These assessment and planning processes should be carried out by a psychiatrist or a general practitioner who has undertaken mental health skills training as defined under the Medicare Benefits Schedule. Reviews should be undertaken by a psychiatrist, a general practitioner, or a psychologist.¹⁰⁷⁶ The treatment plans should include referrals

Hearing 4, Mark Silver, 15 July 2020 at T8163.33–8164.3; Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8108.28–43.

¹⁰⁷² See, for example, Transcript, Sydney Hearing 1, Henry Brodaty, 17 May 2019 at T1904.15–25; Transcript, Melbourne Hearing 1, James Nutt, 11 September 2019 at T5161.31–41; Transcript, Melbourne Hearing 4, Stephen Macfarlane, 15 July 2020 at T8127.36–38; Exhibit 17-1, Melbourne Hearing 4, General Tender Bundle, tab 05, AWF.600.01288.0001 at 0014; Submission of Beyond Blue, 26 September 2020, AWF.001.04302.01 at 0005.

¹⁰⁷³ Exhibit 17-1, Melbourne Hearing 4, General Tender Bundle, tab 05, AWF.600.01288.0001 at 0014; Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0007–0008; Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim WIT.0115.0001.0001 at 0019–0020 [95]–[97]; Submission of Mental Health Carers NSW, AWF.001.04348.01 at 0006–0007.

¹⁰⁷⁴ Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0004–0005; Exhibit 17-3, Melbourne Hearing 4, Response to draft propositions - Alison Argo, RCD.9999.0362.0001 at 0002.

¹⁰⁷⁵ Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0008.

¹⁰⁷⁶ Transcript, Melbourne Hearing 4, Alison Argo, 15 July 2020 at T8113.5–21; Transcript, Melbourne Hearing 4, Diane Corser, 15 July 2020 at T8112.29–44; Transcript, Melbourne Hearing 4, Sunil Bhar, 15 July 2020 at T8154.30–45; Transcript, Melbourne Hearing 4, Leanne Beagley, 15 July 2020 at T8155.1–9.

for treatment provided by appropriate mental allied health practitioners and reimbursed through the Medicare Benefits Schedule.

1073. These measures will restore equity in access to mental health services for people living in residential aged care.

Expanded access to Medicare-subsidised allied mental health services

1074. The Royal Commission has received evidence about the extensive use of psychotropic medication in residential aged care facilities to manage people's behaviours and address mental health conditions like depression and anxiety.¹⁰⁷⁷ On the other hand, the Royal Commission has also received evidence that there is a lack of access to psychosocial supports and psychological services.¹⁰⁷⁸

1075. In 2019, the Australian Government created a package of new Medicare Benefit Schedule items for treating eating disorders. Under these arrangements, patients with anorexia nervosa and other eating disorders can receive up to 40 Medicare-subsidised psychological treatment services in a 12-month period.¹⁰⁷⁹ Evidence before the Royal Commission supports making a similar number of subsidised services available to people receiving residential aged care because of their increased frailty, comorbidities and reduced mobility.¹⁰⁸⁰ The precise number of services for aged care residents for which a benefit is payable should be based on clinical advice.

1076. Further, the Medicare Benefits Schedule rebates for mental health services are significantly lower than the fees recommended by professional bodies.¹⁰⁸¹ As a result, allied mental health practitioners will often charge an out-of-pocket fee to patients. This is likely to create a barrier to access for the many people living in residential aged care who are full or part pensioners. The Medicare benefits for these services should be set at a level to minimise out-of-pocket charges, recognising the range of fees commonly charged by the relevant professional groups. The value of the new Medicare Benefits Schedule items for allied mental health practitioners providing services to people in

¹⁰⁷⁷ Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0004.

¹⁰⁷⁸ Exhibit 17-8, Melbourne Hearing 4, Statement of Harry Lovelock, RCD.9999.0309.0001 at 0007 [32]; TE Davison et al, 'Brief on the role of psychologists in residential and home care services for older adults', *Australian Psychologist*, 2016, Vol 52, 6, pp 397–405.

¹⁰⁷⁹ Australian Department of Health, *Upcoming changes to MBS items - Eating Disorders*, 2019, <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-EatingDisorders>, viewed 28 August 2020.

¹⁰⁸⁰ See, for example, Exhibit 17-6, Melbourne Hearing 4, Statement of Sunil Bhar, RCD.9999.0308.0001 at 0009.

¹⁰⁸¹ See, for example, Australian Department of Health, *Medicare Benefits Schedule Online*, Items 8000-8015; Australian Psychological Society, *Psychologist Fees*, <https://www.psychology.org.au/for-the-public/about-psychology/what-it-costs>, viewed 14 September 2020.

residential aged care should be more closely aligned with recommended professional fees.

1077. These benefits should cease once the aged care allied health funding arrangement detailed in the program design submissions above is established.

Changes to the General Practitioner Aged Care Access Incentive Payment

1078. The General Practitioner Aged Care Access Incentive seeks to encourage general practitioners to deliver more services to people living in residential aged care and to support continuity of care through funding general practitioners to continue seeing patients living in residential aged care.¹⁰⁸²

1079. The current General Practitioner Aged Care Access Incentive is a tiered system. The Tier 1 threshold pays \$1,500 to general practitioners who provide at least 60 services annually – little more than one service per week – in residential aged care. Under the Tier 2 threshold, a further \$3,500 is available to general practitioners who provide 140 services annually.¹⁰⁸³ This still only amounts to fewer than three services per week.

1080. This incentive payment needs to better reflect the additional burden on a general practitioner's time when attending a patient in a residential aged care facility. That burden exists by reason of, for example, travel to and from, and orientation at, the facility, discussions with staff and family, attendances on higher acuity patients, greater medication management, and keeping and reviewing records at the facility.¹⁰⁸⁴ Similarly, a greater burden is placed on general practitioner's time when attending high acuity patients in their homes.

1081. Changes to the General Practitioner Aged Care Access Incentive Payment should address this issue, in part, until introduction of the new primary care capitation-based funding model described above. One possible form of change is as follows.

¹⁰⁸² Exhibit 12-25, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0001.0001 at 0015 [65b].

¹⁰⁸³ Exhibit 12-25, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0001.0001 at 0015 [65b].

¹⁰⁸⁴ Transcript, Canberra Hearing, Anthony Bartone, 9 December 2019 at T7277.33–42; Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7422.26–32; Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7510.9–18.

Tier	Current Qualifying Service Level ¹⁰⁸⁵	Current Service Incentive Payment	New Qualifying Service Level	New Service Incentive Payment
Tier 1	60 services in a financial year (1.1 service per week)	\$1,500	120 services in a financial year (2.3 services a week)	\$3,000
Incremental increase	No incremental increase	Not applicable	160 services in a financial year (3 services a week)	\$4,000
			200 services in a financial year (3.8 services a week)	\$5,000
			240 services in a financial year (4.6 services a week)	\$6,000
Tier 2	140 services in a financial year (2.7 services per week)	\$3,500	280 services in a financial year (5.4 services per week)	\$7,000

1082. The exact nature of the increase in qualifying services and corresponding payments should be ascertained by the Australian Government. There should be incremental steps for every 40 additional services so that a practitioner who provides, say, 279 services does not receive the same incentive as a person who provides 120 services.

1083. These payments should be indexed on the same basis as Medicare Benefits Schedule general practitioner attendance items. This measure should only be a temporary one until the new primary care funding model for aged care recipients described at paragraphs 1015 to 1028 above is implemented. Once that has occurred, this measure could be phased out. During this interim period, the payment should be extended to services provided in a person's home for people who are currently on Level 3 or 4 Home Care Packages.

¹⁰⁸⁵ Australian Department of Health, *Medicare Benefits Schedule Online*, Items 232, 249, 731, 741, 763, 772, 789, 903, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267, 90020, 90035, 90043, 90051, 90092, 90093, 90095, 90096, 90183, 90188, 90202 and 90212; Services Australia, *General Practitioner Aged Care Access Incentive Guidelines*, 2019, <https://www.servicesaustralia.gov.au/sites/default/files/gp-aged-care-pip-guidelines-august-2019.docx>, viewed 22 May 2020.

Recommendation 68: Enhance the Rural Health Outreach Fund to improve access to medical specialists for people receiving aged care

68.1. The Australian Government should:

- a. amend the priorities of the Rural Health Outreach Fund by 1 July 2021 to include delivery of:
 - i. geriatrician services in regional, rural and remote Australia, and
 - ii. medical specialist services to people receiving aged care in regional, rural and remote Australia
- b. increase, for these additional priorities, the annual funds available by \$9.6 million, starting in the 2021–22 financial year, and
- c. ensure that these additional priorities of the Fund are maintained on an ongoing basis.

1084. The Rural Health Outreach Fund was established by the Australian Government to ‘improve health outcomes for people living in regional, rural and remote locations by supporting the delivery of outreach health activities’.¹⁰⁸⁶

1085. The fund is intended to improve access to medical specialist, general practitioner, nursing, allied health and multidisciplinary team services in regional, rural and remote areas of Australia. The funding provided through the Rural Health Outreach Fund is directed at addressing the financial disincentives associated with health professionals providing outreach services in regional, rural and remote locations, including travel, accommodation, and equipment and room hire.¹⁰⁸⁷ At present, the four priorities of the Rural Health Outreach Fund are chronic disease management, eye health, maternity and paediatric health, and mental health.¹⁰⁸⁸

1086. People accessing aged care in regional, rural and remote locations have poor access to health care.¹⁰⁸⁹ This is particularly so in relation to access to specialists.¹⁰⁹⁰

¹⁰⁸⁶ Rural Health Outreach Fund, *Service Delivery Standards*, 2020, p 5.

¹⁰⁸⁷ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0047–0048 [198].

¹⁰⁸⁸ Australian Department of Health, *Rural Health Outreach Fund*, 2020, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/budget2011-flexfund-rural13.htm>, viewed 20 March 2020.

¹⁰⁸⁹ Australian Institute of Health and Welfare, *Rural and Remote Health*, 2019; Exhibit 4-7, Broome Hearing, Statement of Martin Laverty, WIT.0157.0001.0001 at 0002 [9]; Exhibit 14-30, Canberra Hearing, Statement of Christopher McGowan, WIT.0566.0001.0001 at 0038–0039 [205]–[212].

¹⁰⁹⁰ Transcript, Broome Hearing, Martin Laverty, 18 June 2019 at T2050.12–40; T2051.7–11; T2051.20-23; T2058.8–9; Transcript, Mudgee Hearing, Fiona Lysaught, 11 December 2019 at T7428.41–46; Transcript, Mildura Hearing, Darren Midgley, 31 July 2019 at T4097.8–12.

1087. The Australian Government accepts that an additional priority of the Rural Health Outreach Fund should be geriatrician outreach services.¹⁰⁹¹ We agree with prioritising funding for geriatricians under the Fund.

1088. This will not, of itself, address the problems that aged care recipients face in accessing specialist services. Even though chronic disease management and mental health are current priorities for the Rural Health Outreach Fund, and many aged care residents suffer from chronic disease and mental illness, there is no evidence that these needs are being addressed adequately through the Fund.¹⁰⁹²

1089. Aged care should itself added as a further priority area of the Rural Health Outreach Fund so that the full suite of specialist services are available for older people who live in aged care in regional, rural and remote areas.

1090. The Australian Government currently spends a little over \$27 million annually on four priority areas through the Rural Health Outreach Fund.¹⁰⁹³ Based on the number of older people in regional, rural and remote locations and the current per capita spend of the program, estimated additional funding of around \$9.6 million annually (indexed) would be required to address aged care and geriatricians as priority areas.

Recommendation 69: Access to specialist telehealth services

69.1. By 1 November 2021, the Australian Government should:

- a. expand access to Medicare Benefits Schedule-funded specialist telehealth services to aged care recipients receiving personal care at home
- b. require aged care providers delivering residential care or personal care at home to have the necessary equipment and clinically and culturally capable staff to support telehealth services.

1091. The World Health Organisation defines telehealth as ‘the use of telecommunications and virtual technology to deliver health care outside of traditional health-care facilities’.¹⁰⁹⁴ The use of telehealth has become widespread as a result of the COVID-19 pandemic in

¹⁰⁹¹ Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0019 [56].

¹⁰⁹² Australian Institute of Health and Welfare, *Australia’s health 2016: Australia’s health series no. 15*, 2016, pp 248–251.

¹⁰⁹³ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0047–48 [198].

¹⁰⁹⁴ World Health Organization, *Telehealth*, 2020, <https://www.who.int/sustainable-development/health-sector/strategies/telehealth/en/>, viewed 1 May 2020.

2020 and the Australian Government's temporary expansion of telehealth to reduce community transmission of the virus.¹⁰⁹⁵

1092. Telehealth will continue to provide benefits in aged care beyond the COVID-19 pandemic. In short, it is a means of avoiding the potential harm and distress caused by travel for frail older people. At present, telehealth services are underused by specialists and aged care providers. There should be increased use of telehealth for medical specialist consultations with people receiving residential care or personal care at home.

1093. The Australian Government introduced telehealth Medicare Benefits Schedule items in 2011 to address barriers to accessing specialist services.¹⁰⁹⁶ These items allow consultant physicians, psychiatrists or specialists to claim rebates for video consultations provided to patients in specified locations. These MBS-subsidised specialist telehealth services are available to people living in residential aged care. They are not available to older people who access aged care from their homes unless they live in remote Australia or access an Aboriginal Medical Service.¹⁰⁹⁷ However, increasing numbers of older people are accessing aged care services from their homes. As this occurs, more older people with high levels of frailty need to receive proper health care in their homes. Specialist telehealth services should be available to these people also.

1094. Aged care providers need to support the provision of telehealth by ensuring the right equipment and staff members are available to people receiving aged care, whether receiving residential care or personal care at home, to access telehealth services. In particular, aged care providers should ensure that there is a qualified health professional present with the older person during the telehealth consultation to record the outcomes of the consultation and take action to initiate any recommended changes to medication, diet or other regimes.

1095. Finally, the Australian Medical Association and medical colleges should also encourage their members to increase the use of telehealth services. These bodies should report annually to the Australian Government on their members' use of telehealth services.

¹⁰⁹⁵ Australian Government Department of Health, *COVID-19 Temporary MBS Telehealth Services*, 2020, <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB> viewed 17 September 2020.

¹⁰⁹⁶ Australian Department of Health, *Program Guidelines: Financial Incentives for Telehealth*, 2020, p 1; Exhibit 14.31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0042 [175].

¹⁰⁹⁷ Australian Department of Health, *Medicare Rebates for Specialist Video Consultations*, 2020.

Recommendation 70: Increased access to medication management reviews

70.1. The Australian Government should immediately improve access to quality medication management reviews for people receiving aged care by:

- a. allowing and funding pharmacists from 1 January 2022 to conduct reviews on entry to residential care and annually thereafter, or more often if there has been a significant change to the care recipient's condition or medication regimen
- b. amending the criteria for eligibility for residential medication management reviews to include people in residential respite care and transition care
- c. monitoring quality and consistency of medication management reviews.

1096. In aged care, medication management reviews are critical to reduce chemical restraint and other inappropriate use of medications.¹⁰⁹⁸ Medication management reviews allow for assessment of all of the medicines that a person is taking and not just medicines used for chemical restraint. Accredited pharmacists performing medication management reviews can look at whether the long-term medicines a person is taking are still necessary or appropriate based on changes to a person's health condition. They can also look at whether medicines are interacting with other medicines, or potentially causing harmful side effects.

1097. In accordance with our proposed recommendation for provision of allied health in aged care, pharmacists engaged by approved providers as part of their multidisciplinary allied health teams should undertake, among other things, a review of a person's medications whenever appropriate. Implementation of that recommendation will take time. Other measures can be put in place in the meantime.

1098. Currently, Australian Government-subsidised reviews of medication regimes, known as Medication Management Reviews, are governed by the Community Pharmacy Agreement. Under the Community Pharmacy Agreement, people living in residential aged care can have a Residential Medication Management Review performed by an accredited pharmacist when referred by their general practitioner.¹⁰⁹⁹ These reviews are not available for people receiving respite or transition care.¹¹⁰⁰ The accredited

¹⁰⁹⁸ See, for example, Exhibit 3-61, Sydney Hearing 1, Statement of Juanita Westbury, WIT.0117.0001.0001 at 0003–0004 [8]–[9e]; Exhibit 6-32, Darwin Hearing, Statement of Janet Sluggett, WIT.0251.0001.0001 at 0021 [39].

¹⁰⁹⁹ See the Seventh Community Pharmacy Agreement signed 11 June 2020. See also Australian Department of Health, *Medicare Benefits Schedule*, Item 903.

¹¹⁰⁰ Australian Department of Health, *Medicare Benefits Schedule Online Associated Note 0.52 Medication Management Reviews (Items 900 and 903)*.

pharmacist will generate a report at the end of the review, which the general practitioner can use to develop or revise the resident's medication management plan. A Home Medicine Review service is available for those who live in the community.¹¹⁰¹ Pharmacists are paid a fee for each review that they perform.¹¹⁰²

1099. At present, aged care residents are entitled to only one Residential Medication Management Review every 24 months unless there are significant changes to the person's medical condition or medication regimen.¹¹⁰³ They are also entitled to two follow-up interviews by an accredited pharmacist no earlier than one month and no later than nine months after the initial medication review. However, these follow-up interviews are not comprehensive reviews.¹¹⁰⁴ In contrast, general practitioners can access Medicare funding for engaging in medicine review services once in a 12-month period or when there is a significant change to the resident's condition or medication regimen.¹¹⁰⁵ The different funding criteria make little sense and cause difficulties when accessing medication reviews.

1100. The Australian Government should enable more frequent reviews by pharmacists. Those reviews should occur at least annually and more regularly if there has been a significant change to the resident's condition or medication regimen.

1101. Residential Medication Management Reviews should be available to people who are receiving respite care or transition care in a residential aged care facility. Not all people who receive short-term care will need to have a Residential Medication Management Review. This does not mean that all people receiving short-term care should be excluded from getting a review.

1102. On 1 February 2020, the Pharmacy Programs Administrator commenced active monitoring and compliance activities for services delivered through the Community Pharmacy Agreement.¹¹⁰⁶ This work should extend to medication management reviews in aged care. It is not yet clear what effect these compliance activities will have on the provision of medication management reviews. Guidance documents released by the Pharmacy Programs Administrator appear to focus on administrative and eligibility requirements rather than outcomes.¹¹⁰⁷ There is limited information available on how

¹¹⁰¹ Pharmacy Programs Administrator, *Home Medicines Review Program Rules*, 2020, p 3.

¹¹⁰² Pharmacy Programs Administrator, *Residential Medication Management Review and Quality Use of Medicines – claiming and payments*, 2019.

¹¹⁰³ Pharmacy Programs Administrator, *Residential Medication Management and Quality Use of Medicines Program Rules*, 2019, p 6.

¹¹⁰⁴ Pharmaceutical Society of Australia, *Guidelines for comprehensive medication management reviews*, 2019, p 20.

¹¹⁰⁵ Australian Department of Health, *Medicare Benefits Schedule*, Item 903.

¹¹⁰⁶ Pharmacy Programs Administrator, *Compliance*, 2020, <https://www.ppaonline.com.au/compliance>, viewed 24 May 2020.

¹¹⁰⁷ Pharmacy Programs Administrator, *Monitoring, Compliance and Audit Factsheet*, 2020.

services will be assessed for quality. The Australian Government should ensure that compliance activities for Medication Management Reviews focus on the quality of the services being provided as well as the accuracy of claims for payment. Pharmacists not providing a quality service should be suspended from providing services while they undertake further training.

Recommendation 71: Restricted prescription of antipsychotics

71.1. By 1 November 2021, the Australian Government should amend the Medicare Benefits Schedule so that only a psychiatrist or a geriatrician can initially prescribe antipsychotics. General practitioners should be able to prescribe repeat prescriptions of antipsychotics for up to a year for people who have received an original prescription from a psychiatrist or geriatrician.

1103. In the Interim Report, Commissioners Tracey and Briggs identified widespread use of chemical restraints in the purported ‘care’ of many older Australians.¹¹⁰⁸ Such widespread use of chemical restraints is plainly unacceptable.

1104. In response to the Interim Report, the Australian Government announced changes intended to address problems with medication management.¹¹⁰⁹ They included changes to prescribing criteria for the antipsychotic risperidone under the Pharmaceutical Benefits Scheme, education resources to support the appropriate use of antipsychotics and benzodiazepines in residential aged care, funding for medication management programs, and increased dementia training and support for aged care workers and health sector staff.

1105. These measures are commendable, but they do not go far enough to address properly what is a problem that has persisted for decades.¹¹¹⁰ Education and training programs will need to be implemented nationally and consistently. Numbers of care staff employed in residential aged care will have to be increased to ensure more time for better management of behavioural and psychological symptoms of dementia.

1106. There should also be stricter requirements for prescribing antipsychotic medicines. Under the Pharmaceutical Benefits Scheme, risperidone is only subsidised for the treatment of autism in children if the treatment is ‘under the supervision of a paediatrician

¹¹⁰⁸ Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Vol 1, p 212.

¹¹⁰⁹ Australian Prime Minister, Media Release, *Response to the Aged Care Royal Commission Interim Report*, 25 November 2019.

¹¹¹⁰ Exhibit 3-61, Sydney Hearing, Statement of Juanita Westbury (now Breen), WIT.0117.0001.0001 at 0008 [13].

or psychiatrist'.¹¹¹¹ A similar practice should apply to aged care, such that only psychiatrists or geriatricians should be able to initiate treatment with antipsychotic medicines for people receiving residential aged care. This will ensure that every person in residential aged care is reviewed by a specialist before antipsychotic medicines are started.

1107. Such a requirement will relieve the pressure on general practitioners and residential aged care facilities by increasing the availability of specialised psychiatric knowledge and care. It is not intended to prevent general practitioners from writing repeat prescriptions for antipsychotics or from exercising their clinical judgement and knowledge to ensure that people experience continuity of care. However, general practitioners should only be able to write those repeat prescriptions for a period of 12 months from the initial prescription by a psychiatrist or geriatrician. If, at that 12-month mark, there is a perceived need for ongoing use of antipsychotics, a further prescription should be obtained from a geriatrician or psychiatrist.

Recommendation 72: Improving the transition between residential aged care and hospital care

72.1. The Australian and State and Territory Governments should:

- a. by 1 July 2022, implement, and commence publicly reporting upon compliance with, hospital discharge protocols that ensure that discharge to residential aged care from hospital should only occur once appropriate clinical handover and discharge summary (including medications list) has been provided to and acknowledged by the residential care service, and provided to the person being discharged
- b. by 1 December 2021, require staff of aged care services, when calling an ambulance for a resident, to provide the paramedics on arrival with an up-to-date summary of the resident's health status, including medications and advance care directives.

Transferring people from hospital to residential aged care

1108. There is a need for improved communication and collaboration between people working in the aged care system and people working in the health care system. The health care needs of older people cannot be safely and comprehensively met when there is poor

¹¹¹¹ PBS Schedule, items 9079W and 9293D, <http://www.pbs.gov.au/medicine/item/3171X-9293D-3169T-8869T-3170W-3172Y-8789N-9079W-8787L-8100H-8794W-8870W-9080X-8788M-9075P-8781E-8790P-8782F-9076Q-8780D-8792R>, viewed 25 May 2020.

communication and collaboration between them.¹¹¹² And yet evidence was received by the Royal Commission about inadequate sharing of health information about older people as they moved between the health and aged care systems.¹¹¹³

1109. Nationally consistent hospital discharge protocols should be developed and implemented to ensure that discharges to residential aged care only occur once appropriate clinical handover and discharge summaries have been provided to and acknowledged by the residential care service. Those materials should also be provided to the person being discharged.

1110. The requirements for transfer and clinical handover processes from hospital to residential aged care are unclear. The National Safety and Quality Health Service Standards comprehensively set out the requirements for clinical handover between health facilities, but they do not provide any indication of what is specifically required for clinical handover from hospital to residential aged care.

1111. The Australian Government and most State and Territory Governments support the introduction of hospital discharge protocols to ensure that discharge summaries are consistently and promptly provided by hospitals to staff in residential aged care facilities.¹¹¹⁴ To improve the quality of discharges to residential aged care, the health care and aged care systems should have the same standards for transitions of care, and clinical communication should be the same.¹¹¹⁵ Future health funding agreements between the Australian Government and State and Territory Governments should include a requirement for strengthened hospital discharge protocols, including clinical handover.

Transferring people from residential aged care to hospital

1112. There is significant variability in the information staff at residential aged care facilities provide to paramedics or hospitals when residents are transferred to hospital. The type

¹¹¹² D Griffiths, J Morphet, K Innes, K Crawford, A Williams, 'Communication between residential aged care facilities and the emergency department: A review of the literature', *International Journal of Nursing Studies*, 2014, Vol 51 Issue 11, pp 1517-1523; Transcript, Canberra Hearing, Andrew Robertson, 12 December 2019 at T7540.5-9.

¹¹¹³ Transcript, Canberra Hearing, Tess Oxley, 10 December 2019 at T7383.8-44; Transcript, Canberra Hearing, Thomas Woodage, 11 December 2019 at T7440.19-22; Exhibit 14-21, Canberra Hearing, Statement of Fiona Lysaught, WIT.1311.0001.0001 at 0006 [36].

¹¹¹⁴ Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0024 [75]–[76]; Transcript, Canberra Hearing, Dr Andrew Robertson, 12 December 2019, at T7544.26–7545.4; Submissions of Western Australia – Canberra Hearing, 3 February 2020, RCD.0012.0055.0001 at 0004 [12]; Transcript, Canberra Hearing, Dr Nigel Lyons, 12 December 2019, at T7544.7–22; Submissions of NSW Health – Canberra Hearing, 3 February 2020, RCD.0012.0056.0001 at 0008; Transcript, Canberra Hearing, Dr John Wakefield, 12 December 2019, at T7543.43–7544.2; Transcript, Canberra Hearing, Dr Christopher McGowan, 12 December 2019, at T7545.8-14; Submissions on behalf of SA Health – Canberra Hearing, 3 February 2020, RCD.0012.0054.0003 at 0011..

¹¹¹⁵ Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7330.30–7331.2.

of information being shared between staff in aged care and staff in health care is fundamental and should facilitate safe and effective continuity of care. At a minimum, it should include an up-to-date summary of the resident's health status, including medications and advance care directives.

1113. The current Aged Care Quality Standards are vague about the information sharing responsibilities of approved providers. They require an approved provider to ensure that 'information about the consumer's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared'.¹¹¹⁶ Guidance material for the standards refers in broad terms to sharing information with other health care providers, such as when an older person is being transferred to hospital.¹¹¹⁷

1114. This lack of specificity about what, and how, information should be shared permits variability in the transfer practices of approved providers, to the detriment of older people's care. There should be greater standardisation of requirements for clinical handover during the transfer from aged care facilities to hospitals.

1115. Staff at residential aged care facilities need to ensure that sufficient, appropriate and consistent information is provided to treat residents upon any transfer to hospital.

Recommendation 73: Improving data on the interaction between the health and aged care systems

73.1. The Australian Government and State and Territory Governments should improve the data available to monitor the interaction between the health and aged care systems and improve health and aged care planning and funding decisions. In particular:

- a. the Australian Government should implement an aged care identifier by 1 July 2022 in the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule datasets to allow regular public reporting on the number and type of medical and pharmaceutical services provided to people receiving aged care
- b. by 1 July 2023 all National Minimum Datasets reported to the Australian Institute of Health and Welfare should include an item identifying whether a person is receiving aged care services and the type of aged care the person is receiving

¹¹¹⁶ *Quality of Care Principles 2014* (Cth), Schedule 2, Standards 3(3)(e), 4(3)(d) and (e).

¹¹¹⁷ Aged Care Quality and Safety Commission, *Guidance and Resources for Providers to support the Aged Care Quality Standards Guidance*, 2019, pp 27, 76, 78 and 102.

- c. National Minimum Datasets covering all State and Territory Government-funded health services should be implemented by 1 July 2023
- d. all governments should implement a legislative framework by 1 July 2023 for health and aged care data to be directly linked, shared and analysed to understand the burden of disease of current and prospective aged care recipients and their current and future health needs
- e. the Australian Government should direct the Australian Institute of Health and Welfare to include data tabulated on the basis of aged care recipient status in any relevant health statistical publications, and make the de-identified data publicly available through the Australian Government's data portal data.gov.au.

Aged care identifier

1116. The Australian Government currently spends around \$45 billion every year on benefits for medical services and pharmaceuticals under the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme Schedule. It also spends around \$19 billion on aged care each year. Despite this significant investment in health care and aged care, the Australian Government is unable to determine precisely how much of the spending on health care is used by people receiving aged care.

1117. As a result of this lack of information, the Australian Government is denied a proper basis for assessing whether or not health programs are meeting the needs of older people receiving aged care. This needs to be rectified.

1118. The MBS data collection contains information on health services that qualify for a benefit under the *Health Insurance Act 1973* (Cth) and for which a claim has been processed. The MBS data includes information on the patient (date of birth, gender, and postcode) and the service (the date it was provided, MBS item number, provider identifier, fee charged and benefit paid).¹¹¹⁸ For those services that involve consultation by a general practitioner or a specialist, there is no information on the reason for the consultation. Apart from services specifically provided by a general practitioner in a residential aged care facility, the data does not show whether a patient was also receiving aged care.

1119. Similarly, until 2017, the Pharmaceutical Benefits Scheme (PBS) Schedule data did not record whether a medicine had been dispensed to a person in residential aged care. The Australian Government took steps to address this shortcoming in July 2017, by

¹¹¹⁸ Australian Institute of Health and Welfare, *Medicare Benefits Schedule data collection*, 2019, <https://www.aihw.gov.au/about-our-data/our-data-collections/medicare-benefits-schedule-mbs>, viewed 8 April 2020.

introducing the residential aged care facility identification number.¹¹¹⁹ However, use of this data field is voluntary. As of May 2019, pharmacists were not using the residential aged care facility identification number to an extent that would allow for meaningful evaluation, through the PBS Schedule data, of aged care residents' medicine use.¹¹²⁰ The identification number also does not extend to identifying people receiving aged care in the community.

1120. Services Australia administers Australian Government payments for the MBS, PBS Schedule, and aged care. It should be empowered to apply a common personal identifier across all three systems to allow the Australian Government to record the number and type of medical services and medicines used by people receiving aged care. The data should be provided to the Australian Institute of Health and Welfare and made publicly available for use by, among others, researchers and people who are planning service provision.

Minimum health dataset

1121. Data on aged care residents' use of State and Territory Government-funded health services is also not consistently or comprehensively captured. There is no accurate record of the number of people living in residential aged care facilities who have used those health services. Among other things, there is no accurate and comprehensive dataset relating to aged care residents' presentations to emergency departments or their hospital admissions, nor is useful information available on the health conditions that occasioned those attendances. This absence of data capture contributes to a lack of integrated planning for the aged care and health care systems because it inhibits analysis and understanding of the interaction between these systems.

1122. State and Territory Governments collect data on public hospital activity in three datasets: the Admitted patient care data set covering acute admitted patient care and subacute admitted patient care (including rehabilitation, palliative care, geriatric evaluation and management, and psychogeriatric care); the Non-admitted patient emergency department care data set; and the Non-admitted care data set covering outpatient clinics.¹¹²¹

1123. The Admitted patient care and Non-admitted patient emergency department care data sets are health sector National Minimum Data Sets. The Australian Institute of Health

¹¹¹⁹ Australian Department of Health, *Revised dispensing for nursing home residents factsheet*, 2020.

¹¹²⁰ Transcript, Sydney Hearing 1, Brendan Murphy, 14 May 2019 at T1651.25–1652.15.

¹¹²¹ Australian Institute of Health and Welfare, *Admitted patient care NMDS 2020–21*, 2020, METeOR metadata online registry; Australian Institute of Health and Welfare, *Non-admitted patient emergency department care NMDS 2020–21*, 2020, METeOR metadata online registry; Australian Institute of Health and Welfare, *Non-admitted patient care aggregate NBEDS 2019–20*, 2020, METeOR metadata online registry.

and Welfare defines a National Minimum Data Set as ‘a set of data elements agreed for mandatory collection and reporting at a national level’. These National Minimum Data Sets contain standardised health data and are used to ‘help health care organisations to identify where safety and quality problems exist, to identify trends, and to develop practical approaches to addressing these problems’.¹¹²² Of all the States and Territories, only Victoria and the Northern Territory have an aged care indicator in the hospital datasets at present.

1124. It is intended that from 2020–21 the Admitted patient care National Minimum Data Set will capture all movements between hospitals and residential aged care.¹¹²³ This work is progressing in the Health Aged Care Interface Data Project under the auspices of the Australian Health Ministers Advisory Council.¹¹²⁴ This project is designing and working towards the implementation of an aged care identifier in the hospital National Minimum Data Set.¹¹²⁵ Any minimum data set including aged care data should have items identifying whether a person is receiving aged care services and, if so, the type of aged care they are receiving.

1125. This work is encouraging but long overdue. It should be completed quickly. It should extend to all State and Territory Government-funded health services, including any that are introduced following recommendations proposed in these submissions. The resulting data and reports should be held by the Australian Institute of Health and Welfare and, in a de-identified form, made publicly available. Access to this data is integral to inform policy design, service delivery planning, monitoring, research, and evaluation.¹¹²⁶ It is particularly important that de-identified data is made available to researchers outside government without them being required to seek further consent from data custodians.

¹¹²² Australian Commission on Safety and Quality in Health Care, *Minimum data set for safety and quality*, 2005, <https://www.safetyandquality.gov.au/sites/default/files/migrated/minimdata.pdf>, viewed 15 October 2020.

¹¹²³ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0055 [218].

¹¹²⁴ Submissions of the Commonwealth of Australia, Canberra Hearing, RCD.0012.0058.0001 at 0032 [105].

¹¹²⁵ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0055 [218].

¹¹²⁶ See, for example, Transcript, Canberra Hearing, Carolyn Hullick, 10 December 2019 at T7327.27–32; Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7328.28–40.

Recommendation 74: Universal adoption by the aged care sector of digital technology and My Health Record

74.1. The Australian Government should require that, by 1 July 2022:

- a. every approved provider of aged care:
 - i. uses a digital care management system (including an electronic medication management system) meeting a standard set by the Australian Digital Health Agency and interoperable with My Health Record
 - ii. invites each person receiving aged care from the provider to consent to his or her care records being made accessible on My Health Record
 - iii. if the person consents, places that person's care records (including, at a minimum, the categories of information required to be communicated upon a clinical handover) on My Health Record and keeps them up to date
- b. the Australian Digital Health Agency immediately prioritises support for aged care providers to adopt My Health Record.

1126. My Health Record is an Australian Government online summary of a person's key health information. It is progressively being adopted across the health care system. The Australian Digital Health Agency has stated, however, that, 'while a number of aged care clinical information systems are conformant and can connect to My Health Record, it is not extensively used across the aged care sector'.¹¹²⁷ The Australian Digital Health Agency has also stated that aged care is 'a key priority area for future focus'.¹¹²⁸

1127. Universal adoption by approved providers of My Health Record should be an immediate focus. Given the high frailty and acuity of older people receiving aged care and their increased need for health care, it is appropriate to expect that all approved providers should be using My Health Record by no later than the end of 2021. This will ensure that multiple health care and approved providers can access one central source of health information about people receiving aged care. Any improved information sharing will of course depend on aged care recipients having a My Health Record and giving prior consent to their health records being accessed, used and shared in this way.

¹¹²⁷ Australian Digital Health Agency, Public submission, AWF.500.00298.0002_0001 at 0010.

¹¹²⁸ Australian Digital Health Agency, Public submission, AWF.500.00298.0002_0001 at 0010.

1128. System interoperability will support communication and information-sharing between the aged care sector and the health care sector.¹¹²⁹ For instance, system interoperability between the clinical systems of general practice and approved providers would ‘improve communication and minimise any errors in treatment, particularly when a GP is required to respond to a clinical situation’.¹¹³⁰
1129. Interoperability should be pursued in the short term through My Health Record. The adoption of My Health Record, and systems interoperable with it, will assist with information sharing between care providers and others and hence assist with improved and safe care. Data interoperability, whereby data is captured according to a common set of definitions, is also worthwhile pursuing.
1130. The Australian Government has agreed that all residential aged care services should move to digital electronic care records.¹¹³¹ The Australian Government has further supported the use of electronic discharge summaries through My Health Record.¹¹³²
1131. Paper-based systems are outdated, inefficient, and can lead to errors during the transfer of residents between residential aged care and hospital settings. Transition to a digital care management system interoperable with My Health Record will result in a safer, more efficient and more comprehensive transfer of critical information relating to a person’s relevant care and medical history. Such a transition by approved providers should be supported by the Australian Digital Health Agency.

Recommendation 75: Clarification of roles and responsibilities for delivery of health care to people receiving aged care

75.1. By 31 December 2021, the Australian and State and Territory Governments should amend the National Health Reform Agreement to include an explicit statement of the respective roles and responsibilities of approved aged care providers and State and Territory health care providers to deliver health care to people receiving aged care, similar to the Applied Principles and ‘tables of supports’ for the National Disability Insurance Scheme, on the basis that, among other things:

- a. allied health care should generally be provided by aged care providers

¹¹²⁹ Exhibit 14-31, Canberra Hearing, Statement of Glenys Beauchamp, WIT.0573.0002.0001 at 0064 [263].

¹¹³⁰ Exhibit 14-9, Canberra Hearing, Supplementary statement of Anthony Bartone, WIT.1301.0001.0001 at 0002 [11].

¹¹³¹ Transcript, Canberra Hearing, Glenys Beauchamp, 12 December 2019 at T7584.5–13.

¹¹³² Submissions of the Commonwealth of Australia, Canberra Hearing, 7 February 2020, RCD.0012.0058.0001 at 0027 [92]; 0033 [109]–[111].

- b. specialist services, including specialist palliative care and subacute rehabilitation, should be provided by State and Territory health care providers, even if these services involve allied health practitioners
- c. less complex health conditions should be managed by aged care providers' staff, particularly nurses.

75.2. By 31 December 2021, the Australian Government should amend the *Quality of Care Principles 2014* (Cth) to clarify the role and responsibilities of approved providers to deliver health care to people receiving aged care, including but not limited to their particular role and responsibilities to deliver allied health care, mental health care, and oral and dental health care.

1132. In future, there must be far greater clarity about who is responsible for what health care services for people receiving aged care.

1133. While the *Quality of Care Principles 2014* (Cth) set out in broad terms the care and services that should or may be provided by approved providers, they do not provide sufficient detail or clarity. Perspectives on the existing health care responsibilities of approved providers, and what their responsibilities should be, vary.¹¹³³ Where responsibility lies for each aspect of the care provided to older people at any particular time is uncertain.¹¹³⁴

1134. As identified in Part 3 above, this lack of clarity partially results from responsibility for meeting aged care recipients' health care needs being shared between the Australian and State and Territory Governments and between health care providers and aged care providers.

1135. This split of responsibilities is reflected in different streams of funding for different aspects of health care and aged care. These different funding streams for particular types of care, such as general practice, aged care, mental health and public hospital care, can lead to care provision becoming fragmented and service providers seeking to pass responsibility for care to other parts of the system.¹¹³⁵

¹¹³³ See, for example, Transcript, Canberra Hearing, Terry Symonds, 13 December 2019 at T7624.25–40; Exhibit 14-36, Canberra Hearing, Statement of Terry Symonds, WIT.0565.0001.0001 at 0004 [19]; Exhibit 14-26, Canberra Hearing, Statement of Leonard Gray, WIT.0619.0001.0001 at 0005 [33].

¹¹³⁴ See, for example, Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7316.37–7317.13.

¹¹³⁵ See, for example: Transcript, Canberra Hearing, Nikki Johnston, 11 December 2019 at T7460.7–11; Transcript, Canberra Hearing, Kristine Stevens, 9 December 2019 at T7229.4–10.

1136. The fragmentation and passing of responsibilities between the aged care and health care systems should be dealt with by the Australian and State and Territory Governments.¹¹³⁶

It must be made very clear by all governments who exactly within the system is responsible for what and where the funding will come from to achieve the desired result.¹¹³⁷

1137. The Applied Principles and ‘tables of supports’ for the National Disability Insurance Scheme are an example of principles agreed by the Australian and State and Territory Governments to define the funding and service responsibilities of multiple systems, including the disability, health, aged care, justice and education systems.¹¹³⁸ A similar exercise should be undertaken, through the National Health Reform Agreement, for provision of health care services to people receiving aged care. In determining the respective roles and responsibilities of approved aged care providers and State and Territory health care providers, the Australian and State and Territory Governments should follow these principles:

- a. allied health care should generally be provided by aged care providers
- b. specialist services, including specialist palliative care and subacute rehabilitation, should be provided by State and Territory health care providers, even if these services involve allied health practitioners, and
- c. less complex health conditions should be managed by aged care providers’ staff, particularly nurses.

1138. The Australian Government should otherwise legislatively define the roles and responsibilities of aged care providers. That clarification should include measurable requirements for health care provided by aged care providers, including mental, dental and allied health care. Given the high rates of mental health conditions and poor oral health in aged care, aged care providers’ responsibilities for mental and oral health of residents should be made clear. The measurable requirements should be informed by clinical experts.

¹¹³⁶ See, for example: Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7507.38–43; Transcript, Canberra Hearing, Ellen Burkett, 10 December 2019 at T7313.28–37; Transcript, Canberra Hearing, Maggie Jamieson/Terry Symonds/Michael De’Ath/Ross Smith, 13 December 2019 at T7628.1–23.

¹¹³⁷ See, for example, Transcript, Canberra Hearing, Leon Flicker, 12 December 2019 at T7507.26–29.

¹¹³⁸ Council of Australian Governments, *Principles to determine the responsibilities of the NDIS and other service systems*, 27 November 2015, <https://www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf>, viewed 12 October 2020; Submissions of NSW Health, Canberra Hearing, undated, RCD.0012.0056.0001 at 0010.

Recommendation 76: Improved access to State and Territory health services by people receiving aged care

76.1. By 1 July 2022, the Australian and State and Territory Governments should amend the National Health Reform Agreement or any future health funding agreement to include explicit commitments by State and Territory Governments to provide:

- a. access by people receiving aged care to State and Territory Government-funded health services, including palliative care services, on the basis of the same eligibility criteria that apply to residents of the relevant State and Territory more generally
- b. clinically appropriate subacute rehabilitation for patients who:
 - i. are aged care recipients receiving residential care or personal care at home, or
 - ii. may need such aged care services if they do not receive rehabilitation,

as well as performance targets and reporting requirements on the provision of subacute rehabilitation care to people receiving aged care.

1139. People receiving aged care should have the same access to State and Territory health services, such as hospital services, specialist palliative care services and subacute rehabilitation services, as other people in Australia. The Royal Commission has received evidence that that does not always occur. By way of stark example, only 18 per cent of people who reside in residential aged care and received acute care for a hip fracture had subacute rehabilitation, compared with 51 per cent of people living in the community.¹¹³⁹ State-based public health services must be available to all people receiving aged care to meet their care needs.

1140. Under the National Health Reform Agreement, the State and Territory Governments have committed to providing health and emergency services through the public hospital system, based on what are termed the 'Medicare principles'. These are a set of principles that have been in successive health funding agreements and outline universal access to State and Territory hospital services:

- a. eligible persons must be given the choice to receive public hospital services free of charge as public patients;

¹¹³⁹ Exhibit 14-24, Canberra Hearing, Statement of Christopher Poulos, WIT.1316.0001.0001 at 0012 [75].

- b. access to such services by public patients free-of-charge is to be on the basis of clinical need and within a clinically appropriate period; and
- c. arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.¹¹⁴⁰

1141. It should be explicit in the National Health Reform Agreement that State and Territory health services, such as hospital services, specialist palliative care services and subacute rehabilitation services, should be available to people receiving aged care as they are to others. The State and Territory Governments should, through monitoring and benchmarking, be held accountable for the delivery of these health services to people receiving aged care. Subacute rehabilitation should be delivered in an appropriate setting for the patient, whether that is hospital-based or through hospital in the home (including at a residential aged care facility).

1142. The proposals made above for improved data collection and linkage will facilitate this monitoring and benchmarking. This data should be reported annually by the Australian Government.

Recommendation 77: Ongoing consideration by the Health National Cabinet Reform Committee

77.1. The Health National Cabinet Reform Committee should require the Australian Health Ministers' Advisory Council to:

- a. consider the full suite of the Royal Commission's recommendations related to the interface of the health care and aged care systems and report to the next meeting of the Committee
- b. include a standing item in all future meetings of the Council on the aged care system and its interface with the health care system.

1143. Many of the proposed recommendations relating to improving access to health care for people receiving aged care require considerable cooperation between the Australian and State and Territory Governments.

1144. The Australian Health Ministers' Advisory Council is the advisory body to the Health National Cabinet Reform Committee. It is comprised of a representative from the heads of the respective health departments of the Australian and State and Territory Governments. Among other things, the Australian Health Ministers' Advisory Council is

¹¹⁴⁰ Australian Department of health, *Addendum to National Health Reform Agreement 2020–2025*, 2020, p 6.

to advise on strategic issues relating to the coordination of health services across Australia.

1145. Under the new 2020–25 Addendum to the National Health Reform Agreement, the Australian Health Ministers' Advisory Council will monitor 'interface issues' that arise between the health system and the aged care system.¹¹⁴¹
1146. As part of this work, the Australian Health Ministers' Advisory Council should consider the recommendations of the Royal Commission as they relate to the aged care system and its interface with the health care system, and report to the Health National Cabinet Reform Committee with a proposed approach to implementation of those recommendations.
1147. In addition, the Australian Health Ministers' Advisory Council should, on an ongoing basis, have regard at its meetings to problems with the interface between the aged care system and the health care system and how those problems are to be resolved.

¹¹⁴¹ *Addendum to National Health Reform Agreement 2020-2025*, p 76, Schedule F, F14.a, http://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf, viewed 3 July 2020.

Part 3.14 Aged care in regional, rural and remote areas

1148. By paragraph (c) of the Terms of Reference, the Royal Commission is authorised to inquire into ‘the future challenges and opportunities for delivering accessible, affordable and high quality aged care services ... in remote, rural and regional Australia’.¹¹⁴²
1149. The Royal Commission has heard evidence about the particular needs of older people in regional, rural and remote areas and their difficulties accessing high quality aged care services in their local areas.¹¹⁴³ That evidence has referred to: remoteness; scarcity of local services; greater travel times; higher costs to access and provide services; difficulties recruiting and retaining service providers; and a lack of access to health professionals.¹¹⁴⁴
1150. People living in regional, rural and remote areas experience relative disadvantage in various ways. On average, they have lower incomes, poorer education, poorer housing, and poorer health outcomes, including higher rates of disability, disease and injury.¹¹⁴⁵ This disadvantage can increase the need for support in older age. In regional, rural and remote areas, older people make up a greater share of the population than elsewhere in Australia.¹¹⁴⁶ And yet, availability of aged care in regional, rural and remote areas is poor compared with availability in major cities.¹¹⁴⁷ On current trends, the disparity is getting worse.
1151. Existing aged care legislation acknowledges the ‘special needs’ of older people who live in rural or remote areas.¹¹⁴⁸ At least in relation to allocation of residential aged care

¹¹⁴² Letters Patent, 6 December 2018, as amended on 13 September 2019 and 25 June 2020; The words ‘regional’, ‘rural’ and ‘remote’ are used here to refer to areas outside major cities. See Australian Institute of Health and Welfare, *Rural and Remote Australians*, Australian Government, 2019, <https://www.aihw.gov.au/rural-health-rrma-classification>, viewed 6 October 2020.

¹¹⁴³ The Royal Commission conducted hearings in, among other places, Broome, Mudgee, Mildura and Cairns, at those and other hearings, heard evidence from witnesses from regional, rural and remote areas of Australia.

¹¹⁴⁴ See, for example: Transcript, Adelaide Hearing 1, Paul Versteeg, 12 February 2019 at T177.2–5; Transcript, Broome Hearing, Craig Barke, 17 June 2019 at T2018.45–2020.2; Exhibit 7-6, Mildura Hearing, Statement of Barbara McPhee, WIT.0311.0001.0001 at 0004 [27]; Exhibit 12-14, Mudgee Hearing, Statement of Jaclyn Attridge, WIT.0540.0001.0001 at 0008 [31] and 0018 [68].

¹¹⁴⁵ Australian Institute of Health and Welfare, *Rural and remote health snapshot*, 2020, <https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health>, viewed 7 October 2020.

¹¹⁴⁶ Australian Institute of Health and Welfare, *Australia’s health 2018: Australia’s health series no. 16*, pp 1-2; D Taylor et al, ‘Geospatial modelling of the prevalence and changing distribution of frailty in Australia – 2011 to 2027’, *Experimental Gerontology*, 2019, Vol 123, p 61; Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0014 [70].

¹¹⁴⁷ Productivity Commission, *Report on Government Services* series, Part F, 2015-2020.

¹¹⁴⁸ *Aged Care Act 1997* (Cth), ss 11-3, 12-2 and 50-2; *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 7 and 41. Under s 2(1) of the Aged Care Act, the objects of that Act include: to facilitate access to aged care services by those who need them, regardless of, among other things, geographic location (paragraph (e)); and to promote ageing in place through the linking of care and support services to the places where older people prefer to live (paragraph (j)).

places and payment of flexible care subsidies, aged care legislation evinces an intention to identify and meet those needs. That intention does not go far enough. For one thing, it does not extend to home care.¹¹⁴⁹ In any event, the evidence before the Royal Commission does not suggest that the intention translates into practical results in any consistent and systemic way. Indeed, the evidence shows that specific planning to meet the needs of people in regional, rural and remote Australia is either not happening or, if it is happening, is not working.¹¹⁵⁰

Recommendation 78: Planning for the provision of aged care in regional, rural and remote areas

78.1. From 1 December 2021, the Australian Government should:

- a. identify areas where service supply is inadequate and actively respond by supplementing services to meet entitlements and needs, and
- b. plan for the specific needs of different locations and develop aged care service provision based on those identified needs

and by doing so ensure that older people in regional, rural and remote locations are able to access aged care in their community equitably with other older Australians.

78.2. From 1 December 2021, the Australian Government should make it clear when people first engage with the aged care system if they will not be able to access a certain type of aged care in their community.

78.3. On and from 1 July 2023, the Australian Aged Care Commission will assume these functions and powers.

1152. In submissions made on system design, we have emphasised the importance of a strong, independent and engaged system governor. The system governor should have responsibility for, among other things, whole-of-system planning for provision of aged care services, including in regional, rural and remote areas. The system governor must ascertain, on a regular basis:

¹¹⁴⁹ See, for example: Exhibit 10-19, Melbourne Hearing 2, Statement of Nicholas Hartland, WIT.0486.0001.0001 at 0011–0013 [52]–[57]; Exhibit 12-25, Mudgee Hearing, Statement of Graeme Barden, WIT.0498.0001.0001 at 0011 [49]; Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0048 [193].

¹¹⁵⁰ Exhibit 12-25, Mudgee Hearing, Statement of Graeme Barden, WIT.0498.0001.0001 at 0009 [31]–[32]; Transcript, Mudgee Hearing, David Hallinan, 6 November 2019 at T6557.37–6561.31; Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0047 [191].

- a. the aged care needs of older people in different geographical areas, including in regional, rural and remote areas
- b. the services required to meet those needs in those areas, and
- c. the extent to which, in those areas, services are not available and needs are not being met.

1153. By doing so, the system governor can prepare a transparent response to identified unmet need, including increasing service provision, and identify the minimum services that a person living in a particular location can expect to receive.

1154. From no later than 1 July 2023, the system governor will be the Australian Aged Care Commission.

1155. The planning function must rest on a sound understanding of what resources are required and where. Proper planning for provision of aged care services also requires an understanding of the actual costs of providing those services in different areas. It costs more to provide aged care services to an older person living in a regional, rural or remote area than it does in a metropolitan area.¹¹⁵¹ The newly-proposed independent Australian Aged Care Pricing Authority, referred to in submissions made on system design and funding, should have responsibility for accurately determining, each year, the different costs of service provision in different areas in Australia, including regional, rural and remote areas.

1156. Government funding for provision of aged care services should be allocated on the basis of these different costs of service provision in different areas.¹¹⁵² Allocation of funding on that differentiated basis would obviate the need for the Australian Government to make a separate payment, such as the Viability Supplement, to aged care providers in regional, rural and remote areas.¹¹⁵³ Until funding is allocated on that differentiated basis, the Viability Supplement should be retained.¹¹⁵⁴ Thereafter, the Viability Supplement should cease.¹¹⁵⁵

¹¹⁵¹ Exhibit 12-14, Mudgee Hearing, Statement of Jaclyn Attridge, WIT.0540.0001.0001 at 0006–0007 [23]–[26] and 0002 [14]; Exhibit 12-12, Mudgee Hearing, Statement of Dean Chesterman, WIT.0517.0001.0001 at 0008–0009 [38]–[41]; Exhibit 4-10, Broome Hearing, Statement of Belinda Robinson, WIT.0211.0001.0001 at 0008 [42]–[44] and 0009–0010 [50]–[51]; Aged Care Financing Authority, *Financial issues affecting rural and remote aged care providers*, 2016, pp vii and xiv; Aged Care Financing Authority, *Seventh report on the funding and financing of the aged care industry, July 2019*, 2019, pp ix and x.

¹¹⁵² Transcript, Mudgee Hearing, Nigel Lyons, 6 November 2019 at T6527.26–45; Exhibit 14-1, Canberra Hearing, General Tender Bundle, tab 45, AMA.9999.0001.0001 at 0044–0045.

¹¹⁵³ Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0052–0057 [203]–[227]; Transcript, Broome Hearing, Craig Barke, 17 June 2019 at T2018.45–2019.8; Exhibit 12-12, Mudgee Hearing, Statement of Dean Chesterman, WIT.0517.0001.0001 at 0012 [55]–[56].

¹¹⁵⁴ See paragraphs 1212 to 1231 below.

¹¹⁵⁵ Evidence received by the Royal Commission has indicated that the Viability Supplement is not based on an assessment of the actual cost of service provision in regional, rural and remote

1157. Wherever possible, older people should have timely access to high quality aged care services to support them to age in their own communities. In respect of regional, rural and remote areas, the aged care system must be flexible and adaptable, to account for smaller and dispersed populations and fewer aged care providers. Minimum service access standards should reflect what levels and types of aged care service provision should be available within communities of varying sizes, and varying distances from major population centres.¹¹⁵⁶ Government funding should provide for flexible responses in these areas. Integrated services, such as the Multi-Purpose Services Program which combines aged care services with State and Territory-Government health services, are one kind of flexible response.
1158. Even with improvements to planning, costing and funding for different areas, it may still not always be possible to deliver aged care services in an older person's local community. In some very remote, small and dispersed communities, for instance, the provision of certain aged care services may not be feasible and an older person may have to travel or relocate to receive services that are needed. This is far from ideal and should only occur in a small minority of cases. In most cases when there are failed markets, the system governor should commission a provider of last resort. In particular, the system governor should enter into arrangements with individual entities to become default home care providers in particular areas where service supply is inadequate. On doing so, there should be strong and clear governance arrangements to ensure high quality care.
1159. The Australian Government should otherwise publish up-to-date and readily accessible information on the My Aged Care website about the nature and extent of aged care services available in local areas across Australia, including any lack of access to a particular kind of aged care service or to locally-sourced aged care services. The Australian Government should also clearly inform people first accessing aged care what aged care services are and are not available in their local community. On and from 1 July 2023, the Australian Aged Care Commission will assume responsibility for those tasks.

areas. See: Transcript, Mudgee Hearing, David Hallinan, 6 November 2019 at T6566.23–6567.14; Transcript, Mudgee Hearing, Dean Chesterman, 5 November 2019 at T6429.1–11; Aged Care Financing Authority, *Seventh report on the funding and financing of the aged care industry, July 2019*, p 87.

¹¹⁵⁶ Exhibit 12-15, Mudgee Hearing, Statement of Rachel Winterton, WIT.0589.0001.0001 at 0013 [32c]; Transcript, Mudgee Hearing, Rachel Winterton, 5 November 2019 at T6453.5–6454.12.

Recommendation 79: The Multi-Purpose Services Program

79.1. The Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should maintain and extend the Multi-Purpose Services Program in the new aged care system by, from 1 December 2021:

- a. together with State and Territory Governments, establishing new Multi-Purpose Services in accordance with community need as identified by the Australian Government or the Commission
- b. ensuring that people entering Multi-Purpose Services are subject to the same eligibility and needs assessments as all other people receiving aged care
- c. requiring people accessing Multi-Purpose Services to make contributions to the cost of their care and accommodation on the same basis as all other people receiving aged care (with appropriate protections for people currently accessing Multi-Purpose Services)
- d. permitting Multi-Purpose Service providers to access all aged care funding programs on the same basis as other aged care providers
- e. developing a funding model for Multi-Purpose Services which reflects the changing number and acuity of people receiving care over time while maintaining certainty of funding over the course of a financial year
- f. together with State and Territory Governments, establishing a cost-shared capital grants program to rebuild or refurbish older Multi-Purpose Services to ensure that the infrastructure meets contemporary aged care design standards, particularly to support the care of people living with dementia.

1160. The Multi-Purpose Services Program should be retained and expanded.

1161. The Program is a longstanding joint initiative between the Australian and State and Territory Governments. One of its primary objectives is to provide integrated health and aged care services for regional, rural and remote communities in both residential aged care and home care settings. The Program facilitates the presence of health and aged care services in regions that could not viably support a standalone hospital or residential aged care facility.¹¹⁵⁷

¹¹⁵⁷ Transcript, Mudgee Hearing, Nigel Lyons, 6 November 2019 at T6521.25–42; Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 22, NDH.0003.0001.0001 at 0006.

1162. The Multi-Purpose Services Program operates under a series of agreements, usually between the Australian Government and a State or Territory Government.¹¹⁵⁸ The Australian Government provides funding to the approved provider in the form of a flexible care subsidy under the *Aged Care Act 1997* (Cth), based on the number of ‘high care’ and ‘low care’ residential places and the number of home care places allocated to each service.¹¹⁵⁹ The service provider ‘pools’ or combines the aged care subsidy with funding for health care services received from the State or Territory Government.¹¹⁶⁰ As at 30 June 2019, there were 179 operational Multi-Purpose Services across Australia.¹¹⁶¹ They provide for, among other things:

- a. integrated health, community and aged care in regional, rural and remote communities
- b. care that is focused on the needs of the local community
- c. financial viability in some communities
- d. the retention of health services in regional, rural and remote locations, and
- e. efficient use of scarce resources.¹¹⁶²

1163. Evidence received by the Royal Commission about the Multi-Purpose Service model has generally been positive.¹¹⁶³ A 2019 evaluation commissioned by the Australian Government and conducted by the Centre for Health Economics Research and Evaluation at the University of Technology Sydney (the ‘University of Technology Sydney review’) identified the social and economic value of the Multi-Purpose Services Program within regional, rural and remote communities and found that the Program was a ‘sound model’ of aged care service provision.¹¹⁶⁴ The authors of the University of Technology Sydney review made a number of recommendations for improvements to the Program.

¹¹⁵⁸ Currently, all but four of the 179 Multi-Purpose Services are operated by State or Territory Government agencies. Australian Institute of Health and Welfare, *Aged care service list: 30 June 2019*, 2020.

¹¹⁵⁹ The ‘high care’ and ‘low care’ classifications were previously used for ‘mainstream’ residential aged care services, but ceased in 2014. See: Australian Department of Social Services, *Removal of low care – high care distinction in permanent residential aged care from 1 July 2014*, 2014.

¹¹⁶⁰ Exhibit 12-25, Mudgee Hearing, Statement of Graeme Barden, WIT.0498.0001.0001 at 0018 [67]–[69]; Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0023 [106].

¹¹⁶¹ Australian Institute of Health and Welfare, *Aged Care Data Snapshot 2019 – fourth release, Providers and Services*, 2019.

¹¹⁶² Exhibit 12-19, Mudgee Hearing, Statement of Julian Krieg, WIT.0590.0001.0001 at 0002 [12]; 0003 [15]; [17]; Transcript, Mudgee Hearing, Nigel Lyons, 6 November 2019 at T6521.25–42; Exhibit 12-25, Mudgee Hearing, Statement of Graeme Barden, WIT.0498.0001.0001 at 0014 [55].

¹¹⁶³ See, for example, Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8213; Exhibit 1-3, Adelaide Hearing 1, NACA submission integrated care at home, RCD.9999.0001.0122 at 0147.

¹¹⁶⁴ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8214.

The Australian Government has, quite rightly, accepted, or at least agreed to in principle, those recommendations.¹¹⁶⁵

1164. The Multi-Purpose Services Program should be expanded. New Multi-Purpose Services should be established where they are needed in regional, rural and remote Australia.
1165. The Australian Department of Health, which administers the Program, has stated that ‘as a rule, new Multi-Purpose Services are not established in towns where other residential aged care services already exist’.¹¹⁶⁶ That ‘rule’ should no longer apply. The main concern should be the needs of the local community. In any event, existing Multi-Purpose Services often operate in the same area as other aged care providers.¹¹⁶⁷ If the aged care system governor identifies a need for increased access to aged care services in a particular area, the existence of a residential aged care service in that area should not prevent the establishment of a Multi-Purpose Service there.
1166. Nor should the establishment of new Multi-Purpose Services be limited to locations with existing local hospitals. That historical approach is not warranted. Again, the proper location of new Multi-Purpose Services should be determined by local needs in a particular area and not by arbitrary rules. Meeting those local needs through the establishment of a Multi-Purpose Service should be the subject of consultation between the Australian Government and the relevant State or Territory Government.
1167. There is otherwise a need for greater alignment of aged care services provided through the Multi-Purpose Services Program and aged care services provided through what might be called the ‘mainstream’ aged care system.
1168. First, there are inconsistencies between fees and charges paid by people receiving aged care services from Multi-Purpose Services and fees and charges paid by people receiving care from mainstream aged care services. For instance, there is no requirement for Multi-Purpose Services to charge daily care fees or for people entering a Multi-Purpose Service to pay a Refundable Accommodation Deposit or a Daily Accommodation Payment. Multi-Purpose Service providers can determine how much residents are charged for services.

¹¹⁶⁵ Australian Department of Health, *Commonwealth Government Response to the Multi-Purpose Services Program Review*, 2020.

¹¹⁶⁶ Australian Department of Health, *Before providing Multi-Purpose Services (MPS) Program services*, 2020, <https://www.health.gov.au/initiatives-and-programs/multi-purpose-services-mps-program/before-providing-multi-purpose-services-mps-program-services#setting-up-a-new-mps>, viewed 21 October 2020.

¹¹⁶⁷ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8259; Exhibit 1-35, Adelaide Hearing 1, Legislated Review of Aged Care 2017, RCD.9999.0011.0746 at 0903–0904 [9.79].

1169. People entering a Multi-Purpose Service may therefore enjoy a considerable financial benefit compared with those entering other residential aged care facilities.¹¹⁶⁸ This has the potential to create an inequitable and unfair competitive advantage for Multi-Purpose Services.¹¹⁶⁹ It can also create inequities between people receiving aged care services in the same area. In future, people accessing Multi-Purpose Services for residential care should be required to make the same financial contributions as others accessing residential aged care. Any change should be made subject to preservation of the rights of existing residents in Multi-Purpose Services.

1170. Secondly, assessment for entry into aged care is not consistent:

- a. across Multi-Purpose Services; or
- b. between the Multi-Purpose Services Program and the mainstream aged care system.

1171. In particular, there is no formal requirement for assessment by an Aged Care Assessment Team before a person receives residential aged care or home care from a Multi-Purpose Service.¹¹⁷⁰ Nor do State and Territory Governments adopt a consistent approach to assessment before a person enters a Multi-Purpose Service.¹¹⁷¹ As submitted above, there should be a consistent assessment process for all people entering any type of aged care.¹¹⁷² A single eligibility and needs assessment promotes equity of access, improved assessment of need, and better data capture.

1172. Thirdly, the Australian Government's funding contribution to Multi-Purpose Services is different from its funding contribution to other aged care services. Funding for a Multi-Purpose Service is 'calculated according to a determined number of high care and low care residential places and home care places'.¹¹⁷³ Funding is provided in the form of a flexible care subsidy under the Aged Care Act. Under the *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Cth), the amount of funding is determined for each allocated place, adjusted for factors such as care status (high, low or home care) and the remoteness, size and resident mix of the Multi-Purpose Service.¹¹⁷⁴

¹¹⁶⁸ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 31, RCD.9999.0247.0025 at 0037; Exhibit 1-35, Adelaide Hearing 1, Legislated Review of Aged Care 2017, RCD.9999.0011.0746 at 0903 [9.79].

¹¹⁶⁹ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8219.

¹¹⁷⁰ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8294–8295; tab 31, RCD.9999.0247.0025 at 0030.

¹¹⁷¹ Exhibit 12-20, Mudgee Hearing, Statement of Nigel Lyons, WIT.0532.0001.0001 at 0016 [61]; Exhibit 12-23, Mudgee Hearing, Statement of Margaret Denton, WIT.0535.0001.0001 at 0006 [32].

¹¹⁷² In relation to the single assessment process, see submissions on program design above.

¹¹⁷³ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8220.

¹¹⁷⁴ *Aged Care (Subsidy, Fees and Payments) Determination 2014* (Cth), Chapter 4, Part 1.

1173. Under this approach, funding is fixed and not contingent on occupancy. This may provide 'administrative simplicity and reasonable funding certainty'.¹¹⁷⁵ It does not, however, reflect the actual cost of providing care because the funding does not respond to changes in acuity or numbers of people actually receiving care.¹¹⁷⁶ Evidence before the Royal Commission has also suggested that Australian Government funding for Multi-Purpose Services has failed to keep pace with need and with equivalent mainstream aged care funding arrangements.¹¹⁷⁷

1174. The current funding model for Multi-Purposes Services should be updated.¹¹⁷⁸ The authors of the University of Technology Sydney review rightly recommended that consideration should be given to development of a new Australian Government funding model for Multi-Purpose Services which, among other things, would:

- a. retain existing advantages of reasonable funding certainty and administrative simplicity
- b. address concerns about adequate care funding for both resident and home care acuity, and
- c. address 'the issue of market failure in the delivery of HCP [Home Care Packages] and CHSP [the Commonwealth Home Support Programme] in small isolated communities'.¹¹⁷⁹

1175. The Australian Government has agreed in principle to this recommendation.¹¹⁸⁰ The new independent Aged Care Pricing Authority should develop the new funding model for Multi-Purpose Services.¹¹⁸¹

1176. In conclusion, although the Multi-Purpose Services Program is a practical example of the benefits of productive intergovernmental cooperation, many existing buildings that house Multi-Purpose Services are outdated and need improvements.¹¹⁸² They particularly

¹¹⁷⁵ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8220.

¹¹⁷⁶ J Anderson and L Malone, 'Suitability of the Multi-Purpose Service Model for Rural and Remote Communities of Australia', *Asia Pacific Journal of Health Management*, 2014, Vol 9, 3, p 16.

¹¹⁷⁷ Exhibit 1-3, Adelaide Hearing 1, NACA submission integrated care at home, RCD.9999.0001.0122 at 0147.

¹¹⁷⁸ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8220; Transcript, Mudgee Hearing, Nigel Lyons, 6 November 2019 at T6528.23-26; Exhibit 12-25, Mudgee Hearing, Statement of Graeme Barden, WIT.0498.0001.0001 at 0015 [57(b)].

¹¹⁷⁹ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8221.

¹¹⁸⁰ Australian Department of Health, *Commonwealth Government Response to the Multi-Purpose Services Program Review*, 2020, p 5.

¹¹⁸¹ See Parts 3.2 and 3.15.

¹¹⁸² Exhibit 12-21, Mudgee Hearing, Statement of Sharon-Lee McKay, WIT.0533.0001.0001 at 0021–0022 [114]; Exhibit 12-22, Mudgee Hearing, Statement of Sharon-Lee McKay, WIT.0534.0001.0001 at 0021–0022 [114]; Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8218 and 8258.

require improvements to enable the provision of high quality residential aged care services to people living with dementia.¹¹⁸³

1177. The authors of the University of Technology Sydney review found that a large number of Multi-Purpose Services had difficulty accessing funds to upgrade their facilities.¹¹⁸⁴ Under the Multi-Purpose Services Program, the Australian Government is not responsible for providing capital funding to improve infrastructure.¹¹⁸⁵ Multi-Purpose Services are not eligible to apply for Australian Government capital funds for new or renovated infrastructure.¹¹⁸⁶ On the other hand, mainstream aged care providers in regional, rural and remote areas are able to access infrastructure grants provided by the Australian Government, allocated through the annual Aged Care Approval Round.
1178. Evidence received by the Royal Commission from representatives of both the Australian Government and State and Territory Governments supported the need for this discrepancy to be resolved through the Australian Government and State and Territory Governments agreeing on a systematic capital grants program for Multi-Purpose Services.¹¹⁸⁷ The Australian Government has now agreed in principle to review its approach to funding accommodation and infrastructure in Multi-Purpose Services.¹¹⁸⁸ The Australian and State and Territory Governments should together contribute to the cost of ensuring that Multi-Purpose Services infrastructure is up-to-date and conducive to the provision of high quality aged care services.

¹¹⁸³ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8218.

¹¹⁸⁴ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8304.

¹¹⁸⁵ Australian Department of Health, *Setting up a new MPS*, 2020.

¹¹⁸⁶ Exhibit 12-1, Mudgee Hearing, General Tender Bundle, tab 13, CTH.1000.0003.8206 at 8264 and 8304.

¹¹⁸⁷ Transcript, Mudgee Hearing, Nigel Lyons, 6 November 2019 at T6523.20–33; Transcript, Mudgee Hearing, Lyndon Seys, 5 November 2019 at T6475.38–6476.7; Transcript, Mudgee Hearing, Graeme Barden, 6 November 2019 at T6569.25–32.

¹¹⁸⁸ Australian Department of Health, *Commonwealth Government Response to the Multi-Purpose Services Program Review*, 2020, p 4.

Part 3.15 Proposed funding arrangements and outline of financing options

1179. In section 3.2, Design of the new aged care system, we proposed recommendations about institutional changes including the establishment of independent pricing. This is a crucial reform but will take some years to implement. It should be preceded by greater accountability for the expenditure of public funding for high quality care and the other purposes for which it is paid. This should be achieved by improved reporting and transparency. Improved reporting will also provide the opportunity for better regulatory oversight of risks to the quality and continuity of aged care, including financial risks. These measures for greater accountability should be introduced as soon as possible.
1180. In recent years, the aged care sector has been under significant and increasing financial pressure. Evidence from experts,¹¹⁸⁹ banks,¹¹⁹⁰ approved providers,¹¹⁹¹ chartered accounting firm StewartBrown,¹¹⁹² the Australian Department of Health,¹¹⁹³ and the Royal Commission's commissioned research,¹¹⁹⁴ consistently indicates that the financial performance of approved providers has been deteriorating over a period of several years, and that the continued viability of a significant number of residential care providers is doubtful under current funding levels and arrangements. The risk of financial failure by residential care providers is particularly acute in regional, rural and remote areas.¹¹⁹⁵ There are also valid concerns about the effect of a deterioration in occupancy in Victorian residential aged care facilities during the COVID-19 pandemic, accompanied by a trend away from payment of accommodation charges by way of lump sum deposits. Home care providers have also experienced some declines, although these appear to be stabilising.¹¹⁹⁶
1181. There are several factors that are contributing to the current financial pressures, including inflexible and outdated funding models, inadequate indexation arrangements and shortfalls in particular funding and revenue streams compared with the costs of

¹¹⁸⁹ See, for example, Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0004 [24]–[25]; Exhibit 2-86, Adelaide Hearing 2, Statement of Hjalmar Swerissen, WIT.0085.0001.0001 at 0003 [16].

¹¹⁹⁰ Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9491.27–9492.5;

¹¹⁹¹ Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0011–0019; Exhibit 21-23, Sydney Hearing 5, Statement of Chris Mamarelis, RCD.9999.0335.0001 at 0004–0006 [25]–[36].

¹¹⁹² Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0009.

¹¹⁹³ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9421.43–9422.18.

¹¹⁹⁴ BDO, Report on the Profitability and Viability of the Australian Aged Care Industry, prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 50.

¹¹⁹⁵ See, for example, Aged Care Financing Authority, *Sixth Report on the Funding and Financing of the Aged Care Sector*, Australian Government, 2018, p 95; Aged Care Financing Authority, *Seventh Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2019, p 80; Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2020, p 79.

¹¹⁹⁶ Aged Care Financing Authority, *Eight Report on the Funding and Financing of the Aged Care Sector*, Australian Government, 2020, p v, 42.

providing the services which generate the relevant funding and revenue streams. In our submission, some of these issues should be addressed immediately in order to stabilise the sector before the other issues are addressed by longer-term reforms.

Financial viability of providers

1182. Accountancy firm StewartBrown conducts a broad survey of the financial performance of approved providers of aged care on a quarterly basis and publishes regular reports of its analysis of the results. StewartBrown's analysis of recent data indicated that 19.5% of residential aged care facilities experienced an EBITDAR loss (that is, a loss on the basis of Earnings Before Interest Taxation Depreciation Amortisation and Rent, effectively an operating cash loss) in the six months to December 2018.¹¹⁹⁷ This increased to 29% of residential aged care facilities surveyed in the six months to December 2019, with performance likely to deteriorate further as costs increase in excess of revenue.¹¹⁹⁸ StewartBrown notes that a cash loss is unsustainable for any mid-length period of time, and will need to be cross subsidised by other activities.¹¹⁹⁹ The lead manager of StewartBrown's survey work, Grant Corderoy, gave evidence to the Royal Commission in September. Mr Corderoy said that 2012 was a 'breaking point' for the sector, and that since that time there has been a 'continual deterioration' in financial performance and that 'every year it's deteriorating a little further.'¹²⁰⁰

1183. Evidence given by lenders to the sector was consistent with Mr Corderoy's evidence. A panel of witnesses representing the 'Big Four' Australian banks also gave evidence in September. Mr Sam Morris from the Australia and New Zealand Banking Group (ANZ) stated that there has been a 'general decline in profitability and cash flow of [ANZ's] aged care clients' over the last few years.¹²⁰¹ Mr John McCarthy, representing the National Australia Bank (NAB), noted it was 'particularly challenging for the smaller operators to continue to thrive and flourish within the sector'.¹²⁰² Mr Chris Williams of the Commonwealth Bank of Australia told the Royal Commission that 'there is probably no other industry that the Commonwealth Bank supports where I would be able to say that more than 50% of the operators in the industry are either marginally profitable or loss making...'¹²⁰³ Ms Hordern of Westpac Banking Corporation (Westpac) told the Royal

¹¹⁹⁷ StewartBrown, *Aged Care Financial Performance Survey Sector Report December 2018*, p 14.

¹¹⁹⁸ StewartBrown, *Aged Care Financial Performance Survey Sector Report December 2019*, p 19; Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0006.

¹¹⁹⁹ StewartBrown, *Aged Care Financial Performance Survey Sector Report December 2019*, p 19.

¹²⁰⁰ Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9135.17–39.

¹²⁰¹ Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9490.44–47.

¹²⁰² Transcript, Sydney Hearing 5, John McCarthy, 21 September 2020 at T9490.35–38.

¹²⁰³ Transcript, Sydney Hearing 5, Chris Williams, 21 September 2020 at T9491.16–20.

Commission a specific driver of these issues was that wage rises were outstripping the indexing of income for providers.¹²⁰⁴

1184. The financial performance and viability of approved providers in regional, rural and remote areas is particularly concerning. The Aged Care Financing Authority identified that while regional providers generated an aggregate profit of \$62 million in 2016–17, they generated an aggregate loss of \$88 million in 2017–18 and an aggregate loss of \$45 million in 2018–19.¹²⁰⁵ StewartBrown’s analysis of individual residential aged care homes identified that outer regional, remote and very remote facilities had particularly poor profitability. Survey data showed that 37% of outer regional, remote and very remote facilities demonstrated an EBITDAR cash loss in the six months to December 2018.¹²⁰⁶ This worsened by December 2019, with 44% of outer regional, remote and very remote facilities experiencing a cash operating loss.¹²⁰⁷

1185. Many residential care providers in outer regional and remote areas receive the Viability Supplement, which was permanently increased by 30% in 2019 and was increased (in recognition of the additional costs generated by the COVID-19 pandemic) by a further 30% with effect from March 2020.¹²⁰⁸ As at time of introduction of that second increase, Mr Corderoy told the Royal Commissioners that StewartBrown’s data showed that ‘55% of homes in the outer regional, rural and remote are running at an EBITDAR loss which is effectively running at a cash loss’¹²⁰⁹

1186. Even taking both of the 30% increases in the Viability Supplement into account, it appears likely that the number of providers facing financial pressure in these areas is very significant.

1187. Falling occupancy rates compound the deterioration in financial performances. There has been a decrease in average sector-wide occupancy levels over the past few years. Residential care providers receive funding based on care recipients, a decline in occupancy will directly affect their revenue and viability. Data provided by StewartBrown shows that occupancy levels decreased from 94.9% in December 2018 to 93.9% in December 2019.¹²¹⁰ While the Aged Care Financing Authority uses a different method of

¹²⁰⁴ Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9492.10–15.

¹²⁰⁵ Aged Care Financing Authority, *Sixth Report on the Funding and Financing of the Aged Care Sector*, Australian Government, 2018, p 95; Aged Care Financing Authority, *Seventh Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2019, p 80; Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2020, p 79.

¹²⁰⁶ StewartBrown, *Aged Care Financial Performance Survey Sector Report December 2018*, 2018, p 15.

¹²⁰⁷ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0012. See also Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9137.13–16. See also the discussion of the Barnier review in Part 3.16 of these submissions.

¹²⁰⁸ Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9137.13–16

¹²⁰⁹ Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9137.13–16

¹²¹⁰ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0006.

determining occupancy, their data also showed that occupancy rates have declined over the past few years, from a 91.8% occupancy rate in 2016–17, to 90% in 2017–18 and 89.6% in 2018–19.¹²¹¹ The trend will probably continue in the near future in the context of the additional pressures placed on occupancy levels by COVID-19.

1188. Mr Campbell Ansell of Ansell Strategic sounded a note of caution over the residential care sector's reliance upon refundable accommodation deposits, especially in light of the ongoing pandemic. He stated that not every resident who is discharged is being replaced, and that this has an 'obvious cash flow consequence if you're having to repay a lump sum' which is combined with the majority of new arrivals in residential care 'not electing to pay a lump sum.'¹²¹² A report prepared by his firm Ansell Strategic in August 2020 for the Australian Department of Health, estimated that \$1.38 billion in refundable accommodation deposits had left the sector since the beginning of February 2020.¹²¹³

1189. In markets it is normal for businesses to operate at losses for periods, eventually recover and become profitable, or to fail and exit the market. However, in aged care, providers experiencing prolonged financial pressure can induce risks to the quality of people's care, and providers exiting the market can have serious consequences for the availability of care in general. Mr Morris of ANZ identified smaller 'single site operators' as being at particular financial risk in the current environment, stating that 'they're less able to offer a competitive service at a lower cost with this declining margin because with scale comes diversity, and we've found larger operators are able to weather those types of risks in this environment.'¹²¹⁴

1190. Analysis obtained by the Office of the Royal Commission from accountancy firm BDO presented a somewhat different picture, as did an analysis of industry returns obtained by the Office of the Royal Commission from Frontier Economics.¹²¹⁵ BDO considered that limitations in the way financial data was reported by the sector to the Department prevented it from reaching firm conclusions about 'true' returns:

It is possible to calculate a reported profit margin, return on assets and return on equity from the data provided. However, our view is that consideration should also be given to any gains or losses made by related parties to the extent that they can be attributed to capital obtained from the sector (for example, how RADs are used to make gains). It is possible that such gains or losses are quite significant given the total value of RADs in aged care (\$28.4Bn in FY2018).

¹²¹¹ Aged Care Financing Authority, *Sixth Report on the Funding and Financing of the Aged Care Sector*, Australian Government, 2018, p 149; Aged Care Financing Authority, *Seventh Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2019, p 131; Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2020, p 131.

¹²¹² Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9474.43–9475.2.

¹²¹³ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 127, ANS.0001.0007.0001 at 0005.

¹²¹⁴ Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9491.8–11.

¹²¹⁵ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 10, RCD.9999.0388.0044; tab 12, RCD.9999.0388.0223.

In our view, shareholders of individual Approved Providers would consider such benefits when evaluating their investment in the sector. The data that would be required to develop this more holistic, true return, is not available within the ACFR. Approved Providers do not have an obligation to report it.¹²¹⁶

1191. Notwithstanding this limitation, as one of the authors of the report explained during the hearing in September, some of the top 25% of financial performers made a good return in recent financial years.¹²¹⁷ A table presented in the report indicated that the top quartile of for-profit residential care providers made a return (calculated as Earnings Before Interest, Tax, Depreciation and Amortisation over Assets) of 7.61% in financial year 2017-18.¹²¹⁸ Frontier Economics reported that industry returns over several years to 2016-17 appeared sufficient to attract investment:

Average returns in Residential Aged Care were reasonably constant in FY2015, FY2016 and FY2017. Because these returns are averaged over for-profits, not-for-profits and government entities it is not clear that returns covered the cost of capital for all entities. However, the substantial investment in the sector in FY2015 to FY2017 suggests that returns for many providers did cover their cost of capital in these years. Average returns to the sector have decreased in each of the last two financial years.¹²¹⁹

1192. As the reports of both BDO and Frontier Economics acknowledge, there is significant variation in financial performance between approved providers. The fact that some approved providers appear to be making adequate returns does not diminish the force of the evidence that many are not, and that the overall financial position of the sector has been deteriorating over recent years. The Secretary of the Australian Department of Health, Dr Murphy, told the Royal Commissioners that:

the system is under financial pressure at the moment, and definitely does need some financial resetting.¹²²⁰

1193. A major underlying cause of the financial pressures on residential aged care providers is the indexation approach that has been applied to funding levels over many years.

1194. In the lead up to the hearing on funding in September, the Office of the Royal Commission prepared a paper on historical expenditure on aged care and furnished it to the Australian Department of Health for comment.¹²²¹ A version of that document that was amended following that consultation was tendered into evidence.¹²²² Parts of the analysis that follows are drawn from that amended document. The annual indexation applied to aged care subsidies is a composite index constructed by the Australian

¹²¹⁶ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 10, RCD.9999.0388.0044 at 0081.

¹²¹⁷ Transcript, Sydney Hearing 5, Fahim Khondaker, 14 September 2020 at T9163.34–38.

¹²¹⁸ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 10, RCD.9999.0388.0044 at 0082.

¹²¹⁹ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 12, RCD.9999.0388.0223 at 0228.

¹²²⁰ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9421.45–9422.1.

¹²²¹ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 90, CTH.9999.0001.0001; tab 91, RCD.9999.0519.0017;

¹²²² Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 114, RCD.9999.0522.0001.

Department of Finance that comprises a wage cost component (weighted at 75%) and a non-wage cost component (weighted at 25%).¹²²³ Between 1999-2000 and 2018-19, subsidy levels increased by 70.3% in nominal terms, whereas provider input costs increased by 116.3%.¹²²⁴

1195. Over a period of time, the Australian Government has paid annual real increases in average care subsidy per resident per day, attributable to increases in average acuity assessments under the Aged Care Funding Instrument. Mr Nick Mersiades, Director of Aged Care, Catholic Health Australia, characterised this as ‘frailty drift’ – a gradual increase in the average acuity of residents.¹²²⁵ Mr Mersiades gave evidence in September that ‘the funding that’s being provided is not keeping up with costs.’¹²²⁶ He said that funding is ‘predicated on an indexation formula which is based on a labour productivity expectation which is not sustainable’ and ‘involves a significant discount on the minimum wage adjustments.’¹²²⁷

1196. The Australian Department of Health accepted that ‘the level of indexation has not been sufficient to cover the increasing cost of service delivery inputs’ and that ‘[i]f this is not addressed ... over time, it will result in pressure being put on service delivery’.¹²²⁸ The Department also identified that ‘the evidence available indicates financial performance across the residential aged care sector has deteriorated in recent years.’¹²²⁹ These matters were reiterated by Dr Brendan Murphy, in his evidence in September. Dr Murphy said that there was a need to address the level of indexation and for indexation to be determined in a more evidence-based way in the future.¹²³⁰

1197. The Australian Department of Health claimed that low indexation ‘arguably encourages providers to make higher than appropriate funding claims under the ACFI model’.¹²³¹ Other possibilities are that the acuity of residents has been increasing, or assessments

¹²²³ Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2020, pp 66, 67. The indexation approach for residential care and home care is known within government as ‘WCI-9’. A similar approach, known as ‘WCI-3’, is used for the Commonwealth Home Support Programme, by which the wages component is weighted at 60% and the non-wage component at 40%: Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry* Australian Government, 2020, p 39.

¹²²⁴ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 114, RCD.9999.0522.0001 at 0008.

¹²²⁵ Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0008 [52].

¹²²⁶ Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.1.

¹²²⁷ Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.2–4.

¹²²⁸ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9218 [103].

¹²²⁹ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193 [16].

¹²³⁰ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9429.9–13; T9424.10–15.

¹²³¹ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193 [17].

have been more accurate, or some combination of all these factors. As we outlined in Part 3.2 Design of the new aged care system, this topic has generated mistrust between the sector and the Department.

1198. The Australian Department of Health said that in 2012 the Australian Government ‘paused indexation for twelve months’ and ‘made changes to the ACFI tool to address concerns of over claiming and to bring growth more in line with estimated sustainable funding levels.’¹²³² In its post hearing submissions, the Australian Government clarified that the decision occurred after ‘consultation’ with the aged care sector.¹²³³ Further, the Department identified that in 2014-15 and 2015-16, ACFI claiming growth was ‘again higher than expected’ and in particular, in 2015-16 there was ‘higher than anticipated claiming’ under the Complex Health Care domain of the ACFI.¹²³⁴ To address this, the Australian Government implemented the following measures between 2016 and 2018:

- a. a 50% pause in indexation of the Complex Health Care domain of the ACFI on 1 July 2016
- b. a 12-month ACFI indexation pause on 1 July 2017, and
- c. a 50% pause in indexation of the Complex Health Care domain of the ACFI on 1 July 2018.¹²³⁵

1199. The Department said that changes made to the Complex Health Care domain in 2016-17 were ‘driven by the Commonwealth’s concerns regarding the significant and unanticipated increases in ACFI expenditure ... which could not be explained by a corresponding increase in the frailty of residents.’¹²³⁶ The Department said that:

Natural growths in frailty would be expected to occur more gradually over time and be seen across all the ACFI domains. The patterns of claiming indicated the high increase in claim rates was being driven by changes in the claiming behaviour of providers, rather than increasing frailty of residents.¹²³⁷

1200. In post hearing submissions, the Australian Government submitted that:

The intention of the indexation freeze was to respond to the unjustified spike in claims, and to mitigate the impact of actual and potential overclaiming

¹²³² Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [98].

¹²³³ Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0015 [45(c)].

¹²³⁴ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [99].

¹²³⁵ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9216 [99].

¹²³⁶ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9218 [104].

¹²³⁷ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9218 [106].

behaviour of providers; it was not to entirely withhold or withdraw funding to the sector. Overall funding to the sector continued to grow.¹²³⁸

1201. The Australian Department of Health has acknowledged that the ACFI is not an appropriate funding tool.¹²³⁹ The Department has also recognised that, among other things, the ACFI ‘has resulted in a history of unpredictable and unstable funding outcomes for providers and Government’ and it claims that under the funding instrument, ‘providers are encouraged to overstate actual levels of incapacity and support requirements and thereby “upscale” ACFI scores.’¹²⁴⁰

1202. Mr Mersiades said that, in the past, providers managed the ‘punitive indexation arrangement through their claiming arrangement under the ACFI ...’¹²⁴¹ Mr Mersiades said that ‘over the life of the ACFI the real increase’ has been approximately 5% per annum, whereas under the current ACFI arrangements introduced in 2016/17, the ‘real increase is as low as 0.5%.’¹²⁴² Mr Mersiades said:

So you can see with punitive indexation, the low real increase, that there's no chance that the current system is going to be able to match cost increases, and also increases in consumer expectations, older people's expectations about the quality of care that they receive.¹²⁴³

1203. The conclusion of Mr Grant Corderoy based on StewartBrown’s analysis is that ACFI data indicates that there is limited remaining scope for residents to be classified to any higher levels of acuity under ACFI, meaning further revenue will not come from higher ACFI payments.¹²⁴⁴ This will leave the sector dependent on annual indexation for revenue growth, which (as already noted) is unlikely to match increases in input costs.

1204. Mr Mike Callaghan AM PSM, Former Chair of the Aged Care Financing Authority, also gave evidence about the decisions of the Australian Government in relation to the indexation of the ACFI and the effect on the aged care sector more broadly.

1205. Mr Callaghan described the relationship between the decisions of the Australian Government with respect to indexation and the declining financial performance of the residential aged care sector.¹²⁴⁵ With respect to changes made in the period of 2016-17, Mr Callaghan said:

¹²³⁸ Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0014–0015 [45(b)].

¹²³⁹ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9193–9194 [18]; Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0014 [45(a)]; Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9428.30–37.

¹²⁴⁰ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9194 [18(a)], [18(c)] [20(b)].

¹²⁴¹ Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.3–6.

¹²⁴² Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.6–9.

¹²⁴³ Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9522.9–12.

¹²⁴⁴ Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9143.31–9144.9.

¹²⁴⁵ Transcript, Sydney Hearing 5, Mike Callaghan, 17 September 2020 at T9318.14–9319.21.

In terms of the changes that were made in 2016/2017 with the freezing of indexation and with the changing in the scoring level, which led to this almost-zero growth in the revenue of providers while the costs were going up.¹²⁴⁶

1206. Mr Callaghan described his impression of 'mistrust' between approved providers and the Australian Government following his involvement in consultations undertaken by the Aged Care Financing Authority in 2018 to understand the reasons for the growth in claiming under the ACFI.¹²⁴⁷ Mr Callaghan explained that:

It was a very strong view of mistrust between both parties. From the provider's point of view, all of them, the message they were hearing from Department, from the Government, I suppose, was that they were involved in what they were interpreting as unethical claiming behaviour with ACFI.

...

From the Department's point of view, they just didn't have confidence that what was - what they were seeing in terms of the ACFI truly represented the underlying growth in acuity¹²⁴⁸

1207. When asked by Counsel Assisting whether the indexation pauses were a 'proportionate response to some instances of what [the Department] perceived to be over-claiming', Dr Murphy said that:

We absolutely accept that the ACFI instrument, and that was the only tool available at the time to deal with the massive growth in costs. I accept that in that there was a lot of providers were over-claiming. I don't blame them for it.¹²⁴⁹

1208. Dr Murphy and the Australian Government in post hearing submissions clarified that the behaviour on the part of providers was not illegal.¹²⁵⁰

1209. The inference should be drawn that the indexation pauses were, at least in part, motivated by fiscal considerations. Dr Murphy agreed that the claiming behaviour of providers 'would certainly have placed an unpredicted fiscal pressure on Government'.¹²⁵¹ There are clear links between the long-term inadequacy of the indexation approach, patterns of assessment by providers of the levels of funding that should apply to their residents under ACFI, the fiscal pressures that apply to the government of the day, the indexation pauses applied by the government, and the unpredictability of funding residential aged care and a level of mistrust that has been generated between the sector and the Australian Department of Health. As we have submitted in part 3.2 Design of the new aged care system, it will take some time to restore trust in the reliability and predictability of funding for residential care. We address the

¹²⁴⁶ Transcript, Sydney Hearing 5, Mike Callaghan, 17 September 2020 at T9319.4–6.

¹²⁴⁷ Transcript, Sydney Hearing 5, Mike Callaghan, 17 September 2020 at T9320.3–16.

¹²⁴⁸ Transcript, Sydney Hearing 5, Mike Callaghan, 17 September 2020 at T9320.31-42.

¹²⁴⁹ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9428.32–35.

¹²⁵⁰ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9448.35–38; Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0015 [45(c)].

¹²⁵¹ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9449.17–23.

independent pricing mechanism through which this should be achieved later in this section. Before that can occur, there is a need for urgent measures to be taken in the interim.

Urgent interim measures

1210. Pending the introduction of independent pricing, there should be interim changes to the indexation arrangements for residential aged care to ensure the short term viability of the sector. This proposal is supported by evidence received at the funding hearing in September 2020.¹²⁵²

1211. The changes should peg indexation to changes in the major categories of wages in the sector. That means they should include a component based on changes in the minimum wages of personal care workers), rather than the dollar value of changes in the minimum wage divided by average weekly ordinary time earnings. And they should also include a component based on changes in the minimum wages for nurses, without there being any need to represent those changes as proportions of average weekly ordinary time earnings. According to the StewartBrown Aged Care Performance Survey Sector Report, labour costs make up about 75% of direct care costs, with the other 25% made up of non-labour costs and administrative overheads.¹²⁵³ From the same survey, the ratio of nursing hours to personal care hours, and the relative wages of nurses and personal carers, means that the costs of nursing and personal care are roughly split 30/45 within the 75% that represents labour costs.

Recommendation 80: Amendments to residential aged care indexation arrangements

80.1. Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for residential aged care so that all care subsidies, and the viability supplement, are increased on 1 July each year by the weighted average of:

¹²⁵² Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0007, 0010; Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020 at T9144.29–9145.12; Exhibit 21-18, Sydney Hearing 5, Nicholas Mersiades, RCD.9999.0319.0001 at 0009 [61].

¹²⁵³ See Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 61, StewartBrown Aged Care Financial Performance Survey Sector Report March 2020 RHC.9000.0002.0001 at 0018 (Table 4) – (Annexure 2 to Statement of Linda Mellors), section 14 of the Aged Care Award 2010 (<http://awardviewer.fwo.gov.au/award/show/MA000018>), and section 14 of the Nurses Award 2010 (<http://awardviewer.fwo.gov.au/award/show/MA000034>).

- a. 45% of the yearly (to the 30 June immediately preceding the indexation date) percentage increase to minimum wage for an Aged Care employee Level 3 under the Aged Care Award 2010 (section 14.1)
- b. 30% of the yearly (to the 30 June immediately preceding the indexation date) percentage increase to the minimum wage for a registered Nurse Level 2 – pay point 1 under the Nurses Award 2010 (section 14.3)
- c. 25% of the yearly percentage (to the 30 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.

80.2. The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Aged Care Pricing Authority is established and has commenced independent determination of prices for residential care.

1212. While home care providers are not subject to the same volatility between funding model and indexation arrangements, home care basic care subsidies and the majority of supplements are indexed by the same method used for residential aged care, once a year.¹²⁵⁴ The indexation arrangement therefore has the same effect over time as in residential care.

1213. The Australian Department of Health notes that the level of indexation ‘appears’ to have been insufficient to cover the increasing cost of service deliver input, which has resulted in a reduction of hours of care in home care packages overtime.¹²⁵⁵ On this basis, we submit that indexation arrangements for home care should also be amended to reflect the increase to the minimum wage, and in the wages for nurses, rather than the dollar value increase in minimum wages divided by average weekly ordinary time earnings.

1214. We acknowledge that the issue of unspent funds in home care raises questions about whether or not the funding under those packages is, in fact too generous. According to StewartBrown, the quantum of unspent funds in home care has kept rising each quarter over the last few years, and now averages \$8,250 per person receiving a Home Care Package.¹²⁵⁶ In aggregate, this represents around \$1,062 million of funding residing in

¹²⁵⁴ Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2020, p 46; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9215 [94]

¹²⁵⁵ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9202 [45(b)].

¹²⁵⁶ StewartBrown, *Aged Care Financial Performance Survey Sector Report*, March 2020, p 33.

the bank accounts, as a liability, of approved providers.¹²⁵⁷ This is likely to be over \$1,100 million as at the end of the 2020 financial year in the current funding model.¹²⁵⁸

1215. However, the underlying causes of the accumulation of unspent funds appear to be: inadequate care management by the person receiving care and their provider, as well as a distinct lack of detail in the classification of people's needs under the Home Care Packages Program.

1216. Dr David Panter, Chief Executive, ECH gave evidence in September about the indexation and growth arrangements for the Commonwealth Home Support Programme and Home Care Packages. Dr Panter told us that in relation to the arrangements for Commonwealth Home Support Programme funding 'the net effect is that that amount of money buys less hours.'¹²⁵⁹ He said that 'overall, there is less support for older people. And it's the same within Home Care Packages.'¹²⁶⁰

1217. As Mr Paul Versteegen outlined in his evidence, care recipients are assessed as eligible for a certain level of funding, and then without further assistance from an expert, expected to self-assess and self-manage their funding for protracted periods of time while their home care package provider will suggest 'all sorts of ways in which funds could be spent'.¹²⁶¹ We accept that urgent attention is needed to improve care management (and have proposed a recommendation in that regard in Part 3.3 Program Design), but the fact that care management needs improvement is no justification for the perpetuation of inadequate indexation of home care funding levels. We therefore submit that the measures we recommend for the improvement of care management for home care package holders should be accompanied by appropriate indexation of home care funding levels.

Recommendation 81: Amendments to aged care in the home indexation arrangements

81.1. Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for home care so that subsidy rates are increased on 1 July each year by the weighted average of:

- a. 60% of the yearly (to the 30 June immediately preceding the indexation date) percentage increase to minimum wage for an

¹²⁵⁷ StewartBrown, *Aged Care Financial Performance Survey Sector Report*, March 2020, p 33.

¹²⁵⁸ StewartBrown, *Aged Care Financial Performance Survey Sector Report*, December 2019, p 33.

¹²⁵⁹ Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9599.3–12.

¹²⁶⁰ Transcript, Sydney Hearing 5, David Panter, 22 September 2020 at T9599.9–18.

¹²⁶¹ Exhibit 20-1, Sydney Hearing 4, Statement of Paul Versteegen, tab 82, RCD.9999.0359.0001 at 0018-0019 [112].

Aged Care employee Level 3 under the Aged Care Award 2010 (section 14.1)

- b. 15% of the yearly (to the 30 June immediately preceding the indexation date) percentage increase to the minimum wage for a registered Nurse Level 2 – pay point 1 under the Nurses Award 2010 (section 14.3)
- c. 25% of the yearly percentage (to the 30 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.

81.2. The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Aged Care Pricing Authority is established and has commenced independent determination of prices for aged care in the home.

1218. The indexation method that applies to the Commonwealth Home Support Programme is similar to the indexation method for residential care and home care, although the weighting for the wages component is 60%, not 75%.¹²⁶² The Australian Government should also give consideration to urgent interim changes to the indexation method for the Commonwealth Home Support Programme, consistent with the changes we recommend for the indexation of home care package levels, adapted in light of the lower 60% overall wage component.

1219. According to analysis by StewartBrown, another significant cause of financial pressure within the residential aged care sector is a shortfall in revenues intended to meet residents' basic daily living needs (including nutrition). This is attributable to the level of the Basic Daily Fee, which is capped at 85% of the basic single age pension and is intended to cover everyday living expenses such as food, laundry, cleaning, and utilities.¹²⁶³ This currently equates to about \$52 per day.¹²⁶⁴

1220. StewartBrown has identified that for the six months preceding December 2019, the costs of providing everyday living services exceeded revenue by \$8.13 per bed per day (an average across all providers). In December 2018, this was \$7.38 per bed per day.¹²⁶⁵ As Mr Mersiades pointed out at the hearing in September, this is an expected outcome because the age pension is set assuming a significant level of self-provision and self-

¹²⁶² Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2020, p 39.

¹²⁶³ Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0004 [26].

¹²⁶⁴ Transcript, Sydney Hearing 5, Grant Corderoy, 14 September 2020, T9132.23–25.

¹²⁶⁵ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0011.

management by retirees for daily requirements and activities. In residential aged care, most of these activities involved salaried staff. Any economies of scale in bulk purchasing do not offset these costs.¹²⁶⁶

1221. Providers can charge ‘additional services’ fees for things such as better quality food, cleaning and laundry, but this is not a solution to the inadequacy of the revenue stream generated by the Basic Daily Fee. Providers should be required to provide high quality goods and services meeting basic living needs for all residents in return for the Basic Daily Fee. About 48% of all aged care residents are supported residents who do not have the financial means to pay for additional services, or a higher Basic Daily Fee.¹²⁶⁷

1222. In effect, providers are currently compelled either to reduce the quality of goods and services provided to meet everyday living needs because of the inadequacy of the Basic Daily Fee revenue stream, or cross-subsidise the shortfall from other revenue streams.¹²⁶⁸ According to StewartBrown, under current arrangements residential care providers are underspending their ACFI revenue on care at the average level of \$16.68 per resident per day (after inclusion of administration overhead costs), probably in order to meet shortfalls in other areas and perhaps to earn a profit margin.¹²⁶⁹ Cross-subsidisation from a revenue stream generated from the prices for care to meet the costs of a capped price for everyday living could lead to inefficient allocations of resources.¹²⁷⁰ Of more direct concern, money which would be used to provide high quality care (including additional staffing or better training and qualifications) is being directed to meet other costs because the price cap that is imposed to permit recovery of those costs is too low.

1223. It appears that there has never been a study of the costs of providing high quality aged care to which subsidies could be accurately calibrated.¹²⁷¹ Likewise there is no evidence of any objective cost study to determine the cost of everyday living services based on agreed expectations of quality. We recommend that the Aged Care Pricing Authority, once established, should determine the price cap that that may be charged by residential care providers to meet the everyday basic living needs of residents. This may well be in excess of 85% of the basic single age pension. To the extent that it is, for supported residents we propose that the Australian Government should fund the gap, ensuring that

¹²⁶⁶ Exhibit 21-18, Sydney Hearing 5, Statement of Nicolas Mersiades, RCD.9999.0319.0001 at 0004 [26].

¹²⁶⁷ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0011.

¹²⁶⁸ See, for example, Exhibit 21-19, Sydney Hearing 5, Statement of Linda Mellors, RCD.9999.0377.0001 at 0035 [55] – [59].

¹²⁶⁹ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0021.

¹²⁷⁰ Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020, T9627.22–39.

¹²⁷¹ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9424.4–9.

a supported resident will only contribute to the new, independently priced Basic Daily Fee to the level of 85% of the basic single age pension.

1224. Until these longer term arrangements are in place, in light of the fact that the Australian Department of Health accepts that revenue generated by the Basic Daily Fee is insufficient, it is necessary that the Australian Government should provide additional interim funding.¹²⁷² We recommend an immediate conditional increase to the Basic Daily Fee of \$10 per resident per day.

1225. In constructing a plan for additional interim funding for basic daily needs, it is necessary to balance urgency, the desirability of simplicity and minimising administrative burden, and accountability. Approved providers should not *per se* be required to acquit the additional amount provided under the Basic Daily Fee as expended on daily living needs (including nutrition), because particular providers will already be spending appropriately in this area and absorbing the costs, perhaps contributing to losses. However, we think that some accountability is appropriate. In our submission, a provider should only be provided with the additional \$10 per resident per day funding on condition that the provider will give a written undertaking in the form below that it will conduct an annual review of the adequacy of the goods and services it has provided to meet the basic living needs of residents, and in particular their nutritional requirements throughout the preceding 12 months, and that the governing board of the provider will attest that the review has occurred, and will provide a report of its outcome and the attestation, by the end of each year.

1226. This additional funding should contribute, indirectly, to ACFI revenue being spent by approved providers on increasing the quantity (in time) and quality of care that they provide, including through additional staffing.

Recommendation 82: Immediate changes to the Basic Daily Fee

82.1. The Australian Government should, no later than 1 July 2021, offer to provide funding to each approved provider of residential aged care adding to the base amount for the Basic Daily Fee by \$10 per resident per day, for all residents. The additional funding should be only provided on the condition that the provider gives the Australian Government a written undertaking that:

- a. it will conduct an annual review of the adequacy of the goods and services it has provided to meet the basic living needs of residents,

¹²⁷² Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9431.18–26.

and in particular their nutritional requirements, throughout the preceding 12 months, and prepare a written report of the review

- b. the review report will set out in detail the provider's expenditure to meet the basic needs of residents, especially their nutritional needs, and changes in expenditure compared with the preceding financial year
- c. by 31 December each year, commencing in 2021, the governing body of the provider will attest that the annual review has occurred, and will give the review report and a copy of the attestation, to the Australian Aged Care Commission (or, pending its establishment, the implementation unit referred to in Recommendation 123)
- d. in the event of failure to comply with the above requirements, the provider will be liable to repay the additional funding to the Australian Government, and agrees that this debt may be set-off against any future funding as a means of repayment.

82.2. The Australian Government will commence payment of the additional funding to a provider within one month of the provider giving its written undertaking.

82.3. The results of any review may be taken into account in any reviews of the compliance of the provider with the Aged Care Quality Standards.

1227. A range of factors drive up the costs of goods and services in regional, rural and remote Australia. This clearly contributes to the performance of approved providers of aged care in such areas. Residential aged care facilities in regional, rural and remote areas of Australia are experiencing deteriorating financial performance and risks to viability in higher proportions than their metropolitan counterparts.

1228. In recognition of the extra cost of providing aged care services in regional, rural and remote areas, the Australian Government pays the Viability Supplement.¹²⁷³ This is an additional payment to providers of residential aged care and home care services in remote areas and some regional areas, as well as to providers under the Multi-Purpose Services Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. For residential aged care services, the viability supplement is based on the remoteness and size of the service and on the acuity of the resident population.¹²⁷⁴ For home care, the supplement is based on the place of residence of the care recipient,

¹²⁷³ Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0052 [203].

¹²⁷⁴ Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0053 [209].

and is available to people living in remote areas and smaller, more isolated regional areas.¹²⁷⁵ However, at the Mudgee Hearing, Mr David Hallinan of the Australian Department of Health indicated that there was no detailed cost study that supports the basis of the Viability Supplement.¹²⁷⁶

1229. On 17 December 2018 the Australian Government announced a 30% increase to the Viability Supplement. In announcing the increase, the Prime Minister, the Minister for Health, and the Minister for Aged Care stated that providers in rural and remote areas 'face unique circumstances and cost pressures and we want to ensure their sustainability'.¹²⁷⁷ The increase took effect on 20 March 2019, and provided an additional \$101.9 million in supplement annually to 550 services.¹²⁷⁸ On 31 March 2020, the Australian Government introduced a temporary increase of an additional 30% in response to the COVID-19 pandemic.¹²⁷⁹ On 1 September 2020, the Australian Government announced this temporary increase would be extended to 28 February 2021.¹²⁸⁰

1230. As we noted above, a large proportion of outer regional and remote facilities are facing significant financial stress, even taking into account the increases in the Viability Supplement.¹²⁸¹

1231. Once the Aged Care Pricing Authority is established and commences its independent cost analysis and pricing processes, the cost of delivering aged care in regional, rural and remote areas should be accurately ascertained, and prices should be determined that accurately compensate approved providers for the additional costs of providing services in such areas. Once that process is in operation, there should be no need for a separate Viability Supplement. In the interim, the Australian Government should continue the additional 30% increase to the Viability Supplement which was announced in March 2020.

¹²⁷⁵ Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0054 [212].

¹²⁷⁶ Transcript, David Hallinan, Mudgee Hearing, 6 November 2019, T6566.38–6567.1

¹²⁷⁷ Prime Minister of Australia, *Boosting support for older Australians*, <https://www.pm.gov.au/media/boosting-support-older-australians>, viewed 14 June 2020.

¹²⁷⁸ The Hon Ken Wyatt AM MP, *\$467 Million Increase in Aged Care Subsidies*, <https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpresrel%2F6566927%22>, viewed 20 October 2020; Exhibit 4-17, Broome Hearing, Statement of Jaye Smith, WIT.0128.0001.0001 at 0036 [143(b)(iv)].

¹²⁷⁹ Australian Department of Health, *Protecting older Australians: COVID-19 update 31 March 2020*, <https://www.health.gov.au/news/newsletters/protecting-older-australians-covid-19-update-31-march-2020>, viewed 29 September 2020.

¹²⁸⁰ Australian Department of Health, *Update to residential and home care subsidies and supplements from 1 September 2020*, <https://www.health.gov.au/news/announcements/update-to-residential-and-home-care-subsidies-and-supplements-from-1-september-2020>, viewed 29 September 2020.

¹²⁸¹ Aged Care Financing Authority, *Eight Report on the Funding and Financing of the Aged Care Industry, July 2020*, Australian Government, 2020, p ix.

Recommendation 83: Amendments to the viability supplement

- 83.1. With immediate effect, the Australian Government should continue the 30% increase in the viability supplement that commenced in March 2020, as paid in respect of each residential aged care service and person receiving home care, until the Aged Care Pricing Authority has determined new arrangements to cover the increased costs of service delivery in regional, rural and remote areas and has commence independent determination of prices.
- 83.2. For the avoidance of doubt, the increased indexation arrangements proposed in Recommendations 80 and 81 should apply in addition to the measure in this recommendation.

1232. In order to improve the quality of residential aged care, the Australian Government should make additional funding tied to an increase in targeted staff training available immediately. We propose the following interim recommendation, pending the commencement of independent pricing for aged care.

Recommendation 84: Immediate funding for education and training to improve the quality of care

- 84.1. The Australian Government should establish a two-year scheme, commencing on 1 July 2021 to improve the quality of the current aged care workforce. The scheme should reimburse providers of home support, home care and residential aged care for the cost of education and training of the direct care workforce employed (either on a casual, part-time or full-time basis) at the time of its commencement or during the period of its operation. Eligible education and training should include:
- a. Certificate III in Individual Support and Certificate IV in Ageing Support
 - b. continuing education and training courses (including components of training courses, such as 'skill sets' and 'micro-credentials') relevant to direct care skills, including, but not limited to, dementia care, palliative care, oral health, mental health, pressure injuries and wound management.
- 84.2. Reimbursement should also include the costs of additional staffing hours required to enable an existing employee to attend the training or

education. The scheme should be limited to one qualification or course per worker.

Aged Care Pricing Authority

1233. As we outlined in Part 3.2 Design of the new aged care system, the introduction of independent pricing into the system is critical to restore or instil confidence and trust between the sector and government, and thus to instil confidence in the sustainability of the system in the wider community. In section 4.2, we set out our proposed recommendation for the establishment of the Aged Care Pricing Authority

1234. Independent review of costs and prices in aged care was recommended by the Productivity Commission in 2011, but it was not implemented by the Australian Government.¹²⁸² As an idea, independent aged care pricing has been uncontroversial throughout our inquiries. In practice it would be revolutionary.

1235. The Australian Government's key advisory body on aged care funding and financing, the Aged Care Financing Authority, identified appropriate overall funding and sound arrangements for allocating subsidies as one of the key attributes required for a sustainable aged care system.¹²⁸³ The Secretary of the Australian Department of the Treasury, Dr Steven Kennedy, gave evidence that an aged care system based on an independent assessment of costs would contribute towards a Government being able to trust and fund that system.¹²⁸⁴ Similarly, the Secretary of the Australian Department of Health, Dr Brendan Murphy, indicated his strong support for an independent pricing mechanism.¹²⁸⁵

1236. We heard from a number of eminent economists who spoke in favour of the independent assessment of aged care costs. Dr Kenneth Henry AC, the former Secretary of the Treasury, explained that adopting this approach would improve efficiency and remove distortions caused by cross-subsidisation.¹²⁸⁶ Professor Michael Woods of the Centre for Health Economics Research and Evaluation at the University of Technology Sydney, and former Deputy Chairman of the Productivity Commission, said that an independent agency advising the Australian Government on costs, prices and funding was an important design principle for aged care.¹²⁸⁷ Professor Flavio Menezes, Chair of the Queensland Competition Authority and former Head of the School of Economics at the

¹²⁸² Productivity Commission, *Caring for Older Australians*, 2011, Vol 2, pp 421–422.

¹²⁸³ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 46, CTH.9100.0001.0001 at 0005.

¹²⁸⁴ Transcript, Sydney Hearing 5, Steven Kennedy, 18 September 2020 at T9390.44–47.

¹²⁸⁵ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9424.9–10.

¹²⁸⁶ Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9267.17–28.

¹²⁸⁷ Exhibit 21-3, Sydney Hearing 5, Statement of Michael Woods, RCD.9999.0465.0001 at 0017 [65].

University of Queensland, described a conflict of interest for the Australian Government in the current funding arrangements, whereby it is trying to enforce quality standards while constraining costs.¹²⁸⁸ Professor Henry Cutler, Director of the Macquarie University Centre for the Health Economy, said that using an independent agency to determine prices would provide greater financial certainty for aged care providers.¹²⁸⁹ This should serve to reduce investment risk, which reduces the rate of return required on investment in the residential aged care sector.¹²⁹⁰ In this way, funding certainty should put downward pressure on required returns and therefore on prices, over time.

1237. Mr Mike Callaghan AM PSM, the former Chair of the Aged Care Financing Authority described the functions that an independent pricing authority would play in the aged care sector, and its key features:

In the area of funding and finance, a key function for a body that could help strengthen effective governance would be the role of an independent pricing authority that sets the 'price' for the aged care services subsidised by the Government. In fulfilling that role, the body should be charged with the responsibility of setting an efficient price that is cost effective for tax payers, which ensures the overall sustainability of the sector and supports ongoing investment in the sector. To fulfil this role, the body would have to establish good relations with providers and gain a thorough understanding of the financial performance of the sector and the key factors influencing that performance. The body would have to have a sound understanding of the Government's aged care policy objectives along with an understanding of consumer expectations. The body would have to have the resources and capabilities to undertake all these activities. In particular, it would have to ensure that it remains independent and has the ongoing confidence of all stakeholders. In fulfilling this task, the body would have to have a clear understanding of the objective of a sustainable aged care sector, a strategy towards achieving that objective, and would have to ensure that this was consistent with the expectations of all stakeholders. To achieve these outcomes the body would have to have sound governance arrangements, which would contribute to sound governance arrangements within the aged care sector.¹²⁹¹

1238. There was a large degree of consensus on the issue between Australian Government and sector witnesses. For example, Mr Mamarelis of the Whiddon Group spoke of the need for independent pricing from the perspective of an approved provider:

I believe we need independent price setting. I think the examples of the past when we are caring for older Australians, and in Whiddon's case, we have thousands of people we care for annually, we can't operate in an environment where the Government just decides, for example, to put a funding pause on our revenues when we are planning around people's lives, we are planning around the people who care for those individuals and our funding is just withdrawn from us and literally at a minute's notice.

¹²⁸⁸ Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9284.45–9285.2.

¹²⁸⁹ Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0006 [34].

¹²⁹⁰ Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0011 [61].

¹²⁹¹ Exhibit 21-27, Sydney Hearing 5, System Governance tender bundle, WIT.1364.0001.0001 at 0010 [52].

I think the other part of the funding equation as well in terms of planning and long-term planning which is essential in the business of providing care, is the notice. You find out literally days before what you're about to receive for the next 12 months.¹²⁹²

1239. Mr Callaghan emphasised the need to put clear boundaries around the functions that would be performed, and the objects that would guide their exercise.¹²⁹³ We have given careful thought to Mr Callaghan's views in formulating the proposed recommendation that follows.

1240. There is already an existing independent statutory body with proven capabilities on which aged care pricing functions could be conferred – the Independent Hospital Pricing Authority (IHPA). One option would be to confer aged care pricing functions on IHPA. Alternatively, a new entity with a separate statutory existence could be established. We have recommended the latter.

1241. We now outline the functions and purposes of our proposed Aged Care Pricing Authority in more detail, and key features of the statutory regime which should support its work.

1242. The functions of the Aged Care Pricing Authority would fall into three broad categories:

- a. developing funding models and providing advice on their implementation to the Australian Aged Care Commission
- b. undertaking costing studies and using that data to set benchmarked prices for aged care service, and
- c. evaluating where it would be appropriate to regulate prices to protect older people accessing aged care services, and determining what form that economic regulation should take.

Recommendation 85: Functions and purposes of the Aged Care Pricing Authority

85.1. Before the establishment of the Aged Care Pricing Authority, preliminary work on estimating the costs of providing high quality aged care should be undertaken by the implementation unit referred to in Recommendation 123.

85.2. Upon its establishment (by 1 July 2023) under the new Act, the Aged Care Pricing Authority should take over that work and all resources developed by the implementation unit.

85.3. The functions of the Aged Care Pricing Authority should include:

¹²⁹² Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9573.41–9574.6.
¹²⁹³ Transcript, Sydney Hearing 5, Mike Callaghan, 17 September 2020 at T9324.4–9325.32.

- a. providing expert advice to the Australian Aged Care Commission on optimal forms for funding arrangements for particular types of aged care services and in particular market circumstances
- b. reviewing data and conducting studies relating to the costs of providing aged care services
- c. determining prices for particular aged care services based on estimates of the amounts (whether constituted by government subsidies or user payments or both) appropriate to the provision of high quality and safe aged care services
- d. evaluating, or assisting the Australian Aged Care Commission to evaluate, the extent of competition in particular areas and markets
- e. advice on appropriate forms of economic regulation, and implementation of such regulation, where necessary.

85.4. In undertaking its functions, the Aged Care Pricing Authority should be guided by the following objects:

- a. ensuring the availability and continuity of high quality and safe aged care services for people in need of them
- b. ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services
- c. promoting efficient investment in the means of supply of high quality and safe aged care services in the long term interests of people in need of them
- d. promoting the development and retention of a highly motivated and appropriately skilled and numerous workforce necessary for the provision of high quality and safe aged care services in the long term interests of people in need of them.

1243. The Aged Care Pricing Authority's function of advising on funding arrangements would, for example, include developing, designing and maintaining funding models for aged care services, including funding classification and case mix schemes, as well as any associated data standards to support their implementation and operation. Its costs data review function would include conducting benchmarking studies relating to the forecast costs of providing high quality aged care services, including by reference to

improvements in staffing levels, staff remuneration, care models and quality of life and quality of care outcomes.

1244. The Authority's price determination function should include determining and publishing, on an annual or otherwise regular basis, a schedule of benchmarked prices (determined by reference to cost data and benchmarking) that the Australian Government will pay for high quality aged care services that meet the actual cost of delivering high quality aged care services, including in regional, rural and remote areas, and for Aboriginal and Torres Strait Islander aged care services.

1245. Professor Michael Woods recommended that the Independent Hospital Pricing Authority be considered as a model for independent pricing.¹²⁹⁴ The CEO of the Independent Hospital Pricing Authority, Mr James Downie, gave evidence about the process for determining the National Efficient Price for public hospital services.¹²⁹⁵ Mr Brown of the Aged Care Guild said 'an independent authority should set levels of funding based on regular data and frequent cost of care studies. The independent authority should be modelled on the Independent Hospital Pricing Authority....'¹²⁹⁶ There was a degree of consensus that independent pricing of aged care services would resemble aspects of what the Independent Hospital Pricing Authority does, but there was also concern expressed that aged care will present very different challenges. Mr Mersiades said:

Catholic Health Australia also strongly supports this recommendation, but we would note, though, that there would need to be some adaptation in terms of methodology that's applied in the aged care sector compared with the hospital sector. In aged care you're looking at long-term care, you're looking at quality of life, and you're looking at personal private contributions as well. So that just complicates the mix a bit.¹²⁹⁷

1246. During the hearing on funding arrangements in September 2020, there was a degree of contention on the question of whether the independent statutory body should determine prices, or merely recommend them to the Australian Government. Dr Murphy expressed concerns that the Australian Government would be 'locked into delivering a price'.¹²⁹⁸ Dr Murphy said 'price needs to be transparently determined and recommended to Government, but whether Government should have the fiscal right to determine how that's manifested is a matter for debate.'¹²⁹⁹ Professor Woods expressed a similar view:

...you are committing public expenditures of, in this case, very high magnitude, and I would continue to recommend that you separate out regulation from policy, and policy includes fiscal policy. So I'm very happy for it to transparently

¹²⁹⁴ Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9180.3–5.

¹²⁹⁵ Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0002 [10].

¹²⁹⁶ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 78, RCD.9999.0331.0001 at 0026 [72].

¹²⁹⁷ Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9524.22–27.

¹²⁹⁸ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9442.4–6.

¹²⁹⁹ Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9442.4–6.

recommend pricing based on costs, and then it's a matter for the community to judge the Government on whether it follows that open and transparent and objective set of analyses.¹³⁰⁰

1247. In the *Caring for Older Australians* report, the Productivity Commission recommended that the function should be advisory. Professor Woods, who was the lead commissioner on that inquiry, explained the logic behind this approach as follows:

An important design principle in both [Productivity] Commission reports was that an independent agency should objectively and transparently advise government on costs, prices and funding. Actual decisions on levels and forms of funding, however, are ones for the government of the day. The transparency of advice ensures accountability by the government, particularly should it make a decision contrary to the expert independent and objective advice. The Commission's recommendations should be given close consideration as to their ongoing relevance and adopted if appropriate.¹³⁰¹

1248. For public hospitals, the Independent Hospital Pricing Authority retains complete independence from all Australian, state and territory governments in its decision making. In doing so, it must operate within the broad policy parameters set out in the National Health Reform Agreement and 'a cap on total Commonwealth expenditure growth of 6.5% per annum.'¹³⁰²

1249. Professor John Piggott AO disagreed that the role should be limited to providing advice, stating that he 'would like it to be more binding.'¹³⁰³ Professor Henry Cutler said that 'there are good reasons why price should be set by an independent authority', including removing 'volatility to provider revenue' caused by policy change and ensuring transparent price setting.¹³⁰⁴

1250. In light of the history of mistrust on the issue of funding reliability, and the need to restore confidence, on balance we submit that a determinative pricing function rather than a merely advisory one should be conferred on the Aged Care Pricing Commission. In short, the Aged Care Pricing Authority's power to determine prices should be binding on the Australian Government. This would be an important measure to provide confidence for older people and their families, allow providers to undertake long-term planning, and make the necessary investment decisions to ensure access to high quality aged care services.

1251. Consistently with giving the price determinations of the Authority binding force, in our submission ideally the new Act should contain a special appropriation of funding to the

¹³⁰⁰ Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9180.9–11; T9180.37–42.

¹³⁰¹ Exhibit 21-3, Sydney Hearing 5, Statement of Michael Woods, RCD.9999.0465.0001 at 0017 [65].

¹³⁰² Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0010 [59]–[60]; Transcript, Sydney Hearing 5, James Downie, 17 September 2020 at T9379.15–23.

¹³⁰³ Transcript, Sydney Hearing 5, John Piggott, 15 September at T9234. 14–15.

¹³⁰⁴ Exhibit 21-25, Sydney Hearing 5, Statement of Henry Cutler, RCD.9999.0380.0001 at 0011 [64].

Australian Aged Care Commission, specifying that subsidies for aged care services in accordance with individual assessments and with prices determined by the Aged Care Pricing Authority are to be appropriated to and paid to providers by the Australian Aged Care Commission. This would best accord with a demand-driven program of services based on assessed needs, such as we advocate for aged care. As we have proposed in Part 4.2, to better ensure the independence of the new Australian Aged Care Commission from the executive government of the day, its optimal form would be a corporate Commonwealth entity. Responding submissions are invited on whether there are any impediments in combining a special appropriation, individual assessments of need, independent price determination and funds administration by a corporate Commonwealth entity in this manner.

1252. We also propose that the Authority should have economic regulatory functions, including the power to place price caps on essential aged care services where people who need those services would be vulnerable to a risk of price-gouging or other manifestations of approved providers' market power, and where people might have no other options to seek equivalent services.

1253. A number of witnesses gave evidence about the role of economic regulation. Economic regulation may be appropriate to protect the interests of people who need to acquire essential services in the absence of properly functioning market, due to the power a service provider might have in such circumstances to dictate prices. Such circumstances can be referred to as circumstances of 'market failure'. Professor Flavio Menezes described the role of the economic regulator as being twofold: 'to identify where is the failure, why is there a need for intervention, and then the second part of that test is to determine what is the best way to intervene.'¹³⁰⁵

1254. Professor Menezes explained that there are various forms of economic regulation, one of which is price regulation. Price regulation refers to setting prices (or price caps), while economic regulation is a wider concept.¹³⁰⁶

1255. Professor Swerissen gave evidence that 'the preconditions for an effective market and market competition are not present' in aged care because consumers do not have access to comparative information and cannot make informed choices.¹³⁰⁷

¹³⁰⁵ Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9286.28–30.

¹³⁰⁶ Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9284.5–8.

¹³⁰⁷ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 83, RCD.9999.0383.0001 at 0003 [16].

1256. Professor Menezes said that economic regulation is not needed in competitive markets and that ‘the test of whether markets are competitive is an outcome-based test’, which involves considering ‘prices that reflect the efficient costs of providing the services’.¹³⁰⁸
1257. Professor Menezes said that the setting of maximum prices by an independent economic regulator would need to occur when markets fail.¹³⁰⁹ Professor Menezes explained that the setting of maximum prices based on efficient costs by an independent regulator will incentivise providers to ‘pursue cost and process innovation.’¹³¹⁰ Professor Menezes cautioned that poorly designed price regulation ‘may have a negative impact on quality and product innovation, and affect the financial position of the providers.’¹³¹¹
1258. The economic regulatory functions of the Authority should include determining whether and what mode of economic regulation or other intervention is appropriate in the absence of service availability or a workably competitive market for particular services, and where necessary implementing the appropriate forms of economic regulation, advising the Australian Aged Care Commission on implementation of such economic regulation, or advising the Minister on any statutory amendments required to implement economic regulation.
1259. The Aged Care Pricing Authority should carry on the work of the current Aged Care Pricing Commissioner with respect to accommodation charges. At present, for residents who are not supported by the Government, approved providers may ask for an accommodation payment in excess of the Accommodation Supplement, but there are some consumer protections in place.¹³¹² If an approved provider wishes to obtain a refundable accommodation deposit (or corresponding daily accommodation payment) above a prescribed ceiling or threshold (currently \$550,000), application for a higher limit to be set must be made to the Aged Care Pricing Commissioner.¹³¹³ The consensus between Professor Menezes and Professor Cutler was that this lighter form of economic regulation was reasonably appropriate to protect the interests of unsupported residents from approved provider’s market power, and that heavier forms of regulation such as price caps would not be justified.¹³¹⁴ This was a widely accepted position. Dr Mellors and Mr Thorley echoed Professor Cutler’s views about the current system for the

¹³⁰⁸ Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9282.42–45.

¹³⁰⁹ Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2020 at T9283.41–43.

¹³¹⁰ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.00079 at 0082.

¹³¹¹ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.00079 at 0082.

¹³¹² *Aged Care Act 1997* (Cth) s 52G-2.

¹³¹³ *Aged Care Act 1997* (Cth) s 52G-4.

¹³¹⁴ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 21, RCD.9999.0401.00079 at 0133; Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9626.47–9627.2.

regulation of accommodation prices working well.¹³¹⁵ However, Dr Mellors said that there should be regular review of the threshold for accommodation prices.¹³¹⁶

Requirement to provide information to Authority

1260. In order to support the pricing function, it will be necessary for the Aged Care Pricing Authority to obtain cost data from the sector, necessitating wide-ranging powers to obtain financial information from approved providers and their participation in costs studies and standard form cost surveys.

Recommendation 86: Requirement to participate in Aged Care Pricing Authority activities

86.1. By 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require participation by approved providers in cost data reviews.

86.2. By 1 July 2023, the new Act should require that as a condition of approval or continued approval, aged care providers are required to participate in any activities the Aged Care Pricing Authority requires to undertake its functions, including transmitting cost data in a format required by the Authority for the purposes of costing studies. The Aged Care Pricing Authority should take costs associated with these activities into account when determining funding levels.

1261. Costing studies will be critical to the Authority's functions. Mr Downie gave evidence about the need for annual costing studies from the perspective of the Independent Hospital Pricing Authority:

Annual costing studies ensure that the ABF system is self-correcting. For example, if there is a wide spread practice of increasing the coding complexity of patients, then over time the price weight will reduce, and as such the incentive to over code complexity is ameliorated.¹³¹⁷

1262. The Department of Health agreed that upon implementation of an activity based funding model such as the AN-ACC, costing studies would need to 'be undertaken to ensure that the cost weights attached to each class remain relevant.'¹³¹⁸

¹³¹⁵ Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9543.12–13; Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9542.16.

¹³¹⁶ Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9543.13–15.

¹³¹⁷ Exhibit 21-12, Sydney Hearing 5, Statement of James Downie, RCD.9999.0463.0001 at 0006 [33].

¹³¹⁸ Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 117, CTH.1000.0004.9191 at 9210 [77c].

1263. Professor Woods agreed that regular costing studies are needed, stating that '[p]eriodic cost reviews and price setting recommendations to government by an independent regulator would ensure transparency of process and provide some measure of assurance to providers and a basis for ensuring the viability of the sector as a whole.'¹³¹⁹

1264. Mr Versteegen agreed that funding levels should be 'calculated on the basis of systematically collected expenditure and cost activity data on a continuous basis.'¹³²⁰

Specific funding arrangements for particular services

Block and activity-based grant funding for some services

1265. As outlined in Part 3.3 Program Design, we propose recommendations that each of these three service categories should be funded via direct grants, through a combination of block funding and activity based funding:

- a. social supports
- b. respite
- c. assistive technology and home modifications.

1266. As we set out earlier, we are recommending that the Australian Government develop and implement a new planning regime which should provide for demand-driven access to aged care based on assessed need and that this be in place by 1 July 2024. The Australian Government should consider increasing annual growth funding for current Commonwealth Home Support Programme in order to service delivery before the new planning regime is in place.

Recommendation 87: Services to be funded through a combination of block and activity based funding

87.1. The Aged Care Pricing Authority should advise the Australian Aged Care Commission on the combination and form of block and activity based funding that should be adopted for social supports, respite, and assistive technology and home modifications, having regard to the characteristics of these services and market conditions where they are delivered.

Care at home service category

1267. Also as outlined in Part 3.3 Program Design, we submit that the implementation unit, and subsequently the Australia Aged Care Commission and Aged Care Pricing Authority

¹³¹⁹ Exhibit 21-3, Sydney Hearing 5, Statement of Michael Woods, RCD.9999.0465.0001 at 0011 [45].

¹³²⁰ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0016 [100].

should continue the work underway in developing the most appropriate assessment, eligibility and funding arrangements for aged care provided at home, including personal, nursing and allied health care, and basic living supports in the nature of domestic assistance. The Australian Government and Australian Aged Care Commission should be in a position to commence payment of subsidies for service provision within a new 'care at home' category by 1 July 2024.

Residential care

1268. Witnesses who appeared in the funding hearing in September 2020 gave general support to the continuation of separately priced service categories and pricing by approved providers of residential care for:

- a. care
- b. daily living needs, and
- c. accommodation¹³²¹

1269. Currently, the price an approved provider of residential care is permitted charge a resident for basic living needs (which are in our view inaptly called 'hotel services' in Schedule 1 to the *Quality of Care Principles 2014*) is the Basic Daily Fee, currently set at 85% of the basic single age pension. The Basic Daily Fee operates as a price cap for the bundle of goods and services set out in Part 1 of Schedule 1 to the *Quality of Care Principles 2014*.

1270. As outlined above, the evidence received in the hearing in September indicates that the Basic Daily Fee is inadequate to meet the costs of providing an adequate level of goods and services to meet basic living needs. However, while the price-cap is set at an incorrect level, this does not mean that prices for essential living needs should be uncapped. Residents in aged care facilities would be vulnerable to price gouging if this were to be the case. Consistently with the evidence of Professors Menezes and Cutler, the amount approved providers may charge residents for daily living needs should continue to be price-capped, but in our submission that cap should not be limited to 85% of the basic single age pension. The Aged Care Pricing Authority should set the cap from time to time on the basis of cost data and benchmarking. It is possible that the cap will vary between regions, or depending on remoteness. Pensioners should contribute 85% of the basic single age pension and the Australian Government should fund the gap to enable them to pay the regulated price for basic living needs.

¹³²¹ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 69, RCD.9999.0347.0001 at 0005 [12], Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9525.43–45; Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9526.20–22.

1271. Prices for accommodation should continue to be subject to the light form of economic regulation that is currently administered by the Aged Care Pricing Commissioner, and this role should be taken over by the Aged Care Pricing Authority, once that body is established.
1272. As to the funding provided for care in residential facilities, it is clear that the Department of Health supports a transition away from the Aged Care Funding Instrument.¹³²² The new model should take into account the ‘activity’ of the approved provider at a given time (that is, how many residents it is caring for), and the ‘casemix’ of that activity (that is, the variation in needs of the residents). The model should be based on assessment of needs and classification of individuals to one of a number of funding categories, each of which reflects the costs of caring for a person classified to that level of need. The witnesses in the hearing held in September on funding arrangements also supported this reform.¹³²³
1273. Casemix-adjusted activity based funding models are appropriate where a single provider will be responsible for providing or coordinating a bundle of services. Casemix-adjusted activity based funding is also likely to be appropriate in circumstances where people can be classified into groups based on similar characteristics, and where the costs of providing services to each such group is similar. In theory, this means that the level of funding provided will reflect the average costs of providing the bundle of services to a person in that group.
1274. Casemix adjusted activity based funding arrangements have been increasingly used in Australian public hospitals since the 1980s, and could be applied to care at a residential aged care home.¹³²⁴ As in the case of joint Australian Government and state or territory funding of large public hospitals under the National Health Reform Agreement, casemix funding of residential care should be based on an independent pricing process, which is regularly conducted, updated and refined. In the case of large public hospitals, that process is performed by the Independent Hospitals Pricing Authority, and in the case of aged care, we submit that it should be performed by the proposed new Aged Care Pricing Authority.
1275. A team from the University of Wollongong led by Professor Kathy Eagar has been working on the replacement of ACFI by an appropriate casemix model since 2017. In their Resource Utilisation and Classification Study, they developed a proposal for a new

¹³²² Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9421.43–9422.1.

¹³²³ Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9531.11–13; Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9531.37–38; Transcript, Sydney Hearing 5, Nicholas Mersiades, 21 September 2020 at T9533.18–19; Transcript, Sydney Hearing 5, Jonathan Gavshon, 21 September 2020 at T9552.36–37.

¹³²⁴ See generally, SDuckett, *Casemix development and implementation in Australia*, published in J Kimberly, G De Pourville and T d'Aunno, *The Globalization of Managerial Innovation in Health Care*, 2007.

casemix adjusted activity based funding model for residential aged care, the Australian National Aged Care Classification (AN-ACC). Under this model, providers would receive:

- a. a base tariff payable daily to meet the costs of care delivered equally to all residents (such as clinical supervision and training, facility clinical management and shared care activities such as night supervision and resident observation during social activities and meal times), with the level of the base tariff varying by remoteness, and facility size and type
- b. an individualised care payment based on each resident’s casemix classification to meet the costs associated with the care of residents with different needs, and
- c. an adjustment tariff payable during the first 28 days of care to meet the costs of settling residents into new arrangements.¹³²⁵

1276. The AN-ACC is currently in trials. It, or some variant, may be an appropriate casemix model for adoption by the future Australian Aged Care Commission and Aged Care Pricing Authority as the mechanism by which the Australian Government should fund residential aged care. Variations that might be considered by these bodies over time would include the introduction of components relating to enablement, allied health and the improvement in psychosocial, cultural and spiritual aspects of quality of life.

Recommendation 88: Casemix-adjusted activity based funding in residential aged care

88.1. By 1 July 2022, the Australian Government should fund approved service providers for delivering residential aged care through a casemix classification system, such as the Australian National Aged Care Classification (AN-ACC) model. The classification system should take into account the above recommendations for high quality aged care. Ongoing evidence-based reviews should be conducted thereafter to refine the model iteratively, for the purpose of ensuring that the model accurate classification and funding to meet assessed needs.

88.2. The implementation date of 1 July 2022 is needed to support Recommendations 46.2 and 46.3. However, the independent pricing capability referred to in Recommendations 5 and 85 is unlikely to be developed by that time. Therefore an estimated National Weighted Average Unit (NWAU) for interim application of a casemix-adjusted funding model such as AN-ACC should be calculated by or on behalf of

¹³²⁵ J McNamee et al, *AN-ACC: A funding model for the residential aged care sector. The Resource Utilisation and Classification Study: Report 5*, 2019, pp 6–8.

the implementation unit and applied to fund approved providers of residential care prior to the commencement of independent pricing by the Aged Care Pricing Authority.

1277. The AN-ACC model incorporates costs associated with a range of existing supplements, including for specialist homeless services, facilities in regional, rural and remote areas, as well as for facilities catering for Indigenous Australians. It does not account for the cost of the enteral feeding, oxygen, and veterans' supplements.¹³²⁶ If the AN-ACC is implemented in residential aged care, the continuation of these supplements until they can be considered, and their costs ascertained, by the Independent Aged Care Pricing Authority will ensure that providers are not financially penalised after transition.

1278. Any additional supplements required relating to care, and the amount attached to them, should be determined by the Aged Care Pricing Authority having regard to its analysis of costs over time, and may either be paid through iterative refinement of AN-ACC or separately, as the Authority determines.

Upper limit on funding for care at home

1279. In our submissions on program redesign on 4 March 2020, we proposed that funding for care at home should be based purely on the assessment of need, and should otherwise be demand-driven and not subject to population-based rationing. The intent behind this proposal was to enable a greater number of older people to remain in their home, which is overwhelmingly their preference.¹³²⁷ This begs the question, however, of how much funding should be made available to meet the needs of people who wish to remain in their own homes.

1280. The universal entitlement to aged care we propound is an entitlement to receive high quality care to meet ageing-related needs, not an absolute right to have that care delivered in the setting of one's choice.

1281. Care provided to a person in a congregate setting may in certain circumstances be more cost-effective than care provided to that person in their own home. This is more likely to be the case where the needs of the person are intensive, for example where a carer or perhaps a nurse must be on call at all times.

1282. The most appropriate limit to be placed on the funding a person should be entitled to receive for care at home should correspond to the care component of the funding that the Australian Government would provide for them in a residential care setting. If the

¹³²⁶ J McNamee et al, *AN-ACC: A funding model for the residential aged care sector. The Resource Utilisation and Classification Study: Report 5*, 2019, pp 17-18.

¹³²⁷ Counsel Assisting the Royal Commission into Aged Care Quality and Safety, *Submissions on future aged care program redesign*, 4 March 2020, RCD.0012.0062.0001 at 0003-4.

individual is prepared to and able to supplement that funding with their own resources, and if an approved provider of home care is prepared to assume responsibility for care of the person in those circumstances, this may mean the person will be able to remain longer at home, and may be able to remain at home until the end of life.

1283. Taking a person with complex needs as an example, currently the maximum amount available under the ACFI is \$223.14 per day (excluding supplements).¹³²⁸ A person assessed under ACFI as requiring this level of care funding would result in a maximum annual amount available for care at home being available for that person of \$81,446.10, which is a 57% increase on the current level of funding available through a Level 4 Home Care Package. This is an illustrative example only. In practice, the actual level of funding provided would be based on the person's assessed level of need.

1284. We acknowledge that the *Legislated Review of Aged Care 2017* included a recommendation for the introduction of an additional level of home care package to the four existing levels.¹³²⁹ In light of our other recommendations, and the prospect of more comprehensive re-ordering of the service arrangements for care in the home and community in the near future, we do not submit that the Royal Commissioners should recommend the introduction of a new level of home care package.

1285. If AN-ACC is adopted, there is an issue concerning how the ceiling amount would be calculated, because the base tariff payable through AN-ACC is dependent on the features of the particular facility.¹³³⁰ The calculation of the ceiling involves a counterfactual scenario – a determination of the care funding that would be payable if the individual were receiving residential care. There being no actual facility, a notional amount based either on a national average or regional average for the base tariff would be required, and this would be added to the individualised care payment. The adjustment tariff would not apply.

1286. The availability of greater funding to receive care at home raises complex issues, potentially engaging the provider's general duty to ensure high quality and safe care. Where people wish to be cared for at home and their funding is approaching the maximum level, an older person might need to consider moving into residential aged care or supplementing the funding available for care at home out of their own pockets and access to informal care. In cases where the person can no longer safely and appropriately continue to receive subsidised care at home, the assessment team, the

¹³²⁸ Australian Department of Health, *Aged Care Subsidies and Supplements: New Rates of Daily Payments from 1 September 2020*, Australian Government, 2020, <https://www.health.gov.au/sites/default/files/documents/2020/08/schedule-of-subsidies-and-supplements-for-aged-care-schedule-from-1-september-2020.pdf>, viewed 3 September 2020.

¹³²⁹ D Tune, *Legislated Review of Aged Care 2017*, p 13, recommendation 7.

¹³³⁰ J McNamee et al, *AN-ACC: A funding model for the residential aged care sector. The Resource Utilisation and Classification Study: Report 5*, 2019, pp 6–7.

provider and any care finder appointed for the person might have to assist the person to decide whether the person should start receiving residential care. Ultimately the provider may have to decide whether it is willing to continue to provide services to the person at home, in light of its duty to ensure the person receives high quality care. The *User Rights Principles 2014* currently contemplate this scenario and reserve to the provider the right to discontinue home care under certain conditions.¹³³¹

1287. Earlier, we outlined a recommendation that every aged care recipient with a disability or disabilities, regardless of when acquired, should receive through the aged care program daily living supports and outcomes (including assistive technologies, aids and equipment) equivalent to those that would be available under the National Disability Insurance Scheme to a person with the same or substantially similar conditions.

1288. Older people with disability should not, as a matter of principle, experience disadvantage because they access supports and services from the aged care system instead of the disability services system. That accords with one object of the proposed new Act – that is, to provide for ‘a system of aged care based on a universal right to high quality, safe and timely support and care to assist older people to live an active, self-determined and meaningful life’.

1289. The Australian Government should consider an outlier principle to the general approach set out in this section to ensure that older people with disability have access to comparable care under the aged care system.

Recommendation 89: Maximum funding amounts for care at home

89.1. With effect from 1 July 2024, the Australian Government should ensure that the maximum Commonwealth funding amount available for a person receiving care at home is the same as the maximum Commonwealth funding amount that would be made available to provide care for them if they were assessed for care a residential aged care service.

¹³³¹ *User Rights Principles 2014* (Cth) ss 17(2)(a) and (d)(i) provide: ‘The approved provider may cease to provide home care to the care recipient only if: (a) the care recipient cannot be cared for in the community with the resources available to the approved provider; or ... d) the care recipient’s condition changes to the extent that: the care recipient’s needs, as assessed by an aged care assessment team, can be more appropriately met by other types of services or care; ...’

Assessment principles – incentives for providers to adopt an enabling approach

1290. As we have submitted in Part 4.1 Principles of the new aged care system, one of the guiding objectives in the reform of the aged care system should be its re-orientation toward providing aged care that supports and enables people to maintain independence. One of the perceived defects in the Aged Care Funding Instrument has been the incentives it might generate to reinforce dependency and the absence of any countervailing incentive toward enablement.¹³³² We therefore propose that the assessment process should be reformed to reward providers where residents become less dependent in two ways, outlined in the recommendation that follows.

1291. Professor John McCallum of National Seniors Australia was supportive of this approach in the September hearing, saying that ‘not reassessing people in residential care when their condition improves is a great positive for, you know, improving people's health and wellbeing. So that's a big positive.’¹³³³

Recommendation 90: Framework for the assessment of funding to incentivise an enablement approach to residential care

90.1. From 1 July 2022, the following enablement incentives should be incorporated into the rules, principles and guidelines for assessment and funding eligibility:

- a. where reassessment determines that a person is entitled to a higher level of funding, and the approved provider can demonstrate that they have been providing the higher level of care then it should be eligible for back-payment to the date that the reassessment was requested
- b. in order to promote an enablement approach in care at a residential aged care home, a resident should not be required to be reassessed if their condition improves under the care of a provider.

Accountability

1292. Residential care providers receive about \$11.7 billion a year in total Commonwealth care subsidies, and about \$12.4 billion in overall care related revenue, including contributions

¹³³² Exhibit 21-22, Sydney Hearing 5, Statement of Natasha Chadwick, WIT.1361.0001.0001 at 0007 [37]; Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 84, WIT.0764.0001.0001 at 0017 [54]; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 82, RCD.9999.0359.0001 at 0018 [108]; Exhibit 21-11, Sydney Hearing 5, Statement of Kathleen Eagar, RCD.9999.0351.0001 at 0006 [26].

¹³³³ Transcript, Sydney Hearing 5, John McCallum, 14 September 2020 at T9120.39–42.

from residents.¹³³⁴ While providers must meet particular quality standards associated with the delivery of services, there is no specific requirement on residential aged care providers to spend any portion of the money they current receive on care. As noted above, some analysis suggests that despite financial pressures in recent years, some providers have achieved high profit margins. If adequate care is being provided, then no criticism could be made of those providers who have achieved returns. However, as the evidence we outlined in section 2 indicates, the current aged care system is not well designed to ensure whether care is being provided that meets people's needs. .

1293. Almost every witness we asked at Sydney Hearing 5 supported more transparency and accountability in the spending of public money for care. This included experts, providers, the Australian Department of Health, and consumer advocates.¹³³⁵ In our submission, transparency and accountability are critical goals of the new aged care system. The question is, how should these goals be met with respect to funding?

1294. During Sydney Hearing 5, Professor Henry Cutler explained that in seeking to ensure quality aged care, we should measure outcomes and not inputs.¹³³⁶ Measuring outcomes focusses on whether the approved provider is meeting the required benchmarks of quality, not whether it is spending enough money on care, which is characterised as an input. Outcome indicators are generally of most importance in the context of quality measurement because they reflect the outcome of the care provided.¹³³⁷ If outcome indicators are sufficiently robust and an understanding of high quality sufficient developed, achieving a particular benchmark of quality can be taken as a measure of whether money is being spent in the right areas.

1295. As it is currently constituted, however, there can be no confidence that the quality and safety regime in aged care is capable of the reliable measurements that are necessary. As we outlined earlier, performance against the current Aged Care Quality Standards is currently measured on a binary 'pass or fail' basis. This disguises the actual distribution of provider performance. And the current quality indicator program is immature, only measuring limited clinical areas and not factoring people's quality of life outcomes. We have made recommendations to address these issues, but it will be sometime before the

¹³³⁴ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 7, CTH.1000.0004.9017 at 9104.

¹³³⁵ See, for example, Transcript, Sydney Hearing 5, Paul Versteeg, 14 September 2020 at T9123.5–6; Transcript, Sydney Hearing 5, Michael Woods, 15 September 2020 at T9188.39–40; Transcript, Sydney Hearing, Jason Ward, 16 September 2020 at T9310.34–35; Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9447.25–36; Transcript, Sydney Hearing 5, Linda Mellors, 21 September 2020 at T9537.34–9538.1.

¹³³⁶ Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9628.9–31.

¹³³⁷ J Mant, , 'Process Versus Outcome Indicators in the Assessment of Quality of Health Care', *International Journal for Quality in Health Care*, 2002; K Hung and J Jerng, 'Time to have a paradigm shift in health care quality measurement', *Journal of the Formosan Medical Association*, Vol 113, 10, 2014, pp 673–679.

regulatory system is capable of such an approach. In the meantime, it is appropriate to measure and control some inputs in order to ensure the right standards of quality are achieved.

1296. During the hearing in September, we also asked witnesses whether providers should be required to acquit overall expenditure on care as a mechanism to ensure money provided for care is spent on care. At one end of the spectrum, there was support for a requirement to acquit all expenditure on care and impose a 'clawback' mechanism if the funding was not spent on its intended purpose. ¹³³⁸ However, other witnesses expressed doubts about the efficacy of acquittal and the burdens it would impose. ¹³³⁹ In addition, Professor Menezes pointed out that such approaches may in fact disincentivise providers operating more efficiently and innovating. If a provider is assured that it will be funded to a particular level, and it must demonstrate it has spent all of that money on care, there is little incentive to reduce costs and innovate. ¹³⁴⁰

1297. We acknowledge both these issues, but where significant public funds are being provided for care, there must be some mechanism to ensure they are spent on that care. Professor Woods was of the view that:

An approach worthy of further analysis is to require a clear level of specification of care service levels, including both clinical and care staffing standards, as well as ring-fencing of the funding for care services to ensure that the public and consumer funds are not sources of excess profits. Such ring-fencing should include very high levels of transparency and public accountability for expenditure on those care services. ¹³⁴¹

1298. According to the Aged Care Financing Authority, in 2018-19, overall employee costs represent 68% of the expenses incurred by providers. This is around \$191 per resident per day. ¹³⁴² StewartBrown state that direct care staffing costs average \$147.25 per bed day and represents 81.6% of Aged Care Funding Instrument revenue. ¹³⁴³

1299. Our proposed requirement will, in effect, require residential aged care providers to spend a significant proportion of the money they receive for care on care. It will ensure that public funds for care are not sources of excess profits.

1300. We have elected not to make the same submission for providers of home care. As we will outline, in the future providers of home care will be only be paid for services after

¹³³⁸ Transcript, Sydney Hearing 5, Jason Ward, 16 September 2020 at T9310.35–43.

¹³³⁹ See, for example, Transcript, Sydney Hearing 5, Brendan Murphy, 18 September 2020 at T9447.25–36; Transcript, Sydney Hearing 5, Nicolas Mersiades, 21 September 2020 at T9538.15–27; Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9628.9–31.

¹³⁴⁰ Transcript, Sydney Hearing 5, Flavio Menezes, 16 September 2019, T9297.31–39.

¹³⁴¹ Exhibit 21-3, Sydney Hearing 5, Statement of Michael Woods, RCD.9999.0465.0001 at 0014 [56.5].

¹³⁴² Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2020, p 75.

¹³⁴³ StewartBrown, *Aged Care Financial Performance Survey Sector Report*, March 2020, p 14.

they have been delivered by them or they have incurred a relevant liability to deliver them. This process of accounting between government and provider will in effect operate as a useful transparency and accountability measure. In our view, the invoicing arrangements should serve as the mechanism for reporting staff hours, which should be logged by the Australian Aged Care Commission in the same way as residential aged care providers will report staffing hours.

Payment on an accruals basis for home care

1301. Under the current payment system for home care, the Government is wholly reliant on an approved provider for accurate reporting and reconciliation of funds. This is because home care providers are currently paid a person's full entitlement to a daily government subsidy for each month in advance, less any income-testing care fee, and regardless of the services actually provided.¹³⁴⁴ This arrangement has a several undesirable effects, including the phenomenon of 'unspent funds', and a lack of clarity around what services are delivered. This practice is unnecessarily complex and has inherent prudential risk. A more efficient, transparent and accountable system would involve providers only being paid after they have delivered services.
1302. Under the current payment arrangements for home care, any amount that is not spent providing care and services in any given month is held by the provider as available funds to be used by the person receiving the package in the future. These funds are commonly referred to as 'unspent funds'.¹³⁴⁵ According to StewartBrown, unspent funds in home care has kept rising each quarter over the last few years, and now averages \$8,250 per person receiving a Home Care Package. In aggregate, this represents around \$1,062 million of funding residing in the bank accounts, as a liability, of approved providers. This is likely to be over \$1,100 million as at 30 June 2020, under the current funding model.¹³⁴⁶
1303. Providers hold and use unspent funds in a variety of ways. Some treat unspent funds as part of their working capital, reducing the need to access other sources, some quarantine unspent funds in a separate account and use them only to pay for care and services, and some have the money held by a third part effectively in trust.¹³⁴⁷ The Australian Government does not give guidance to providers on whether interest may be earned and does not require interest to be paid to the Commonwealth if it has been earned.¹³⁴⁸ Due to

¹³⁴⁴ Aged Care Financing Authority, *Consideration of the final impact on home care providers as a result of changes in payment arrangements*, December 2019, p 8.

¹³⁴⁵ Aged Care Financing Authority, *Consideration of the final impact on home care providers as a result of changes in payment arrangements*, December 2019, p 8.

¹³⁴⁶ StewartBrown, *Aged Care Financial Performance Survey Sector Report*, March 2020, p 33.

¹³⁴⁷ Aged Care Financing Authority, *Consideration of the final impact on home care providers as a result of changes in payment arrangements*, December 2019, p 9.

¹³⁴⁸ Exhibit 2-89, Adelaide Hearing 2, Statement of Fiona Buffinton, 11 March 2019, WIT.0058.0001.0001 at 0018–0019 [54].

the high level of unspent funds per care recipient, there is a reluctance by some providers to levy (and consumers to be charged) a client contribution in home care, as it would effectively only add to the quantum of unspent funds. This practice distorts the overall funding model.¹³⁴⁹

1304. The other issue inherent in the practice of payment in advance for government subsidies in home care is that the Australian Government current has little visibility over what goods and services are provided to people on home care packages. Home care providers are not required to report to the government what kinds of goods and services are provided with the home care package subsidies the Commonwealth supplies – which amount to about \$2.5 billion a year (based on 2018-19 data).¹³⁵⁰ To try to gain an understanding of this, the Department of Health conducted a survey of home care providers and the results were disturbing. The survey revealed that in 2018-19 there were negligible amounts spent on nursing and allied health care of 15 mins of each per fortnight, even for the most needy package holders.¹³⁵¹

1305. In the 2019-20 Budget, the Government announced that payment arrangements in home care are to be changed from payment in-advance to payment upon delivery of service. One of the intentions of this change was to avoid Commonwealth subsidies and supplements funding being held as unspent funds by providers. The Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 1) Bill 2020 (the Bill) was introduced on 27 February 2020 to change the payment of home care subsidy to approved providers from being paid in advance to being ‘paid in arrears’.¹³⁵² The Bill would implement Phase 1 of a broader package of reform to home care payment arrangement by changing monthly subsidy payments from payment in advance to in arrears. Phase 2 would see payments based on services provided to people receiving home care packages. Phase 3 would act to reduce the total amount of unspent funds but drawing down on those fund for services delivered.¹³⁵³

1306. In December 2019, at the request of the Minister for Aged Care and Senior Australians, the Aged Care Financing Authority, examined the potential approved provider and consumer impact of the 2019-20 Budget measure. It concluded:

- a. In relation to Phase 1, most home care providers should be able to accommodate the cash flow impact of the Phase 1 change. However, it is possible that some

¹³⁴⁹ StewartBrown, *Aged Care Financial Performance Survey Sector Report*, March, 2020, p 34.

¹³⁵⁰ Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, Australian Government, 2020, p 53.

¹³⁵¹ Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 4, RCD.9999.0444.0001 at 0046.

¹³⁵² Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 1) Bill 2020, explanatory memorandum, p 1.

¹³⁵³ Parliament of Australia, Bills Digest No.93, 2019-20, Aged Care Legislation Amendment (Improved HomeCare Payment Administration No. 1) Bill 2020, p 5.

small providers operating in 'thin or difficult markets and under financial pressure may face challenges.' Short-term assistance should be able to support such providers and that any provider seeking financial assistance should first utilise the Business Advisory Service operated by PricewaterhouseCoopers on behalf of the Australian Government.¹³⁵⁴

- b. In relation to Phase 2, a range of actions need to be taken include: determining how the new payment arrangements would operate, the timeframe for trailing and implementation, considering financial support to providers who may find it particular challenging to adjust their systems to deal with the new payment arrangements.¹³⁵⁵
- c. In relation to Phase 3, providers should have a choice to either a) return the unspent funds when the phase commences, or b) retain the unspent funds and allow those be drawn down or return to government when the person leaves home care.

1307. We submit that great weight should be placed on the conclusions of the Aged Care Financing Authority with respect to the implementation of the reforms. We note that the Aged Care Legislation Amendment (Improved Home Care Payment Administration No. 1) Bill 2020 remains before parliament. Work should continue to implement the arrangement as soon as possible having regard to the need for an orderly transition, with arrangements for Phase 2 in place no later than 1 September 2021, consistent with the Australian Government's recent budget announcement.¹³⁵⁶

1308. In light of all these factors, we have settled on a measured approach that ensures a reasonable level of transparency about expenditure on care, but should not be administratively burdensome. We submit that each quarter an approved provider of residential care should be required to report on the daily direct care staffing at each of its facilities. Providers of home care will, under a proposal for accruals-based invoicing of funds from packages, effectively be under even more stringent requirements. In addition, we recommend that the financial reporting regime to which approved providers are subject should be tightened, as recommended in Part 3.16 Prudential regulation and financial oversight, below. In that section we recommend empowering the Australian Aged Care Commission to require the provision of financial reports that will be more detailed on the costs and revenues associated with aged care operations, and which

¹³⁵⁴ Aged Care Financing Authority, *Consideration of the final impact on home care providers as a result of changes in payment arrangements*, December 2019, p 2.

¹³⁵⁵ Aged Care Financing Authority, *Consideration of the final impact on home care providers as a result of changes in payment arrangements*, December 2019, p 2.

¹³⁵⁶ Australian Department of Health, *Improved Payment Arrangements for Home Care*, 2020, <https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/improved-payment-arrangements-for-home-care>, accessed 20 October 2020.

should provide transparent information on the performance of an entity's aged care business (or 'operating segment', whether that business is operated by a standalone company or as part of a corporate group. For home care, we recommend accruals-based transactions between providers and the government, and the provision of standardised statements to package holders.

Recommendation 91: Reporting of staffing hours

91.1. From 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require any approved providers of residential aged care to provide reports, on a quarterly basis in standard form reports, setting out total direct care staffing hours provided each day at each facility they conduct, broken into different employment categories (including personal care workers, enrolled nurses engaged in direct care provision, registered nurses engaged in direct care provision, and allied healthcare professionals engaged in direct care provision).

Recommendation 92: Payment on accruals basis for care at home

92.1. By 1 September 2021, home care providers should commence invoicing and receipt of payments from the Australian Government out of their clients' home care packages on an accruals basis, only once services have been delivered or the liability to deliver them has been incurred.

Recommendation 93: Standardised statements on services delivered and costs in home care

93.1. The Australian Government should develop and implement a standardised statement format for home care providers to record services delivered and costs incurred on behalf of home care package holders. From 1 July 2022, providers should be required to issue completed statements in the standardised format to people receiving their care on a monthly basis.

Reform of co-contributions and means testing

1309. In Part 3.1, we submitted that the new Act should recognise the universal entitlement of older people to receive support and care for ageing-related conditions, on the basis of

assessed needs. Consistent with the universality of this entitlement to aged care, we submit that the current requirement to pay a user contribution toward care (the means-tested care fee) in residential care should be repealed.

1310. We also submit that the equivalent user contribution in home care (the income-tested care fee) should be repealed, and that it should be replaced with nominal co-payments providing a contribution toward services in the nature of domestic assistance.

1311. During the funding hearing in September 2020 Professor Piggott said that co-payments ‘may introduce some form of discipline, and you introduce a sense of consumer engagement’ which may increase the value that people attach to the subsidies services.¹³⁵⁷ Nominal co-payments provide an incentive for the person seeking services to be judicious about doing so, a particularly important point when it comes to services that have intrinsic value in the general economy. Co-payments also arguably tend to lead to higher levels of consumer engagement in the quality of the services and the way they are delivered. For similar reasons, we advocate nominal co-payments for assistive technology and home modifications.

1312. In the event that substantial co-payments toward the costs of care were to be retained in the new aged care program, substantial reform to the existing means-testing arrangements would be required. There was significant support for reform of the means-testing arrangements from the witnesses who appeared in the hearing in September.¹³⁵⁸

1313. As for respite, as in other forms of aged care, people should not be required to pay for the care they receive during respite and (in contrast to residential care) we submit that people in respite should not be required to pay for accommodation either. The rationale for this submission is connected with the purpose of respite. Respite should sustain the long-term capability of people to remain in their own home and to receive care there. Such people are likely to be bearing accommodation-related costs in doing so, and it cannot be assumed that they would be able to pay for additional accommodation while receiving respite. Further, if and to the extent that the deferral or prevention of entry into residential care can be achieved, this will represent a saving to the Commonwealth on the costs of residential care (including any accommodation supplement), and so can be seen as an ‘investment’ by the Australian Government.

1314. On the other hand, the everyday costs of living should be borne by the person in respite, but (as in the case of residential care) they should be regulated by the Aged Care Pricing Authority to protect against exercises of market power by respite providers against

¹³⁵⁷ Transcript, Sydney Hearing 5, John Piggott, 15 September at T9226.46–9227.4.

¹³⁵⁸ Transcript, Sydney Hearing 5, Ian Yates, 14 September 2020 at T9115.25–26; Transcript, Sydney Hearing 5, Ian McCallum, 14 September 2020 at T9115.31–36; Transcript, Sydney Hearing 5, Ian Yates, 14 September 2020 at T9115.40–44; Transcript, Sydney Hearing 5, Henry Cutler, 22 September 2020 at T9640.46–9641.2.

consumers who are vulnerable by reason of their need and their limited ability to seek alternative service offerings.

Recommendation 94: Fees for social supports, assistive technology and home modifications

94.1. Individuals receiving social supports, assistive technology and home modifications should be required to make nominal co-payments for the services that they receive.

94.2. The levels of these notional co-payments should be set in the new Act.

Recommendation 95: Fees for respite care

95.1. Individuals receiving respite care should be required to contribute to the costs of the services that they receive associated with ordinary costs of living and additional services. They should not be required to contribute to the costs of the accommodation and care services that they receive.

95.2. The level of any payment for the ordinary costs of living should be determined from time to time by the Australian Aged Care Pricing Authority.

Recommendation 96: Fees for care at home

96.1. Individuals receiving care at home should not be required to contribute to the costs of any care services that they receive. They should, however, be required to make nominal co-payments for any domestic assistance services that they receive.

96.2. The levels of these notional co-payments should be set in the new Act.

Recommendation 97: Fees for residential aged care – ordinary costs of living

97.1. From 1 July 2023, the amount that providers should be paid for services that are associated with ordinary costs of living should be determined by the Aged Care Pricing Authority. Funding for this amount should be provided by:

- a. a basic fee paid by the resident equal to 85% of the maximum amount of the basic age pension
- b. a means tested fee paid by the resident
- c. a subsidy paid by the Australian Government to make up any gap.

97.2. The means tested fee should have the following features:

- a. it should be zero for anyone in receipt of the full pension
- b. it should be recalibrated to achieve progressively greater contributions from people who have greater levels of assets and income without imposing hardship, or arbitrary outcomes on people in certain asset or income brackets
- c. non-pensioners should be required to pay the full costs of ordinary living (without any contribution by the Australian Government).

Recommendation 98: Repeal co-contributions for care component of funding in residential care

98.1. From 1 July 2023, the means tested daily care fee for care provided in residential care facilities should be repealed.

1315. An accommodation supplement is paid by the Australian Government for supported residents, subject to means-testing arrangements. The amount of accommodation supplement is currently fixed. It should be determined on the basis of an estimate of the required returns on capital investment of approved providers of residential care in particular categories or rooms, and in particular regions or areas categorised by remoteness. The means-testing arrangements applicable to qualification for full or partial accommodation supplement should be reformed to ensure they do not have a disproportionately harsh impact on people who do not meet the requirements for full support by the government, but who nevertheless are positioned at the lower end of the wealth spectrum. As already noted, for residents who receive no support from the Government, the existing arrangements constraining approved providers from charging above a provisional ceiling, subject to application for the ceiling to be lifted in particular cases, should be retained.

Recommendation 99: Reform of means testing for accommodation charges

- 99.1. From 1 July 2023, the maximum amount that the Australian Government will pay for a person's accommodation costs in residential aged care should be determined by the Aged Care Pricing Authority.
- 99.2. The amount payable in respect of any individual should be determined by a means test that is calibrated to achieve progressively greater contributions from people who have greater levels of assets and income without imposing hardship, or arbitrary outcomes on people in certain asset or income brackets.
- 99.3. Where a resident is eligible under this means test for some Australian Government assistance with their accommodation costs then the fee that they can be charged is capped at the amount worked out by the means test.
- 99.4. Where a resident is not eligible for any Australian Government assistance with their accommodation costs then the fee that they can be charged should be not be price-capped, but should remain subject to a provisional upper limit (to be set by the Aged Care Pricing Authority from time to time) that may be raised upon application by the approved provider to the Authority.

Ongoing consultation and consideration of capital financing for provers and long term financing of the system

1316. As we indicated at the outset, these submissions do not cover or make proposed recommendations about the topics of long-term care financing or capital financing. However, it is appropriate to say something about these topics, including what the evidence and information we have received suggests for the future.

Long-term care financing

1317. If 'funding' refers to the provision of funds to approved providers for the delivery of aged care, 'financing' refers to the raising of those funds: where will they come from, and how will they be raised? In work commissioned by the Office of the Royal Commission, Deloitte Access Economics modelled the additional expenditure entailed by the additional staffing levels and certain other reforms we propose as corresponding to 0.5% of Gross Domestic Product by 2050, or around a third of what the projected budget for aged care would be in the absence of those reforms.¹³⁵⁹ That is of course a very

¹³⁵⁹ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 4, Deloitte Access Economics - Aged Care Reform - Projecting Future Impacts, RCD.9999.0388.0001 at 0038 and 0040 (tables 4.9 and 4.10).

significant additional outlay, but in other work obtained by the Office of the Royal Commission, a team from Flinders University conducted a survey which indicates that there is a reasonable level of public support to devote more public funds to achieving high quality aged care.¹³⁶⁰ Aged care in Australia is currently financed by a mix of pay-as-you-go public funding, sourced through the general taxation system, and private contributions in the forms of means-tested fees and co-payment for certain services. It has never been financed from a dedicated and committed source and there is no guarantee that governments will make available sufficient funds to meet future needs.¹³⁶¹

1318. In June 2020, the Royal Commission released *Consultation Paper 2 – Financing aged care*. It examined how aged care is financed in Australia and overseas, and considered a range of options that have the potential to transform the way aged care is funded and delivered in Australia. The consultation paper attracted a diverse range of submissions reflecting a wide cross-section of views on financing arrangements for aged care. These submissions were made by individuals and organisations spanning aged care providers; academics; peak and advocacy bodies; healthcare groups; accounting and financing organisations; and governments.

1319. The Royal Commission also examined the issue of financing at the Funding, Financing and Prudential Regulation Hearing in September. The Commissioners heard from the Hon Paul Keating, the Hon Peter Costello, Dr Kenneth Henry, Professors John Piggott, Michael Sherris, Naoki Ikegami, the Secretary of the Australian Department of the Treasury Dr Stephen Kennedy, and his colleague Ms Jenny Wilkinson, among others.

1320. Financing arrangements are another necessary but not sufficient condition for the operation of an aged care system delivering high quality aged care. It is clear from the consultation and the recent hearing that the long-term financing of aged care requires attention on a fundamental level.

1321. Although we do not propose to make any recommendations on the topic of long-term financing here, we outline a broad vision for the Commissioners' consideration. There are three pillars to the approach we propose:

- a. The first pillar is that we should make the financing of aged care as predictable, reliable, objective, and economically efficient as possible, without compromising the quality and safety of aged care, or the equity of financing arrangements.

¹³⁶⁰ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 22, Flinders University - Australia's aged care system: assessing the views and preferences of the general public for quality of care and future funding, RCD.9999.0401.0001.

¹³⁶¹ Aged Care Financing Authority, *Seventh report on the Funding and Financing of the Aged Care Industry*, 2019, p 68; Australian Department of Health, *2018-19 Report on the Operation of the Aged Care Act 1997*, 2019, p 10.

- b. The second pillar is that 'here and now' we need a significant increase in the level of funding to bridge the gap we have documented in the quality of aged care. That gap includes the probability of actually getting aged care when the need arises, since aged care is defined by us as the expectation of getting care as needed, when needed, and at the right quality level.
- c. The third pillar is that there are reliable demographic projections that the share of Australians needing aged care is growing rapidly. So we need to build capacity and arrangements that can accommodate the increasing demand for the share of available resources, rather than reacting in a poorly planned way when that demand is placed on the aged care system.

1322. Predictable financing is fundamental to the vision we propound for aged care in Australia, and again related to the definition of aged care as the expectation of getting care. So it is an expectation that is delivered to the 20-year old Australian just as it is delivered to the 50-year old Australian: each shares the entitlement of expecting aged care if and when needed.

1323. Economic efficiency means allowing those that pay for that expectation of aged care to make those payments before its actual delivered. All Australians receive the expectation, so all Australians should pay: not just those that need and get the aged care services. This does not mean that the more financially fortunate should pay the same share as the less financially fortunate. As they do now for aged care and government services in general, the more financially fortunate should continue to pay a greater share.

1324. The first pillar has an important implication for the political empowerment of those that are at the centre: all Australians. If we consistently take the view that the aged care entitlement should be seen as an expectation that quality aged care will be provided when and if needed, then it is something that all Australians should value. And if they value it and are paying for it, they will pay attention to what they are 'getting for their money' from the political process.

1325. By highlighting the financing of aged care we hope to ensure that greater priority is placed on the needs of older people, and aged care can never again be 'out of sight and out of mind' to all Australians.

1326. There are different models that could be used to implement a predictable, reliable objective, and economically efficient arrangement for aged care in Australia. To take just one approach:

- a. Funds could be collected through a new aged care levy as a fixed proportion of income tax.

- b. The levy could be hypothecated – that is, paid into a dedicated account within the Consolidated Revenue Fund, established for the specific purposes of aged care and only used for those purposes. This was an option preferred by Dr Ken Henry, former Secretary of the Department of the Treasury. He said ‘there are very few heads of government expenditure that, to my mind, satisfy the conditions for having a hypothecated levy. But aged care certainly does’.¹³⁶² Dr Henry was of the view that such an approach would instil a rigour in the process of raising funds and establish a connection between the levy and the benefit that society is getting from the levy.¹³⁶³ A hypothecated levy would provide some measure of assurance to taxpayers about how their taxes will be used. It could educate people to make better informed decisions about the balance between tax burden and the level of services provided. And it can generate public support for tax increases where the service set to benefit from the tax is perceived to merit it. We acknowledge, however, that government could at some future point pass legislation to change its nature.
- c. The contribution rates could be based on insurance principles, and could be actuarially calculated (on an aggregated basis). Contribution rates could be fixed by an independent authority applying insurance principles to secure sufficient funds over time to provide expected benefits to meet expected needs. That is, to provide the quality of care to which *all* older Australians are entitled, and have the quality of care that *all* Australians are entitled to expect if needed.

1327. Of course, there are a range of other issues that need to be thought through, and options that could be formulated to help achieve the desired system. For example, additional insurance and savings products that are linked to current superannuation and retirement incomes arrangements. These could include combined deferred annuity and aged care insurance products, superannuation linked savings or insurance schemes or insurance to cover for home supports. These could be voluntary or have some aspect of compulsion or incentives to encourage take up.

1328. The considerations should inform the Commissioners’ recommendations on this topic in the final report.

Capital financing

1329. The Royal Commission’s terms of reference require the Commissioners to consider how to best deliver aged care services in a sustainable way, including through investment in capital infrastructure. In aged care, capital infrastructure can be thought of as the physical assets necessary to deliver care. For example, the provision of residential aged

¹³⁶² Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9275.1–10.

¹³⁶³ Transcript, Sydney Hearing 5, Kenneth Henry, 16 September 2020 at T9279.37–9280.46.

care requires the investment of substantial amounts of capital for the purchase or construction of a building and for equipment. Capital financing, therefore, is how and where funds for capital infrastructure are sourced.

1330. In general, businesses raise the capital that they need to pay for capital infrastructure in a variety of ways. This may include equity investments, loans from financial institutions, or from their accumulated profits. While aged care providers use these forms of capital financing, they are also supported by arrangements within the aged care system that assist them both to access capital, and to pay for the required returns on investments and service debts. Residential aged care providers have access to interest free loans from residents in the form of Refundable Accommodation Deposits, previously known as Accommodation Bonds. The Australian Government also provides capital grants to build or upgrade residential aged care accommodation in particular areas or for particular cohorts of people.¹³⁶⁴ Providers can raise the revenue to pay for their capital investment from residents, through Daily Accommodation Payments, and from the Australian Government, which pays an Accommodation Supplement in respect of those residents who cannot pay for their own accommodation costs.¹³⁶⁵

1331. The amount of capital investment necessary in residential aged care into the future requires careful consideration. In 2019, the Aged Care Financing Authority estimated that the combined total investment for new and rebuilt residential care places over the next decade will be about \$55 billion.¹³⁶⁶ This compares to \$16.7 billion in building approvals for new and rebuilt residential care places over the decade to 30 June 2020.¹³⁶⁷ The average cost of building a new residential aged care bed sits at around \$250,000.¹³⁶⁸ Additional investment may also be required to improve the quality of accommodation. Residential aged care facilities need to be suitable for delivering the care necessary for older and frail people. They also need to be designed in ways that support a high quality of life for residents, which research suggests may be achieved through smaller facilities.¹³⁶⁹ However, people's preference to remain at home as they

¹³⁶⁴ Australian Department of Health, *Aged Care Approvals Round*, <https://www.health.gov.au/health-topics/aged-care/providing-aged-care-services/funding-for-aged-care-service-providers/aged-care-approvals-round-acar#what-you-can-apply-for>, viewed 20 October 2020.

¹³⁶⁵ Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, 2020, pp 15, 130.

¹³⁶⁶ Aged Care Financing Authority, *Attributes for Sustainable Aged Care – a funding and financing perspective*, 2019, p 41.

¹³⁶⁷ Australian Bureau of Statistics, *8731.0 Building Approvals, Australia*, Table 51: Value of Non-residential Building Approved, By Sector, Original—Australia. Australian Government, 2020, <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/8731.0Jul%202020?OpenDocument>, viewed 3 September 2020.

¹³⁶⁸ Author calculation based on data from the Australian Department of Health.

¹³⁶⁹ Royal Commission into Aged Care Quality and Safety, *Research Paper 9: The cost of residential aged care*, 2020, p 1; ES Gnanamanickam et al, 'Clustered Domestic model of

age and the reflection of this preference through aged care policy and programs may reduce the amount of capital financing required in residential aged care over time. In Part 3.10 Aged care accommodation, we have made submissions relating to capital financing in the future, in a manner that will incentivise dementia-friendly design in residential aged care and encourage small home models of accommodation in order to increase the offerings of 'deinstitutionalised' options in the residential aged care sector.

1332. In September 2020, the Office of the Royal Commission released *Capital financing for residential aged care: call for submissions*. It sought input from interested individuals and organisations on whether the current capital financing arrangements are appropriate and sufficient for the future requirements of residential aged care, and whether there are potential improvements to these arrangements that should be recommended.

1333. A total of 33 public submissions were received in response to the paper from a diverse cross-section of the community. This included families of people receiving aged care, approved providers and peak bodies, think tanks, academics, and governments. A number of important views emerged from the submissions.

1334. A significant focus in both the submissions and the evidence has been placed on the current arrangements for capital financing in residential aged care, including the issue of Refundable Accommodation Deposits.

1335. Refundable Accommodation Deposits are unique to residential aged care in Australia. At 30 June 2019, a total of \$30.2 billion of Refundable Accommodation Deposits were held by providers.¹³⁷⁰ Non-supported residents have the choice of paying either a Refundable Accommodation Deposit or a Daily Accommodation Payment for their accommodation. The Australian Government pays providers an Accommodation Supplement for supported residents.

1336. Both approved providers and financial institutions gave evidence about the role of Refundable Accommodation Deposits in supporting the development of new residential aged care homes. They described a typical situation whereby approved providers use a combination of equity and debt to finance the initial construction of a residential aged care home. However, the bank's expectation would be that the provider would repay the debt with incoming Refundable Accommodation Deposits as residents moved in.¹³⁷¹ Bank debt is typically repaid within three years of construction, and only accounted for 4.1% of providers' total assets as at 30 June 2019. In contrast, Refundable

residential care is associated with better consumer rated quality of care', *International Journal for Quality in Health Care*, 2018, Vol 31, 6, pp 1–7.

¹³⁷⁰ Aged Care Financing Authority, *Eighth Report on the Funding and Financing of the Aged Care Industry*, p 96.

¹³⁷¹ Transcript, Sydney Hearing 5, Sam Morris, 21 September 2020 at T9505.6–19; Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9586.30–39.

Accommodation Deposits accounted for 57.4% of providers' total assets.¹³⁷² As a result, a provider's ability to attract Refundable Accommodation Deposit paying residents is a key lending criterion applied by the banks.¹³⁷³

1337. Providers have submitted that Refundable Accommodation Deposits have been important to the expansion of the residential aged care sector in recent years. For example, Estia submitted that:

The introduction of Refundable Accommodation Deposits ("RADs") has been successful in attracting capital to the sector: from the 5 years to 30 June 2019 the RAD/Bond balance in the sector has increased from \$15.6 billion to more than \$30.1 billion. This has been used to fund significant expansion and the improvement of existing facilities.¹³⁷⁴

1338. However, both in Sydney Hearing 5 and in the responses to the call for submissions on capital financing, a range of issues were identified with Refundable Accommodation Deposits:

- a. Refundable Accommodation Deposits introduce structural risks for providers' liquidity, increasing the likelihood of insolvency events and threatening the continuity of care for residents. These risks arise in situations where a provider is required to repay a Refundable Accommodation Deposit for a resident who leaves, but does not necessarily have an incoming Refundable Accommodation Deposit paying resident. There are three broad scenarios in which this might play out:¹³⁷⁵
 - i. Residents who paid a Refundable Accommodation Deposit are replaced by either a supported resident or a resident paying a Daily Accommodation Payment. There has been a gradual shift over recent years to residents paying Daily Accommodation Payments.¹³⁷⁶
 - ii. House prices decline, reducing residents' ability to secure the funds necessary to pay a Refundable Accommodation Deposit.¹³⁷⁷
 - iii. Occupancy declines, meaning there is no incoming Refundable Accommodation Deposit to repay the resident who left or their estate. This risk has been highlighted in the context of COVID-19, with older people being either unwilling or unable to enter residential aged care.¹³⁷⁸

¹³⁷² Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, table 7.5, p 97.

¹³⁷³ Exhibit 21-15, Sydney Hearing 5, Statement of Westpac Banking Corporation, WPC.9999.0002.0001 at 0014.

¹³⁷⁴ Estia Health, Public submission, AWF.680.00048.0001 at 0007 [33].

¹³⁷⁵ Exhibit 21-13, Sydney Hearing 5, Statement of Campbell Ansell, WIT.1382.0001.0001 at 0003-0004 [17].

¹³⁷⁶ Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9472.72.24-40.

¹³⁷⁷ Transcript, Sydney Hearing 5, Thea Horden, 21 September 2020 at T9495.15-27.

¹³⁷⁸ Transcript, Sydney Hearing 5, Campbell Ansell, 18 September 2020 at T9474.8-T9475.2.

- b. The risks arise where the provider does not have sufficient current assets to cover the Refundable Accommodation Deposit outflow. Refundable Accommodation Deposits are guaranteed to residents by the Australian Government through the Accommodation Payment Guarantee Scheme.¹³⁷⁹ This means that the Australian Government bears any financial risk from a provider becoming insolvent and being unable to refund the Refundable Accommodation Deposits.
- c. The reliance on Refundable Accommodation Deposits to access bank loans to construct new or refurbish existing homes disadvantages people and providers in regional, rural and remote areas. Major banks at the hearing in September stated that Refundable Accommodation Deposits in these areas are typically lower, making it less likely will satisfy the banks' lending criteria.¹³⁸⁰
- d. Refundable Accommodation Deposits and Daily Accommodation Deposits are not economically equivalent. The Daily Accommodation Payment amount is derived from the agreed Refundable Accommodation Deposit value using the Maximum Permissible Interest Rate, which is currently set at 4.1%.¹³⁸¹ However, providers submitted that the Maximum Permissible Interest Rate is not the appropriate basis for converting a Refundable Accommodation Deposit to a Daily Accommodation Deposit.¹³⁸²
- e. Providers relying on Refundable Accommodation Deposits increase the risk of complacency and inefficiency. COTA Australia submitted that:
- RADs can be a lazy form of capital compared to debt, where the lender plays an active monitoring role and has covenants in place and equity where clearly the investor has a keen stake in performance in terms of both security of the investment and certainty of return. By contrast RADs are a loan from an individual who has almost no way of monitoring and assessing how it is used.¹³⁸³
- f. Some residents are being forced into paying Refundable Accommodation Deposits. COTA Australia submitted that:
- Despite the fact that legally residents are required; to have free choice as to whether they pay by RAD or DAP or a combination, there are many providers that require a RAD or they will not accept the new resident. They may be informed that they have a choice but then then it will be made clear that a place in this facility is only possible if they pay a RAD. This pressure is inevitable when providers are over-dependent on RADs.¹³⁸⁴

¹³⁷⁹ *Aged Care (Accommodation Payment Security) Act 2006* (Cth).

¹³⁸⁰ Transcript, Sydney Hearing 5, John McCarthy, 21 September 2020 at T9496.4–12.

¹³⁸¹ Australian Department of Health, *Base interest rate (BIR) and maximum permissible interest rate (MPIR) for residential aged care*, https://www.health.gov.au/sites/default/files/documents/2020/07/baseinterest-rate-bir-and-maximum-permissible-interest-rate-mpir-for-residential-aged-care-bir-and-mpir-forresidential-aged-care_0.pdf, viewed 13 July 2020.

¹³⁸² Regis Healthcare, Public submission, AWF.680.00052.0001 at 0011.

¹³⁸³ COTA Australia, Public submission, AWF.680.00058.0001 at 0002.

¹³⁸⁴ COTA Australia, Public submission, AWF.680.00058.0001 at 0002.

1339. Given these issues, in due course consideration should be given to phasing out Refundable Accommodation Deposits. Instead, residential aged care providers should receive rental payments for accommodation based on the existing Daily Accommodation Payments and the Accommodation Supplement. With appropriate modifications, this type of arrangement would enable providers to access higher levels of debt and equity financing to replace Refundable Accommodation Deposits.
1340. Providers would continue to receive the Accommodation Supplement for supported residents. However, the rate of the Accommodation Supplement should reflect the cost of providing accommodation, including a return of capital (depreciation), return on capital (based on the Weighted Average Cost of Capital), operating expenses, and taxes.
1341. The Office of the Royal Commission commissioned Frontier Economics to develop a building block model for required revenues to support investment through debt or equity in residential aged care.¹³⁸⁵ This model is capable of distinguishing between different facilities, based on factors like land value, and providers, based on factors like taxation status, in determining the rate for the Accommodation Supplement. It would be the role of the Aged Care Pricing Authority to determine the rate of the Accommodation Supplement.
1342. For residents who are contributing to the cost of their accommodation, Daily Accommodation Payment prices could be deregulated in areas that the Aged Care Pricing Authority will have determined are workably competitive for residential aged care. Where that is not the case, Daily Accommodation Payment prices should be determined on the same basis as the Accommodation Supplement.
1343. As with our submissions about dementia-friendly design and small home models, price signals could be incorporated into these mechanisms to incentivise the construction of particular types of residential aged care. They could also be used to encourage investment in underserved areas.
1344. The phased removal of Refundable Accommodation Deposits would be a long-term project, and one that would require the support of the government, and cooperation from the sector and lenders. There would be significant issues associated with any transition away from Refundable Accommodation Deposits. One option suggested by the Grattan Institute would be for the Australian Government to establish a capital financing pool that providers could apply to access, or a system of loan guarantees.¹³⁸⁶ This would enable providers to repay the Refundable Accommodation Deposits of residents leaving residential aged care during the transition to a purely rental model for accommodation

¹³⁸⁵ Exhibit 21-1, Sydney Hearing 5, general tender bundle, RCD.9999.0402.0002 at 0034–0042.

¹³⁸⁶ Grattan Institute, Public submission, AWF.680.00043.0001 at 0005.

payments. Importantly, this does not increase the risk for the Australian Government as it already guarantees Refundable Accommodation Deposits.

1345. Respondents to the call for submissions overwhelmingly said that such a transition would need to be carefully planned and managed, and that providers should be closely consulted on how this should occur and allow sufficient lead times to plan the transition.¹³⁸⁷ This is entirely appropriate given the impact this type of reform would have on the capital structure of residential aged care providers.

¹³⁸⁷ Exhibit 21-15, Sydney Hearing 5, Statement of Australia and New Zealand Banking Group Limited, RCD.9999.0393.0001 at 0012; Aged and Community Services Australia, Public submission, AWF.680.00056.0001 at 0017.

Part 3.16 Prudential regulation and financial oversight

1346. Prudential and financial regulation have two substantial and related policy goals. The first concerns continuity of care to those in receipt of care; i.e. ensuring that providers have the ongoing financial capacity to deliver the high quality care that is described in these submissions. The second concerns the ability of providers to meet their obligations to repay accommodation lump sums (refundable accommodation deposits, accommodation bonds) as and when the need arises.
1347. Earle Haven painted a stark picture of the distress and devastation on older people, their families and workers where, for whatever reason, there is a sudden cessation of residential aged care services. Since then, the COVID-19 pandemic has confronted the aged care system in a way that is unparalleled in recent history. Although the prudential effects in terms of the repayment of accommodation lump sums is yet to fully play out, it is clear that the sector was already under considerable stress and that COVID-19 will have a further detrimental impact.
1348. The aged care prudential regulatory system should be consistent with best practice in other sectors where there is prudential oversight. It should be able to identify and reflect the risks in the sector as a whole, and be responsive to changes in accounting standards, innovations in financial and prudential oversight, and other relevant developments and circumstances.
1349. It should complement economic regulation (discussed separately in Parts 3.2 and 3.15]) by facilitating oversight of financial risk among providers in the sector and imposing reasonable safeguards over providers' financial management. It should require risk based financial reporting requirements by providers; building on the reporting of financial information required for economic regulatory purposes.
1350. The recommendations we propose in these submissions outline the elements of a new prudential and financial oversight framework, guiding principles for its refinement over time, certain statutory duties directly binding on providers, enhanced regulatory powers, and measures to improve regulatory capability.
1351. Conceptually, prudential regulation in the aged care context has been primarily focussed on the risk surrounding refundable accommodation deposits (RADs) and accommodation bonds¹³⁸⁸ that residents pay to providers on entry into care.¹³⁸⁹ This is reflected in the four relevant prudential standards are set out in the *Fees and Payment Principles 2014 (No 2) (Cth)*: Liquidity, Records, Governance; and Disclosure (Prudential Standards).¹³⁹⁰

¹³⁸⁸ Accommodation bonds were paid by residents who entered care before 1 July 2014.

¹³⁸⁹ *Fees and Payments Principles 2014 (No. 2) (Cth)*, s 41.

¹³⁹⁰ *Fees and Payments Principles 2014 (No. 2) (Cth)*, Part 5.

1352. The Liquidity Standard requires providers to establish their own liquidity management strategy that addresses the amount of funds required to meet a stated minimum level of liquidity which the provider calculates by reference to its ability to meet all 'expected' outflows of RADs in the year ahead.¹³⁹¹ The strategy must identify the form that the liquidity funds can take, but, the standard essentially leaves it to providers to devise and implement that strategy; without prescribing any minimum level of liquidity. The Governance Standard is concerned with ensuring providers have systems in place to ensure that RADs are only used for permitted purposes and repaid as and when required under the legislation. The Records and Disclosure Standards are largely about record-keeping, auditing, disclosure to people receiving aged care and prospective care recipients and reporting.

1353. Reporting against these standards is done through the audited Annual Prudential Compliance Statement (APCS) required under section 51 of the *Fees and Payments Principles 2014*, contained in the Disclosure Standard. The obligation to complete an APCS sits alongside separate financial reporting obligations in the *Aged Care Act 1997* (Cth). In 2020, the Aged Care Quality and Safety Commission assumed responsibility for the prudential regulation of approved providers, previously undertaken by the Australian Department of Health.¹³⁹²

1354. The Aged Care Quality and Safety Commission's Prudential Compliance Section (PCS) has primary operational Australian responsibility for assessing and monitoring providers' compliance with the Prudential Standards.¹³⁹³

1355. Critical features of the current arrangements are:

- a. Three different annual reports are provided: the Aged Care Financial Report, which is required in the case of all providers; the APCS (required in the case of a provider that held a refundable accommodation deposit, accommodation bond or entry contribution during the reporting year); and General Purpose Financial Statements (applicable to non-government approved providers of one or more residential care services).¹³⁹⁴ Home care providers are also required to submit a Home Care Income and Expenses Statement to the Department of Health annually.¹³⁹⁵

¹³⁹¹ *Fees and Payments Principles 2014* (No. 2) (Cth), s 43.

¹³⁹² Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3553 [8].

¹³⁹³ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3552 [7].

¹³⁹⁴ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3553–3554 [12].

¹³⁹⁵ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3554–3555 [13].

- b. The Department of Health collects this data and provides the results to the Prudential and Financial Analysis Section (PFAS), and to the PCS in the case of the APCS.¹³⁹⁶ First pass risk assessments of financial viability of all providers are conducted by the PFAS and communicated to the PCS.¹³⁹⁷
- c. Detailed risk assessments are conducted on providers categorised as ‘severe’ in the first pass risk assessment, and summary risk assessments can be conducted ad hoc as requested by other areas of the Department of Health and the Aged Care Quality and Safety Commission.¹³⁹⁸ The PCS receives the first pass risk assessments in February of the following year.¹³⁹⁹ Mr Nigel Murray (Assistant Secretary, Department of Health), acknowledged that this represents a delay, but said that the Department had recently been proactively seeking out high risk providers and obtaining more up to date information, as well as encouraging them to access assistance through the Business Advisory Service or the Business Improvement Fund.¹⁴⁰⁰
- d. Non-compliance with the Prudential Standards can be met with a range of actions: education, administrative compliance activities (including increased monitoring), regulatory compliance activities (including inspections and investigations), regulatory non-compliance actions (including revocation of approval and sanction), and court action (if a provider becomes insolvent and refundable accommodation deposits have been used for non-permitted purposes).¹⁴⁰¹

1356. There have been multiple reviews of the prudential regulatory function¹⁴⁰² and the Commonwealth accepts that the current, ‘prudential framework is not currently fit for purpose, that it requires fundamental reform to make sure that it can meet contemporary needs in the system’.¹⁴⁰³ The Commonwealth’s submissions in response to Sydney Hearing 5 indicate support for the need to strengthen the existing arrangements¹⁴⁰⁴ and

¹³⁹⁶ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3553–3554 [9]–[12].

¹³⁹⁷ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3555 [15].

¹³⁹⁸ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3555 [15].

¹³⁹⁹ Transcript, Janet Anderson, Sydney Hearing 5, 18 September 2020 at T9455.14–20.

¹⁴⁰⁰ Transcript, Nigel Murray, Sydney Hearing 5, 18 September 2020 at T9459.10–14, T9460.18–25.

¹⁴⁰¹ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3557 [21].

¹⁴⁰² See, for example, Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 51, CTH.9100.0001.0266 at 0270; tab 101, CTH.1038.0003.3302 at 3306; tab 103, CTH.1038.0003.3433.

¹⁴⁰³ Transcript, Jaye Smith, Sydney Hearing 5, 18 September 2020 at T9452.39–42.

¹⁴⁰⁴ Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0005 [16].

that the Commonwealth 'generally agrees with (or supports in principle) all of the prudential regulation propositions'.¹⁴⁰⁵

1357. In addition, the Tune Review also addressed prudential regulation, and recommended reform to the Prudential Standards and oversight, taking account of the recommendations of a review conducted by EY in 2017.¹⁴⁰⁶

1358. The 2018-19 Budget allocated \$8.6 million for the purposes of improving financial information collected from providers, strengthening the Prudential Standards, increasing transparency of providers' corporate structures, and improving the Commonwealth's prudential and financial reporting regulatory capability.¹⁴⁰⁷ This has involved:

- a. engaging StewartBrown to design amendments to the Aged Care Financial Report¹⁴⁰⁸
- b. commissioning Mr Gary Barnier, (Aged Care Financing Authority) to undertake a project to review its financial analysis processes and activities, which was expected to be finalised in the first half of 2020¹⁴⁰⁹
- c. embarking on a public consultation (the Prudential Standards Review) between 1 February 2019 and 15 March 2019 following the release of the Department of Health's *Managing Prudential Risk in Residential Care* discussion paper.¹⁴¹⁰

1359. As of Sydney Hearing 5 (September 2020), we are not aware of any decision concerning the implementation of any proposed changes.¹⁴¹¹

1360. In addition, the Earle Haven Inquiry made a number of recommendations in the field of prudential regulation;¹⁴¹² each of which is supported by the Commonwealth.¹⁴¹³ Recommendation 6 of the Earle Haven Inquiry called for a finalisation of prudential

¹⁴⁰⁵ Submissions of the Commonwealth of Australia, Sydney Hearing 5, 8 October 2020, RCD.0012.0079.0001 at 0011 [42].

¹⁴⁰⁶ Exhibit 1-35, Legislated Review of Aged Care 2017, RCD.9999.0011.0746 at 0867.

¹⁴⁰⁷ Commonwealth of Australia, *Budget Measures. Budget Paper No. 2 2018-19*, <https://archive.budget.gov.au/2018-19/bp2/bp2.pdf>, viewed 13 October 2020, p 118; Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3568–3569 [58]–[62].

¹⁴⁰⁸ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3570 [63g].

¹⁴⁰⁹ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3570 [63h].

¹⁴¹⁰ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3551–3552 [6], 3561 [35].

¹⁴¹¹ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3551–3552 [6]; Australian Government Department of Health, *Managing Prudential Risk in Residential Aged Care*, <https://consultations.health.gov.au/residential-and-flexi-aged-care-division/managing-prudential-risk-in-residential-aged-care/>, viewed 13 October 2020.

¹⁴¹² Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 4, RCD.9999.0266.0003 at 0008–0009.

¹⁴¹³ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 116, CTH.1038.003.3550 at 3572 [69]–[70].

reforms ‘as a matter of priority’.¹⁴¹⁴ While planning for prudential regulatory reform continues, the urgency of the reform has only increased with recent events.

1361. Mr Chris Mamarelis of the Whiddon Group criticised the current prudential system of being reactive rather than proactive, warning that ‘there is a house of cards, a \$30 billion house of cards that we are sitting on.’¹⁴¹⁵

1362. Mr Barnier’s report to the Department of Health dated 25 February 2020 demonstrated the urgency of the situation.¹⁴¹⁶ In that report he indicated that nearly a third of approved providers (i.e. some 229 in total, representing 37,000 operating places and \$5.3 billion in RADs) were either suffering or would soon suffer severe financial stress; which he defined as having an EBITDA of less than 4%.¹⁴¹⁷ Mr Barnier’s analysis was that 67 were experiencing immediate or imminent financial stress requiring close scrutiny with 46 requiring immediate interventions. He stated that identifying and working closely with high risk providers well before they fail is the best way to minimise resident and community disruption, but that the Government was not currently set up to do this task.¹⁴¹⁸

1363. All of this was known before the effects of the COVID-19 pandemic.

1364. As matters stand, and with the broader financial effects of the pandemic yet to fully play out, there has never been greater need for the prudential regulatory and financial oversight role in aged care to be recast and modernised.

Recommendation 100: Prudential regulation by the Australian Aged Care Commission

100.1. From 1 July 2023, the Australian Aged Care Commission should be given the statutory role as the prudential regulator for aged care with responsibility for ensuring that, under all reasonable circumstances, providers of aged care have the ongoing financial capacity to deliver high quality care and meet their obligations to repay accommodation lump sums as and when the need arises.

100.2. The Commission should also be given the statutory role of developing and implementing an effective financial reporting framework for the aged care sector that complements the purposes of the prudential standards.

¹⁴¹⁴ Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 4, RCD.9999.0266.0003 at 0008.

¹⁴¹⁵ Transcript, Sydney Hearing 5, Chris Mamarelis, 21 September 2020 at T9581.35–39.

¹⁴¹⁶ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 93, CTH.1000.0006.3499.

¹⁴¹⁷ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 93, CTH.1000.0006.3499 at 3506.

¹⁴¹⁸ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 93, CTH.1000.0006.3499 at 3501.

100.3. The Presiding Commissioner shall allocate the responsibilities associated with prudential oversight and the establishment of an effective financial reporting framework to an Assistant Commissioner.

1365. The prudential and financial reporting objectives of the Australian Aged Care Commission should be about providing proactive, effective, risk based and timely oversight of the financial sustainability of approved providers. That oversight should be for the purpose of ensure that providers:

- a. have the financial capacity to provide ongoing and high quality care to older people
- b. use RADs for permissible purposes
- c. are able to repay RADs as and when they fall due.

1366. It follows that the responsibilities of the Australian Aged Care Commission when it comes to prudential regulations and financial reporting should include establishing and enforcing:

- a. prudential standards and corresponding prudential guidelines that meet these objectives
- b. a financial reporting framework that involves the collection of financial information, primarily from providers, that is targeted at these objectives.

1367. Consistently with prudential regulation in other contexts, the Australian Aged Care Commission should seek to identify prudential risks proactively and take action to prevent harm before it occurs.

1368. The processes of the Australian Aged Care Commission will therefore necessitate:

- a. effective monitoring and analysis of information received under approved providers' continuous disclosure obligations
- b. continuous monitoring of the ongoing financial sustainability and performance of providers
- c. sharing of information with other parts of the aged care institutional framework, including the quality and safety regulatory function and complaints handling function
- d. the use of prudential and financial information to inform the evaluation of the risk profiles of providers
- e. selective interventions where required to manage financial risk in the system and safeguard the interests of people receiving aged care services

- f. agile use of enhanced information gathering powers, akin to those conferred on the Commissioner of Taxation¹⁴¹⁹
- g. oversight of financial and commercial arrangements that have the potential to affect continuity of care.

1369. Development of this framework will be critical during the period of reform and transition to the new aged care system: a period in which some approved providers will be unable to attain and maintain the required standards of care and should be assisted to an orderly exit from the sector and a sale of assets to better-performing providers. Financial risk monitoring and analysis will be a source of important intelligence for the quality and safety regulatory function to be most effective, efficient and responsive to risk. It will also be an important source of intelligence to inform the most appropriate performance of system management functions relating to the orderly exit of poorly performing providers and the maintenance of continuity of care and service coverage for older people.

Recommendation 101: Establishment of prudential standards

101.1. From 1 July 2023, the Australian Aged Care Commission should be empowered to make and enforce standards relating to prudential matters that must be complied with by approved providers.

101.2. In this context prudential matters are matters relating to:

- a. the conduct of the affairs of approved providers in such a way as to:
 - i. ensure that providers remain in a sound financial position, or
 - ii. ensure continuity of care in the aged care system, or
- b. the conduct of the affairs of approved providers with integrity, prudence and professional skill.

1370. In contexts other than aged care, prudential standards are independently set by the relevant prudential regulator rather than the Commonwealth.¹⁴²⁰ Although the Aged Care Quality and Safety Commissioner is designated as the regulator of the Prudential

¹⁴¹⁹ See *Taxation Administration Act 1953* (Cth) Schedule 1, ss 353-10, 353-15. The predecessor powers conferred on the Commissioner through the *Income Tax Assessment Act 1936* (Cth), ss 263, 264 have been interpreted broadly: e.g. in *Industrial Equity Ltd v Deputy Federal Commissioner of Taxation* (1996) 170 CLR 649, a majority of the High Court upheld the dismissal of a judicial review application against a random audit. The powers proposed for the prudential regulatory body would permit it to conduct random audits of compliance by providers with their prudential regulatory requirements.

¹⁴²⁰ See, for instance, *Private Health Insurance (Prudential Supervision) Act 2015* (Cth), s 92.

Standards, neither the Commission or the Commissioner has any ability to vary or amend the Prudential Standards; control rests with the Commonwealth and the Department of Health. This must change.

1371. A further fundamental criticism of the current Prudential Standards is that the Liquidity Standard enables providers to set their own liquidity management strategies.¹⁴²¹ In our view there should be clear and enforceable liquidity requirement to ensure that residential care providers are able to repay RADs promptly as and when required without jeopardising their financial viability.

1372. The Australian Aged Care Commission should have the power to set prudential standards for all approved providers. Those standards should encompass each of the elements of the current standards, ie liquidity, governance, record keeping and disclosure.

1373. The Australian Aged Care Commission, when exercising prudential functions should seek, in the first instance to work co-operatively with approved providers with a view towards identifying and rectifying problem before they threaten continuity of care or the ability of a provider to refund accommodation deposits as and when such obligations arise.

1374. In our proposed recommendations concerning system regulation we propose stronger for the Aged Care Quality and Safety Commission on an interim basis to conduct inquiries, enter and search premises without consent, compel the production of documents and compel people to give evidence. These new powers should carry over into the new Act and should extend to the enforcement of prudential standards and the other prudential functions of the Australian Aged Care Commission.

Recommendation 102: Liquidity requirements

102.1. From 1 July 2023, the Australian Aged Care Commission should be empowered under statute to impose liquidity requirements on approved providers of residential aged care which hold refundable accommodation deposits, for the purpose of ensuring that such providers are able to repay refundable accommodation deposits promptly as and when required without jeopardising their financial viability.

1375. An issue under consideration in the various reviews that have been carried out over the last 5 to 10 years is whether the existing Prudential Standards should be amended so

¹⁴²¹ *Fees and Payments Principles 2014 (No. 2), Part 5, Division 2, s 44.*

as to give effect to a specific liquidity ratio. In this respect the Commonwealth has proposed that that an approved provider must maintain a prescribed percentage of liquid assets, for example, 10% of the value of lump sum accommodation payments held.¹⁴²² This follows the EY recommendation that the Liquidity Standard be redefined, and identifying three options to achieve this:

- a. setting the liquidity threshold as a defined percentage of accommodation payment money held by an approved provider group
- b. phase in the defined threshold over a 5-10 year period; for example, require 5% within five years and 10% within 10 years
- c. define the form of liquidity as real liquid or accessible funds being a combination of unpledged cash in the bank, a bank facility or money that can otherwise be accessed immediately.¹⁴²³

1376. In its 2019 Implementation Options Review, Deloitte noted that there was 'room for improvement within the aged care legislation' in relation to liquidity management requirements.¹⁴²⁴ It proposed three options:

- a. tiered liquidity threshold requirements based on a standard and advanced approach
- b. defined acceptable forms of liquidity
- c. phased roll-out of liquidity requirements.¹⁴²⁵

1377. Whereas Deloitte had recommended a liquidity level of 35% of RADs, the StewartBrown Prudential Framework Review recommended a level of 15% of total debt.¹⁴²⁶ StewartBrown argued that, as many approved providers have a variety of operating segments, to consider only RADs in calculations of liquidity ratios may create a misleading picture of the approved provider's position; consequently, they recommended that liquidity be assessed against all debts at the provider level.¹⁴²⁷

1378. The Earle Haven Inquiry Report supported the introduction of specific liquidity requirements, and also recommended that approved providers be required to assess their liquidity and ability to continue as a going concern on a quarterly basis.¹⁴²⁸ Mr Nigel

¹⁴²² Australian Government Department of Health, *Managing Prudential Risk in Residential Aged Care Discussion Paper*, p 2.

¹⁴²³ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 51, CTH.9100.0001.0266 at 0284.

¹⁴²⁴ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 101, CTH.1038.0003.3302 at 3324.

¹⁴²⁵ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 101, CTH.1038.0003.3302 at 3326.

¹⁴²⁶ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 101, CTH.1038.0003.3302 at 3309;

Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 103, CTH.1038.0003.3433 at 3480.

¹⁴²⁷ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 103, CTH.1038.0003.3433 at 3458–3459.

¹⁴²⁸ Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 4, RCD.9999.026.0003 at 0009.

Murray told us that a specific liquidity requirement would assist the Department of Health to assess provider risk, and that the regulator should have discretion to alter this in certain circumstances.¹⁴²⁹

1379. Mr Grant Corderoy recommended that a liquidity level be set (at the provider level) at a minimum of 15%.¹⁴³⁰ Mr Corderoy further recommended that the Annual Prudential Compliance Statement be amended to include questions relating to provider liquidity levels.¹⁴³¹

1380. Mr Bernard Gastin (Victorian Registrar of Housing) told us that the Victorian Housing Registrar determines liquidity and capital adequacy requirements for individual agencies based on several factors, including financial ratios, funding streams and associated financial risks.¹⁴³²

1381. Ultimately, these are all matters that should be determined by the Australian Aged Care Commission as the prudential regulator of the sector.

1382. It follows that, without limiting the manner in which the Australian Aged Care Commission may impose liquidity requirements, the body may:

- a. require providers to obtain and submit annual certification by an independent auditor that the provider is able to meet its financial liabilities, including RADs, likely to become due and payable in the next 12 month period
- b. require providers to maintain a particular ratio of liquid assets to financial liabilities, including RADs, in excess of a specified ratio (liquidity threshold) and to notify the prudential regulatory body with a specified time if at any time that liquidity threshold is infringed.

1383. The Australian Aged Care Commission should be empowered to apply risk adjusted liquidity requirements to providers, pursuant to guiding statutory principles.

1384. The Australian Aged Care Commission should have flexibility in setting appropriate liquidity thresholds for different providers, based on criteria to be determined by the prudential regulatory body. The Commission should determine the liquidity thresholds and criteria on a basis that strikes a balance between the risk of providers defaulting on their obligations and the capital requirements of the providers' operations necessary for the provision of high quality aged care services. For example, the criteria may involve an assessment of:

¹⁴²⁹ Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9458.46–T9459.3, T9465.18–21.

¹⁴³⁰ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0027.

¹⁴³¹ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0028.

¹⁴³² Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 94, WIT.1344.0001.0001 at 0026 [134].

- a. the provider's financial risk, balance sheet strength and financial viability
- b. the nature of the provider's services (i.e. residential care only, or residential care combined with other services)
- c. the provider's business strategies and direction, including capital requirements
- d. the size of their financial liabilities, if any.

1385. Where liquidity thresholds are proposed, there will be a need for a transition pathway, which enables approved providers take the necessary action to meet a higher liquidity threshold without affecting the continuity of aged care services.

Recommendation 103: Capital adequacy requirements

103.1. From 1 July 2023, the Australian Aged Care Commission should be empowered under statute to impose capital adequacy requirements on approved providers for the purpose of ensuring that providers maintain adequate net assets above the liabilities they owe.

1386. Consistent with our submissions regarding liquidity adequacy requirements, we favour the Australian Aged Care Commission as the prudential regulator having complementary capital adequacy requirements to help ensure that in the event of insolvency of providers, RADs are repaid without recourse to the Aged Care Accommodation Payment Guarantee Scheme and associated industry levies.

1387. The Commonwealth has previously proposed a specific capital adequacy requirement involving maintenance of a prescribed percentage of net assets, for example, assets must exceed liabilities by an amount exceeding 20% of total assets.¹⁴³³

1388. In 2017, EY recommended the introduction of 20% capital adequacy metric based on a definition of capital that included tangible assets such as land and buildings, and intangible assets which are able to be valued, such as bed licenses.¹⁴³⁴

1389. In its 2019 Implementation Options Paper, Deloitte noted that capital adequacy management requirements are a way for government to mitigate the risk of an approved provider defaulting and to ensure RADs are refunded on time, and that there is room for improvement within the aged care legislation (as with liquidity requirements).¹⁴³⁵ It proposed three options:

¹⁴³³ Australian Department of Health, *Managing Prudential Risk in Residential Aged Care Discussion Paper*, p 2.

¹⁴³⁴ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 51, CTH.9100.0001.0266 at 0284.

¹⁴³⁵ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 101, CTH.1038.0003.3302 at 3324.

- a. tiered requirement for level of capital adequacy based on a standard and advanced approach
- b. some intangibles allowed to count toward capital adequacy ratio
- c. phased roll-out of capital adequacy requirements.¹⁴³⁶

1390. Mr Peter Kohlhagen (Australian Prudential Regulation Authority) highlighted the need for capital adequacy requirements to reflect the risks of a particular organisation: as risks of potential future stressors differ between organisations, the capital required to deal with those stressors varies.¹⁴³⁷

1391. In contrast, Stewart Brown did not recommend a minimum capital adequacy requirement, but rather that capital adequacy be examined in the context of determining viability risk.¹⁴³⁸

1392. The question of capital adequacy should be a matter for the Australian Aged Care Commission in its capacity as the prudential regulator.

1393. Consistently with our submissions about liquidity, the Australian Aged Care Commission should have the ability to impose capital adequacy requirements require providers to maintain a particular ratio of net assets to liabilities in excess of a specified ratio (capital adequacy threshold), and to notify the Commission within a specified time if at any time that capital adequacy threshold is infringed.

1394. Any proposal to introduce capital adequacy thresholds as part of the new prudential standards will necessitate a transition pathway that has regard to the fact that approved providers with low current net capital to liability ratios have adequate time to prepare for the adherence to higher capital adequacy thresholds without affecting their ability to ensure continuity of aged care services.

Recommendation 104: More stringent financial reporting requirements

104.1. From 1 July 2023, the Australian Aged Care Commission should be empowered under statute to require approved providers to submit regular financial reports.

104.2. The frequency and form of the reports should be prescribed by the Commission.

¹⁴³⁶ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 101, CTH.1038.0003.3302 at 3326.

¹⁴³⁷ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 86, WIT.0749.0001.0001 at 0018 [68]–[69].

¹⁴³⁸ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 103, CTH.1038.0003.3433 at 3485.

1395. The Australian Aged Care Commission will need timely access to information that is relevant to exercising financial risk oversight functions in relation to the sector.

1396. Without limiting the powers of the Australian Aged Care Commission to determine the manner and form of the regulatory financial reporting regime, the body may decide:

- a. to require approved providers, or certain classes of approved providers, to submit special purpose financial statements
- b. to specify the required content of special purpose financial reports
- c. to determine the frequency of reporting based on historical prudential compliance
- d. a change in circumstances that may give rise to heightened prudential risk
- e. to specify the frequency of reporting for all providers, or for particular classes of providers
- f. to publish the financial reports received from providers.

1397. The required content of the financial reports should be specified by the Australian Aged Care Commission to achieve the following purposes:

- a. improve transparency of approved providers' businesses and how they use accommodation payments
- b. improve understanding of the financial sustainability of approved providers and assist the regulator to identify and monitor providers potentially at risk of financial failure or non-permitted use of accommodation payment balances.

1398. Guided by these purposes, the Australian Aged Care Commission may, in determining the required content of the special purpose financial statements, be informed by such accounting standards as it deems fit.

1399. The Australian Aged Care Commission should consult with the aged care sector prior to making any determination as to the content of aged care specific financial reports.

1400. Part 8 of the *Aged Care Quality and Safety Commission Act 2018* (Cth) permits, in a range of circumstances, authorised officers of the Aged Care Quality and Safety Commission to enter any premises, exercise a range powers of search and ask questions of persons at the premises.¹⁴³⁹ Before exercising any of these powers, the relevant officer is required to inform the provider of their 'responsibility' under para 63-1(1)(b) of the *Aged Care Act 1997* to 'co-operate with a person who is performing functions' under the Act, however despite this, the occupier of the premises can simply refuse to consent to entry of the premise and any person to whom questions are directed

¹⁴³⁹ See *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 64A (applications for approval as an aged care provider), 65 (complaints), 68 (exercising regulatory powers).

can simply refuse to answer. We do not regard such a situation as consistent with best practice regulatory oversight.

1401. The Australian Aged Care Commission should be empowered to require the information or evidence to be given orally or in writing, and on oath or affirmation. For that purpose the Commission or authorised individual should be empowered to administer oaths and affirmations.

1402. Further, the relevant legislation should provide that the Australian Aged Care Commission or an individual authorised by the Commission should be entitled:

- a. at all reasonable times to enter and remain on any land, premises or place
- b. to full and free access at all reasonable times to any documents, goods or other property
- c. to inspect, examine, make copies of, or take extracts from, any documents.

1403. An individual authorised by the Australian Aged Care Commission for the purposes of this section should not be entitled to enter or remain on any land, premises or place if, after having been requested by the occupier to produce proof of his or her authority, the individual does not produce an authority signed on behalf of the Commission stating that the individual is authorised to exercise powers under the above provisions.

1404. Ms Janet Anderson supported this proposition, subject to the judicious use of proposed powers, to which Mr Smith agreed.¹⁴⁴⁰

Recommendation 105: Continuous disclosure requirements in relation to prudential reporting

105.1. From 1 July 2023, approved providers should be required under statute to comply with continuous disclosure requirements, under which an approved provider that becomes aware of material information that:

- a. affects the provider's ability to pay its debts as and when they become due and payable, or
- b. affects the ability of the provider or any contractor providing services on its behalf to continue to provide aged care that is safe and of high quality to individuals to whom it is currently contracted or otherwise engaged to provide aged care

must immediately disclose the information to the Commission.

¹⁴⁴⁰ Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9464.22–23; Jaye Smith, 18 September 2020 at T9464.27–32.

105.2. The Australian Aged Care Commission should have the power to designate events, facts or circumstances that should give rise to continuous disclosure obligations.

1405. Prudential and financial risks occur in real time. This means that information relevant to these risks needs to be identified by the regulator in real time as well. Without such information, the regulator cannot effectively respond to risks as and when they occur.

1406. Assessment of risk carried out purely on the basis of the various financial and prudential reports that are due for lodgement on 31 October each year is not likely to enable a timely response or intervention.

1407. More regular reporting, for example on a monthly or quarterly basis would provide the regulator with relevant information that could identify risks more promptly and before they pose a risk to the continuity of care to people receiving aged care services.

1408. The balance is to be found in establishing a continuous disclosure triggered by significant events that provide a reliable indicator of impending risk.

1409. At the Sydney 5 hearing, some time was devoted to the issue of what might constitute an appropriate early warning sign that the regulator should know about in order that remedial action could be taken.¹⁴⁴¹ The issues identified follow on from the *Managing Prudential Risk in Residential Care* discussion paper, in which the Australian Department of Health proposed reform whereby approved providers would be required to inform the Secretary of concerns relating to viability.

[option 4] Enhancing information and disclosure requirements to the Department where 'significant events' occur, such as major changes in corporate structure or ownership, significant related party transactions and where a provider is at imminent risk of no longer being able to continue operations.¹⁴⁴²

1410. This was echoed in the Earle Haven Inquiry report, which recommended clarification of section 9-1 of the *Aged Care Act 1997*, that the requirement to advise aged care regulators of material changes would apply to any identified issues about an approved providers' ability to continue as a going concern.¹⁴⁴³

1411. In our view, although events of this kind appear to be warranted, they are not likely to provide sufficient early warning and may themselves be too late to enable an appropriate

¹⁴⁴¹ See, for example: Transcript, Sydney Hearing 5, John McCarthy, 21 September 2020 at T9501.18-24. See also: Transcript, Sydney Hearing 5, Thea Hordern, 21 September 2020 at T9502.42-45; Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9540.22.

¹⁴⁴² Australian Department of Health, *Managing Prudential Risk in Residential Aged Care Discussion Paper*, p 3.

¹⁴⁴³ Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 4, RCD.9999.0266.0003 at 0008.

regulatory response. Put another way, a trigger based on insolvency is likely to be too late in identifying risk given the consequences of that fact under existing legislation.

1412. Another possible trigger that might be applied is a material deterioration in performance against budget. The problem with a trigger of this kind is that it would require regulation of the budgetary processes of providers; a matter that would likely add a layer of regulatory burden that is not necessary.

1413. In its 2019 Implementation Options Review, Deloitte noted that there were no requirements for approved providers to self-report risks to viability or prudential obligations; consequently, the report put forward an option for providers to report financial viability concerns.¹⁴⁴⁴ The Deloitte option involved quarterly reporting that required providers to attest as to whether or not they have financial viability concerns, and to report significant risk events within 28 days of the event.¹⁴⁴⁵ We do not favour such a response, given that quarterly reporting is likely to create a higher regulatory burden than is necessary in the circumstances.

1414. In its Prudential Framework Review, StewartBrown supported continuous disclosure on a risk-based exception basis, rather than required of all providers as proposed by Deloitte.¹⁴⁴⁶ StewartBrown proposed a continuous disclosure requirement for any provider that 'is deemed to be high risk, has breached certain rules, can foresee a breach of rules or is requested to do so by the Department'.¹⁴⁴⁷

1415. The Department of Health and the Aged Care Quality and Safety Commission supported continuous disclosure, this support being subject to a clear definition of what information is considered material.¹⁴⁴⁸

1416. Mr Grant Corderoy recommended that providers be required to report **certain matters** to the Department of Health within 14 days; these included moving below minimum liquidity levels or into a negative capital adequacy ratio position, as well as material adverse change in financial position and breaches of permitted use rules.¹⁴⁴⁹ This reflects the requirements of the Victorian Housing Registrar, in which registered agencies must notify the Registrar as soon as possible about reportable events, of which financial examples are significant new funding, liquidity issues, breaches of loan covenants, changes in borrowings and new loans, and major investment strategy changes.¹⁴⁵⁰

¹⁴⁴⁴ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 101, CTH.1038.0003.3302 at 3339.

¹⁴⁴⁵ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 101, CTH.1038.0003.3302 at 3340.

¹⁴⁴⁶ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 103, CTH.1038.0003.3433 at 3491.

¹⁴⁴⁷ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 103, CTH.1038.0003.3433 at 3528.

¹⁴⁴⁸ Transcript, Sydney Hearing 5, Nigel Murray, 18 September 2020 at T9459.26–28; Jaye Smith, 18 September 2020 at T9462.31–35; Janet Anderson, T9463.8–13.

¹⁴⁴⁹ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0029.

¹⁴⁵⁰ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 94, WIT.1344.0001.0001 at 0011 [59]–[61].

1417. The Australian Aged Care Commission should be empowered to provide guidance as to the circumstances in which continuous obligations will be engaged. For example, and without limitation, the Commission may provide guidance about the relevance and materiality of changes in key financial metrics such as occupancy, liquidity, capital adequacy and performance against budget.

1418. A failure to comply with the continuous disclosure obligation should be an offence. It may be the subject of an application by the Australian Aged Care Commission to a court of competent jurisdiction for a civil penalty.

1419. A person involved in a contravention should be subject to accessorial liability. A person involved in the contravention should not be liable if the person proves that they took all steps (if any) that were reasonable in the circumstances to ensure that the approved provider complied with its continuous disclosure obligations, and that after doing so the person believed on reasonable grounds that the provider was complying.

Recommendation 106: Tools for enforcing the prudential standards and guidelines and financial reporting obligations of providers

106.1. From 1 July 2023, the Australian Aged Care Commission should have the power to impose a range of regulatory responses where there has been a breach of the new prudential standards or the financial reporting requirements, including a failure to comply with the continuous disclosure requirements.

106.2. Such responses should include:

- a. the power to give directions to a provider that mirror those that can be made by the Australian Prudential Regulatory Authority pursuant to the *Private Health Insurance (Prudential Supervision) Act 2015 (Cth)*
- b. the power to impose civil and administrative penalties in respect of any breach
- c. the ability to accept enforceable undertakings
- d. the ability to impose sanctions to limit the ability of the provider to expand its services, revoke accreditation for a service, or revoke approved provider status.

1420. Good prudential and financial regulation should be agile and responsive. The regulator should have a cascading range of powers enabling it to take proportionate corrective

action promptly.¹⁴⁵¹ The tools should also include consequences in terms of the prudential risk profile of the approved provider, with the result that the provider will be subject to increased regulatory scrutiny. Those powers should include the ability to issue infringement notices and civil penalties.

1421. Going back to the 2017 EY Report, it proposed consequences for approved providers who do not comply with the proposed liquidity and capital adequacy requirements, such as:

- a. restricting their ability to charge new accommodation payments; or
- b. requiring them to provide additional security until they comply with those thresholds.¹⁴⁵²

1422. The Australian Department of Health and the Aged Care Quality and Safety Commission have given support to this recommendation.¹⁴⁵³

1423. A broad range of enforcement options and tools are needed to support, encourage and foster prudential regulatory compliance.

1424. The ability to limit the ability of providers in default of prudential standards from charging new accommodation payments is supported: mirroring as it does the sanctions that are currently imposed for breaches of the standards, i.e. the ability to prevent the admission of new residents. Similarly the ability to require security in appropriate circumstances would seem to enable a measured and appropriate regulatory response.

1425. In this respect we have already indicated that in our view that the information gathering powers of the existing Aged Care Quality and Safety Commission are inadequate across a number of domains, including prudential regulation. The Commonwealth would seem to agree that the regulator needs an increased capability to seek information from providers and investigate issues relating to the prudential financial management of providers.¹⁴⁵⁴

1426. Following the 2009 Australian National Audit Office *Protection of Residential Aged Care Accommodation Bonds* report and a consultation with the sector in 2010–11, criminal penalties were introduced for misuse of lump sum payments.¹⁴⁵⁵ Given the importance

¹⁴⁵¹ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 94, WIT.1344.0001.0001 at 0028 [147].

¹⁴⁵² Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 51, CTH.9100.0001.0266 at 0270.

¹⁴⁵³ Transcript, Sydney Hearing 5, Jaye Smith, 18 September at T9467.12–15; Janet Anderson, 18 September 2020 at T9467.19–27.

¹⁴⁵⁴ Australian Department of Health, *Managing Prudential Risk in Residential Aged Care Discussion Paper*, p 3.

¹⁴⁵⁵ Exhibit 1-35, Legislated Review of Aged Care 2017, RCD.9999.0011.0746 at 0865. See also *Aged Care Act 1997* (Cth), s 52N-2(1) which provides that an offence occurs punishable by a fine of 300 penalty units where a provider uses a refundable deposit or accommodation bond in a way that is not permitted, within 2 years of an insolvency event and there has been at least one

to the those in receipt of care and the sector as a whole of securing funds paid as accommodation lump sums, it is hardly surprising that the legislature has taken the view that criminal law should be deployed to ensure prudential compliance in this way.

1427. As a matter of principle, the Australian Aged Care Commission should, at least in the first instance, be able increase regulatory scrutiny or impose additional reporting requirements where there is a reasonable basis to do. The triggers for such action should include, identification, on reasonable grounds, of the likelihood of the approved provider being in breach of the proposed new prudential standards or the financial reporting requirements or a past history of breach. The power to intervene should be expressed in precautionary terms; i.e. recognising the need, in appropriate circumstances to take action to ensure continuity of care.

1428. In addition, the Australian Aged Care Commission should have the power to give directions to a provider that mirror those that can be made by the Australian Prudential Regulatory Authority by the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth). Section 96 enables APRA to give a direction in where it reasonably believes that one of a number of circumstances has arisen, including, for relevant purposes, there has been a contravention of an enforceable obligation, there is a likelihood of a contravention that is likely to give rise to a prudential risk.

1429. Adapting the language of section 96 to the circumstances of aged care, further triggers should extend to situations where:

- a. the direction is necessary in the interests of residents, or prospective residents, of an approved provider
- b. a provider is, or is about to become, unable to meet its liabilities
- c. there is, or there might be, a material risk to the security of the provider's assets
- d. there has been, or there might be, a material deterioration in the provider's financial condition
- e. the provider is conducting its affairs in an improper or financially unsound way
- f. the failure to issue a direction would materially prejudice the interests of residents or prospective residents of the provider.

outstanding accommodation balance for the provider. An individual who is one of the key personnel of a provider and in a position to influence yet failed to prevent the conduct of a provider that breaches ss 52N-2(2) and who knew, or was reckless or negligent as to whether the deposit would be used in a such a way commits an offence punishable by imprisonment for 2 years.

1430. The scope of the power to give directions should be broad, mirroring, for example see section 97(1) of the *Private Health Insurance (Prudential Supervision) Act 2015* and should include such matters as:

- a. ordering an actuarial investigation or audit of the affairs of the approved provider, at the expense of the providers, by an actuary or auditor chosen by the Australian Aged Care Commission
- b. not borrowing a particular amount or capping the level of borrowings
- c. not repaying any amount paid on shares
- d. not paying a dividend on any shares
- e. not transferring any asset
- f. not paying or transferring any amount to any person, or creating an obligation (contingent or otherwise) to do so
- g. not undertaking any financial obligation (contingent or otherwise) on behalf of any other person
- h. holding a specified amount of capital
- i. taking specified action to ensure that the providers will be able to meet the liabilities of the business conducted by the provider out of the assets of the business as and when they fall due
- j. taking specified action to ensure that the assets of the provider will provide adequate capital for the conduct of the business of the provider in accordance with the relevant legislation and in the interests of the people who receive aged care services.

1431. The Australian Aged Care Commission should be free to accept enforceable undertakings as an alternative to civil or administrative action in the case of a contravention of the proposed new prudential standards or the financial reporting requirements. The Commission should also be able to publish guidelines about the circumstances in which such undertakings may be accepted, including the form of the undertaking. A failure to comply with undertaking should result in enforcement action in a court of competent jurisdiction.

1432. Where the nature of the breach is such that undertakings are not an appropriate regulatory response, the Australian Aged Care Commission should also have the power to apply to a court of competent jurisdiction for penalties for contravention of provisions that are integral to the prudential regulatory regime.

1433. Finally, the Australian Aged Care Commission should have the flexibility to impose of sanctions to limit the ability of the provider to expand its services, the revocation of accreditation for a facility, or the revocation of approved provider status/license to operate.

1434. Critically, the Australian Aged Care Commission's prudential regulatory functions should operate seamlessly and in tandem with all of its other regulatory functions.

Recommendation 107: Building the capability of the regulator

107.1. In establishing the Australian Aged Care Commission, the Australian Government should ensure that its prudential capability in relation to the aged care sector includes the following:

- a. an effective program to recruit and retain senior forensic accountants and specialists with prudential regulatory experience, and sufficient numbers of supporting employees who have either accounting qualifications or other financial skills
- b. systems and processes to capture, collate, analyse and share regulatory intelligence from internal and external sources to build a risk profile of approved providers
- c. a system and processes to monitor indicators of risk revealed by providers' financial reporting tailored to the aged care sector and to respond to them in a timely manner
- d. an electronic forms and lodgement platform for the use of all large operators, with an optional alternate electronic filing system available for smaller operators
- e. appropriate resourcing of the above system and processes, including design expertise, Information Communications Technology requirements, technical support, and recruitment and training of sufficient numbers of appropriately skilled staff.

1435. The prudential capacity of the Australian Aged Care Commission needs to be adequately resourced to carry out its functions, and those resources include well-trained staff with specialised skills, and processes and systems to allow these staff to meaningfully build a picture of prudential and financial risk within the sector. For some time now the Commonwealth has been on notice of the need for enhancement of this capacity.

1436. In 2009, the Australian National Audit Office report made several recommendations to strengthen the capability of the then Australian Department of Health and Ageing as a prudential regulator, including:

- a. a structured and systematic risk management methodology
- b. an integrated and balanced set of performance measures and targets for key regulatory activities
- c. policy and procedural documentation for key aspects of its prudential regulation
- d. a process or system to capture, collate and share regulatory intelligence from internal and external sources to build a risk profile of regulated entities.¹⁴⁵⁶

1437. The 2017 EY Review recommended that the Australian Department of Health recalibrate its risk assessment methodology and model to reflect the proposed compliance requirements.¹⁴⁵⁷ The review also recommended strengthening of the tools, resources and capabilities of the prudential regulatory part of the Department through:

- a. enhanced data collection and analysis in light of the proposed revisions to the Prudential Standards
- b. increased resources and more sophisticated tools to conduct compliance activities.¹⁴⁵⁸

1438. More recently, the need for capacity building of the necessary specialist expertise has been emphasized. As well as being a matter of general concern across the Australian Public Service, the need for capacity building of specialist expertise has been specifically recommended in relation to prudential and financial risk analysis in the aged care context.¹⁴⁵⁹ The Earle Haven Inquiry recommended that steps be taken to ensure that aged care regulators have the capacity to understand risks to quality of care that might arise from an approved provider's financial or contractual arrangements, including by:

'increasing the capacity of aged care regulators to effectively scrutinise financial information' and

'provid(ing) the Quality and Safety Commission with the capacity to include people with expertise in contracts and accounting in the team undertaking assessment contacts where there is an indication that there are risks associated with the approved providers' financial or contractual arrangements.'¹⁴⁶⁰

¹⁴⁵⁶ Australian National Audit Office, *Protection of Residential Aged Care Accommodation Bonds*, Audit Report No.5 2009–10, https://www.anao.gov.au/sites/default/files/ANAO_Report_2009-2010_5.pdf, viewed 13 October 2020, pp 26–27.

¹⁴⁵⁷ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 51, CTH.9100.0001.0266 at 0286.

¹⁴⁵⁸ Exhibit 21-1, Sydney Hearing 5, General Tender Bundle, tab 51, CTH.9100.0001.0266 at 0287.

¹⁴⁵⁹ Australian Department of the Prime Minister and Cabinet, *Independent Review of the Australian Public Service. Our Public Service, Our Future*, 2019, <https://pmc.gov.au/sites/default/files/publications/independent-review-aps.pdf>, viewed 13 October 2020, pp 183–187.

¹⁴⁶⁰ Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 4, RCD.9999.0266.0003 at 0008.

1439. Mr Callaghan emphasised the need for a specialised skill set for staff of a prudential regulator.¹⁴⁶¹ In Sydney Hearing 5 he told us that:

in terms of ensuring that we have the capacity, that we have the resources, we have the skill mix to be able to do this job of being a proactive prudential regulator, that is something that's required now, it's not something that we're going into the future in terms of establishing a new prudential authority some time in the future, we need those now.¹⁴⁶²

1440. Mr Grant Corderoy criticized the level of specialist financial and analytical resources currently available within the Department of Health to adequately deal with information from providers.¹⁴⁶³ He was also critical of a lack of clarity within the Department of Health as to responsibilities for oversight and assessment, as well as overlapping of responsibilities between the Department and the Aged Care Quality and Safety Commission.¹⁴⁶⁴

1441. Ms Janet Anderson, told us that the Commission's prudential regulation staff are 'highly competent, but there aren't enough of them'.¹⁴⁶⁵

1442. Mr Jaye Smith supported the proposed recommendation and added that the Department of Health is already focussed on increasing capacity and ensuring the right skill mix.¹⁴⁶⁶

Recommendation 108: Requirement to report on outsourcing of care management

108.1. From 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require that aged care providers approved to provide residential care or personal care services at home notify the Australian Aged Care Commission of any proposed sub-contracting of general management of care before the arrangement takes effect.

1443. The absence of regulation to govern the circumstances in which approved providers are able to sub-contracting care management was brought into sharp relief by the events at Earle Haven.

1444. The Earle Haven Inquiry concluded that the prudential requirements in aged care legislation were not geared to uncover sub-contracting arrangements or other non-

¹⁴⁶¹ Exhibit 21-10, Sydney Hearing 5, Statement of Mike Callaghan, WIT.0748.0001.0001 at 0024 [65].

¹⁴⁶² Transcript, Sydney Hearing 5, Mike Callaghan, 17 September 2020 at T9335.34–38.

¹⁴⁶³ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0025.

¹⁴⁶⁴ Exhibit 21-2, Sydney Hearing 5, Statement of Grant Corderoy, RCD.9999.0320.0001 at 0025.

¹⁴⁶⁵ Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9453.32–33.

¹⁴⁶⁶ Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9469.22–31.

financial risks related to an approved provider's commercial arrangements.¹⁴⁶⁷ Indicating a clear gap in regulatory oversight, the report stated that:

The suggestion that an approved provider would sub-contract the management of its aged care facility to an organisation with little or no aged care experience should have been flagged as something warranting further attention. There is, however, no evidence that an assessment of the suitability of Help Street to deliver aged care services to residents of Hibiscus House and Orchid House was ever undertaken.¹⁴⁶⁸

1445. The Earle Haven Inquiry made several relevant recommendations, including that care management can only be outsourced to an approved provider, the requirement for providers to notify regulators in advance of subcontracting of care or sale, and the power for the Secretary of the Department of Health to consider whether proposed arrangements are in the best interests of people receiving aged care services and to potentially veto the arrangements.¹⁴⁶⁹

1446. Mr Jaye Smith told us that while there had been changes made to the material changes notification form, other current reforms require legislative change that is in its planning stage.¹⁴⁷⁰ Ms Janet Anderson acknowledged the value of considering contracting arrangements in determining risk.¹⁴⁷¹

1447. Mr Ian Thorley (Estia Health) agreed with the proposed recommendation but added that an outsourcing contractor should also be an approved provider.¹⁴⁷²

1448. If an approved provider appoints a sub-contractor to manage the provision of care on its behalf, the following provisions should apply under statute:

- a. before the appointment, the approved provider must inform the proposed sub-contractor of the effect of these proposed provisions
- b. the continuous disclosure obligations apply to the sub-contractor as if the subcontractor were the approved provider
- c. further, the approved provider remains bound by the continuous disclosure provisions in relation to the aged care provided by the sub-contractor on its behalf.

¹⁴⁶⁷ Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 4, RCD.9999.0266.0003 at 0048.

¹⁴⁶⁸ Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 4, RCD.9999.0266.0003 at 0050.

¹⁴⁶⁹ Exhibit 13-1, Hobart Hearing, General Tender Bundle, tab 4, RCD.9999.0266.0003 at 0009.

¹⁴⁷⁰ Transcript, Sydney Hearing 5, Jaye Smith, 18 September 2020 at T9468.4–9.

¹⁴⁷¹ Transcript, Sydney Hearing 5, Janet Anderson, 18 September 2020 at T9468.36–37.

¹⁴⁷² Transcript, Sydney Hearing 5, Ian Thorley, 21 September 2020 at T9539.32–36.

Part 3.17 Effective regulation

Introduction

1449. Effective regulation is essential to the delivery of high quality and safe care to older Australians.

1450. Aged care quality and safety regulation has been marked by frequent review and piecemeal reform and change for at least a decade. In 2011, the Productivity Commission in its *Caring for Older Australians* report recommended a significant restructuring of quality and safety regulatory functions.¹⁴⁷³

1451. In 2017, following significant failures in the quality of care provided at Oakden Older Persons Mental Health Service, aged care regulation was examined in detail by Ms Kate Carnell AO and Professor Ron Paterson ONZM.¹⁴⁷⁴ Recommendations made in their report to improve aged care regulation have been implemented in a slow and haphazard way. Almost three years after the report was handed down, key aspects of the recommendations remain to be implemented.¹⁴⁷⁵

1452. Current regulation of the quality of aged care remains inadequate. As Professor Paterson stated, 'the regulation of aged care in Australia has paid lip-service to the welfare of care recipients. The system fails to ensure the provision of safe, high quality care and pays insufficient attention to the quality of life of aged care users'.¹⁴⁷⁶

1453. If the systemic failures of Australia's aged care system are to be addressed, a meaningful shift in the system, and culture, of aged care regulation is required.

1454. The people in the centre of the system, including the aged care workforce, people receiving care and their friends and families must be listened to. The quality regulator must proactively identify, understand and require rectification of deficiencies in the quality and safety of care. Where issues with provider performance are identified, the quality regulator needs to be equipped with the resources and powers to respond in a manner proportionate to the failing at hand. For regulation to act as a genuine deterrent, there must be the likelihood of the imposition of strong sanctions where standards are not met.

¹⁴⁷³ Exhibit 1-31, Adelaide Hearing 1, Productivity Commission Inquiry Report - Caring for Older Australians (Overview), RCD.9999.0011.0943; Exhibit 1-32, Adelaide Hearing 1, Productivity Commission Inquiry Report - Caring for Older Australians (Volume 1), RCD.9999.0011.1031; Exhibit 1-33, Adelaide Hearing 1, Productivity Commission Inquiry Report - Caring for Older Australians (Volume 2), RCD.9999.0011.1261.

¹⁴⁷⁴ Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833.

¹⁴⁷⁵ See Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0004 [31]; Exhibit 17-1, Melbourne Hearing 4, general tender bundle, tab 29, CTH.1000.0004.0739 at 0763; Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1718, 1722.

¹⁴⁷⁶ Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, RCD.9999.0143.0001 at 0002 [14].

The prospect of genuine accountability of providers for any failure to meet such standards is vital.¹⁴⁷⁷

Consequences for a breach of the general duty

1455. In Recommendation 22, we submit that a general duty to provide high quality and safe care should be imposed on providers. Where this duty is not met, both the Australian Aged Care Commission and the people harmed by the conduct should have an ability to hold relevant providers and their key personnel accountable.

Recommendation 109: Civil penalty for certain contraventions of the general duty

109.1. The new Act should provide that:

- a. on application by the Australian Aged Care Commission to a court of competent jurisdiction, the following is a contravention of the Act attracting a civil penalty:
 - i. a breach by an approved provider of the general duty to provide high quality and safe aged care so far as reasonable (see 'Recommendation 22), and
 - ii. where the breach gives rise to harm, or the risk of harm, to a person whom the provider is providing care or engaged under a contract or understanding to provide care; and
 - iii. where a failure to provide 'high quality' care is taken to occur if and only if the approved provider has failed to comply with one or more of the Aged Care Quality Standards
- b. the contravention attracts a civil penalty, and attracts accessorial liability for directors, key personnel and any other person who:
 - i. aids, abets, counsels or procures the approved provider to commit the contravention
 - ii. induces the approved provider to commit the contravention
 - iii. is in any way, directly or indirectly, knowingly concerned in, or party to, the contravention by the approved provider(who should be defined as a person 'involved in the contravention').

¹⁴⁷⁷ See Exhibit 5-7, Perth Hearing, general tender bundle, tab 67, AWF.001.00519_0001 at 0002.

1456. The evidence highlights a pressing need for both providers and their key personnel to be held accountable where there is a contravention of aged care legislation, particularly where that results in harm to an older person.

1457. At present, the civil penalty provisions that may be imposed under the *Aged Care Act 1997* do not relate to the quality and safety of care provided. They are also all targeted at approved providers and not their directors, key personnel or other people involved. Deterrence is more likely to be effective if a wider range of decision-makers can be held accountable for contravention of standards.

1458. In 2018, the South Australian Coroner handed down findings in the matter of the death of Dorothy Baum, a resident of an aged care facility who was living with dementia and who died after being physically attacked by another resident.¹⁴⁷⁸ The Coroner concluded that there ‘had been a gross dereliction of proper management on the night in question’, that Ms Baum would have been helpless in her bed and unable to escape, and that she lay for at least two hours bleeding in her bed before she was attended to.¹⁴⁷⁹ The Coroner expressed concern that the aged care framework did not ‘produce an outcome commensurate with the seriousness of the events that had occurred’, and concluded:

I do not propose to recommend any particular change to the Scheme but I do intend to refer this finding to the Commonwealth Minister for Aged Care and the South Australian Minister for Health and Wellbeing to note my concern that the senior management and the governing bodies of aged care providers should be subjected to a system of personal accountability when standards of care are not met. Only by adopting a scheme in which there is some personal risk to those involved in the management of aged care providers at the highest level could the public be confident that an event such as the appalling treatment of Mrs Baum in life and then in death could not happen again.¹⁴⁸⁰

1459. The Aged Care Quality and Safety Commission Advisory Panel, in a 2019 options paper, supported the imposition of legislated financial penalties on directors or key personnel in appropriate circumstances where an approved provider is not operating to the expected standards.¹⁴⁸¹

¹⁴⁷⁸ Courts Administration Authority of South Australia, *Inquest in to the death of Dorothy Mavis Baum - Finding of Inquest 17 May 2018*, <http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/763/Baum%20Dorothy%20Mavis.pdf>, viewed 21 October 2020.

¹⁴⁷⁹ Courts Administration Authority of South Australia, *Inquest in to the death of Dorothy Mavis Baum - Finding of Inquest 17 May 2018*, <http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/763/Baum%20Dorothy%20Mavis.pdf>, viewed 21 October 2020, 11.1.

¹⁴⁸⁰ Courts Administration Authority of South Australia, *Inquest in to the death of Dorothy Mavis Baum - Finding of Inquest 17 May 2018*, <http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/763/Baum%20Dorothy%20Mavis.pdf>, viewed 21 October 2020, 10.13, 11.4.

¹⁴⁸¹ Aged Care Quality and Safety Commission, *An options paper on the regulatory powers of the Aged Care Quality and Safety Commission: Advice from the Aged Care Quality and Safety Advisory Council*, <https://www.agedcarequality.gov.au/sites/default/files/media/Options%20Paper%20->

1460. Evidence by officers of the Australian Department of Health also supports the introduction of sanctions aimed at directors or others involved in the management of approved providers.¹⁴⁸² One such officer said that such options would be ‘amazing’, citing concern about a lack of understanding by directors of approved providers’ responsibilities under the *Aged Care Act 1997* as an impediment to returning a service to compliance.¹⁴⁸³
1461. Implementation of this recommendation would empower the Australian Aged Care Commission to initiate proceedings against an approved providers and, in circumstances that attract the operation of the statutory accessorial liability provision we propose, on one or more of its directors, key personnel or other people involved.
1462. As identified in Part 3.4 above similar duties can be found in work health and safety legislation, and environmental protection legislation.¹⁴⁸⁴ In the work health and safety context, since the introduction of general duty provisions, the compliance and enforcement activity of workplace safety regulators has largely focussed on these provisions.¹⁴⁸⁵

Recommendation 110: Private right of compensation for certain contraventions of the general duty

110.1. The new Act should provide:

- a. that an order may be made on the application of the Australian Aged Care Commission to a court of competent jurisdiction that an approved provider that has contravened the civil penalty provision (referred to in Recommendation 109), or a person involved in the contravention, pay damages for any loss and damage suffered by a person as a result of the contravention, and
- b. for a private right of action for damages in a court of competent jurisdiction by or on behalf of a person who has suffered loss and damage as a result of any such contravention, in which proceeding any findings or admissions of the contravention in another

%20Regulatory%20Powers%20of%20the%20ACQSC%20-%20Final%20201219.pdf viewed 21 October 2020, p 12.

¹⁴⁸² Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4423.12–35; Transcript, Amy Laffan, Brisbane Hearing, 8 August 2019 at T4668.19–30.

¹⁴⁸³ Transcript, Brisbane Hearing, Elsy Brammesan, 6 August 2019 at T4423.12–35.

¹⁴⁸⁴ See for example s 19 of the *Work Health and Safety Act 2011* (NSW), s 32 of the *Gas Safety Act 1997* (Vic), and s 25 of the *Environment Protection Act 2017* (Vic).

¹⁴⁸⁵ See Johnstone, Bluff and Clayton, *Work Health and Safety Law and Policy* (3rd ed, 2012) at [8.455]; Creighton WB and Rozen P, *Health and Safety Law in Victoria* (4th ed, 2017, Federation Press) at [10.60]–[10.66].

proceeding may be adduced in evidence as proof that the contravention occurred.

1463. Under the *Aged Care Act 1997* there are no mechanisms to compensate those harmed by approved providers' conduct. People are only able to receive compensation by undertaking private litigation. There are numerous reasons why private civil proceedings may not be feasible or desirable for those who have suffered harm in aged care, including the cost and likely duration of such processes.¹⁴⁸⁶

1464. Currently, the Aged Care Quality and Safety Commission has the power to determine that there is an immediate and severe risk to the safety, health and well-being of individual care recipients as a result of non-compliance. Such findings factor into decisions to impose sanctions.¹⁴⁸⁷ An example of a serious risk decision was seen in the MiCare Case Study evidence, in which it was concluded that from 2018 the safety, health or wellbeing of fourteen residents of a residential aged care facility had been or may have been placed at serious risk.¹⁴⁸⁸

1465. However, even having reached such a conclusion, the Aged Care Quality and Safety Commission remains powerless to take further action that would compensate those harmed.

1466. The daughter of a woman abused in residential aged care gave evidence of her frustration that 'legal redress is severely limited, restricting the ability of residents and families to hold providers to account for negligence and non-compliance issues which cause harm and suffering'.¹⁴⁸⁹

1467. As submitted by the Australian Lawyers Alliance: 'the issue of remedies is important. There needs to be power to award compensation for breaches of human rights rather than simply powers to conduct an investigation or revoke accreditation'.¹⁴⁹⁰

Wider range of enforcement powers

1468. Enforcement is an important part of ensuring that the regulatory system deters poor quality or unsafe care. Any such enforcement must be credible and effective.

1469. Professor John Braithwaite described aged care enforcement in Australia as 'enfeebled'.¹⁴⁹¹ We agree with his assessment. Existing enforcement options fail to meet

¹⁴⁸⁶ Australian Lawyers' Alliance, Public submission, AWF.001.04068.01 at 0027 [70].

¹⁴⁸⁷ See *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63U.

¹⁴⁸⁸ Exhibit 8-14, Brisbane Hearing, MiCare Tender Bundle, tab 59, CTH.4007.1000.3511 at 3513.

¹⁴⁸⁹ Exhibit 6-20, Darwin and Cairns Hearing, Statement of Lisa Backhouse, WIT.0221.0001.0001 at 0008 [47].

¹⁴⁹⁰ Australian Lawyers' Alliance, Public submission, AWF.001.04068.01 at 0019 [42].

¹⁴⁹¹ Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 126, RCD.9999.0156.0001 at 0188.

community expectations.¹⁴⁹² Substandard care, which we noted earlier is widespread, rarely has serious consequences for providers or those in positions of leadership within providers.¹⁴⁹³

1470. In its 2011 report *Caring for Older Australians*, the Productivity Commission recommended that the quality and safety regulator be provided with a broader range of enforcement tools 'to ensure that penalties are proportional to the severity of non-compliance'.¹⁴⁹⁴ However, although the agency exercising regulatory functions has changed, there have been few substantive changes to the regulator's enforcement options since that time. This recommendation was echoed in a 2019 options paper on the performance of the Aged Care Quality and Safety Commissioner's functions, prepared by the Aged Care Quality and Safety Advisory Council.¹⁴⁹⁵

1471. Revocation of a provider's approval is the most serious enforcement tool currently available to the Aged Care Quality and Safety Commissioner. Other enforcement options include: conditional revocations;¹⁴⁹⁶ sanctions (many directed towards the financial operation of an approved provider);¹⁴⁹⁷ requiring undertakings from providers to take action to remedy non-compliance;¹⁴⁹⁸ and criminal penalty provisions (primarily relating to the financial, notification and record keeping responsibilities of approved providers).¹⁴⁹⁹

1472. The Australian Aged Care Commission should have additional enforcement tools to give it sufficient flexibility to respond to the variety of non-compliance issues arising under the new Act.

¹⁴⁹² Transcript, Darwin and Cairns Hearing, Lisa Backhouse, 11 July 2019 at T3203.37–3204.2; Brisbane Hearing, Exhibit 8-28, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0012 [75].

¹⁴⁹³ Exhibit 8-44, Brisbane Hearing, Document titled 'Answers to questions posed by the Commission to John Braithwaite, Valerie Braithwaite and Toni Makkai', RCD.9999.0149.0001 at 0013; Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833, p 70.

¹⁴⁹⁴ Exhibit 1-33, Adelaide Hearing 1, Productivity Commission Inquiry Report - Caring for Older Australians (Volume 1), RCD.9999.0011.1261 at 1704.

¹⁴⁹⁵ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 85, RCD.0010.0001.0015 at 0141–0142.

¹⁴⁹⁶ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63U(3); Transcript, Brisbane Hearing, Anthony Speed, 5 August 2019 at T4289.29–43.

¹⁴⁹⁷ *Aged Care Quality and Safety Commission Act 2018* (Cth) s 63R.

¹⁴⁹⁸ *Aged Care Quality and Safety Commission Act 2018* (Cth) s 63T.

¹⁴⁹⁹ See for example *Aged Care Act 1997* (Cth) ss 9-1(4), 52N-2 and 88-1.

Recommendation 111: A wider range of enforcement powers

111.1. The new Act should confer on the quality regulator:

- a. a wider range of enforcement powers, including enforceable undertakings, infringement notices and banning orders
- b. the power to impose a sanction suspending or removing the group of people responsible for the executive decisions of a provider and appoint an external administrator of the provider, or manager of specified assets or undertakings of the provider
- c. the power to impose a sanction to be applied to a non-compliant provider revoking the provider's approval unless the provider agrees to the appointment of an external administrator or manager.

Enforceable undertakings and infringement notices

1473. The Aged Care Quality and Safety Commission currently has the power to require an approved provider to give an undertaking to remedy non-compliance in certain circumstances.¹⁵⁰⁰ This power can only be used after the Commission has made a finding of non-compliance, and the scope of the undertaking is limited to remedying non-compliance.¹⁵⁰¹ This existing power should be retained and supplemented with a new power to accept enforceable undertakings. An enforceable undertaking could be accepted on the basis of alleged or potential non-compliance. A Court may, if satisfied that the undertaking has been breached, direct the provider to take steps to comply with the undertaking, or make any other order it considers appropriate including an order that the provider compensate a person for loss or damage as a consequence of the breach.¹⁵⁰²

1474. Infringement notices should be introduced to enable the Australian Aged Care Commission to deal efficiently with certain types of non-compliance. Such notices provide an administrative method for dealing with alleged breaches of the law.¹⁵⁰³ The infringement notices should only apply to strict or absolute liability offences, and the notices should only be issued where an enforcement officer can easily make an

¹⁵⁰⁰ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63T.

¹⁵⁰¹ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63T.

¹⁵⁰² See *Regulatory Powers (Standard Provisions) Act 2014* (Cth), s 115(2).

¹⁵⁰³ Australian Law Reform Commission, *Principled Regulation Report: Federal Civil & Administrative Penalties in Australia* (ALRC Report 95), <https://www.alrc.gov.au/publication/principled-regulation-federal-civil-and-administrative-penalties-in-australia-alrc-report-95/>, viewed 21 October 2020, p 92 [2.129].

assessment of whether an offence has occurred.¹⁵⁰⁴ This may be appropriate, for example, where a provider has failed to comply with obligations to report certain information to the quality regulator in the relevant timeframe.¹⁵⁰⁵ This power would assist the quality regulator to focus its attention and resources on more serious non-compliance.

Appointment of an external manager

1475. The enforcement powers currently available to the Aged Care Quality and Safety Commission do not give it sufficient flexibility to respond to a circumstance where people receiving care are at risk of harm, and where it may not be possible or desirable to move those people to another service.

1476. The most serious enforcement measure currently available is the revocation of the accreditation of an aged care service or the revocation of the approval of a provider. However, these measures will inevitably lead to the closure of the relevant service (or services) and are rarely used. In circumstances where the regulator is considering revocation, it will take time to make the necessary arrangements to ensure the impact on people receiving aged care is minimised and managed. As seen in the Earle Haven case study, the human cost that can be occasioned by a situation where residents have to be moved at short notice and without prior planning is unacceptable.¹⁵⁰⁶ At the same time, all measures must be taken to ensure that any risks of harm to people receiving care from a non-compliant provider are minimised.

1477. To remove the practical impediment the quality regulator currently faces in this regard, an additional power should be given to the quality regulator to suspend or remove the group of people responsible for the executive decisions of the provider and to appoint an external manager.

1478. The primary role of the external manager appointed by the regulator would be to stabilise the provider's conduct of its aged care services and bring the those services back into compliance with the aged care standards, or to facilitate the orderly exit of the provider from the sector and the transfer of its service or services to a provider capable of delivering safe and high quality care. In an appropriate case, where it appears to the

¹⁵⁰⁴ Attorney-General's Department, *A Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, <https://www.ag.gov.au/sites/default/files/2020-03/A%20Guide%20to%20Framing%20Cth%20Offences.pdf>, viewed 13 October 2020, p 58.

¹⁵⁰⁵ In the Earle Haven Case Study, there was evidence that in 2019, officers in the prudential area of the Department of Health thought it would be 'disproportionate' to issue a sanction against People Care for its failure to lodge an annual prudential compliance statement in due and complete form, and the delegate made a decision to take no further action. See Submissions of Counsel Assisting the Royal Commission: Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0041 [140].

¹⁵⁰⁶ Submissions of Counsel Assisting, Earle Haven Case Study, 26 August 2019, RCD.0012.0026.0001 at 0062 [214]–[216].

external manager that the provider can be managed into sustainable compliance, the external administrator might choose to facilitate a renewal of the executive team. The appointment of an external manager to an approved provider will be better suited in the case of entities that conduct standalone aged care operations, and may not be appropriate for entities which conduct multiple businesses. The external manager should possess appropriate experience in the provision of aged care and exhibit an ability to put together a highly qualified and experienced team with the range of skills needed to address the issues that have led to the failure of the service.

1479. The *Australian Charities and Not-for-profits Commission Act 2012* and the *Private Health Insurance (Prudential Supervision) Act 2015* provide guidance on how such an enforcement power may operate.¹⁵⁰⁷

Strengthen the investigatory powers of the quality regulator

1480. To better equip the quality regulator to monitor and investigate the provision of aged care, the functions conferred on it by Parts 2, 8 and 8A of the *Aged Care Quality and Safety Commission Act 2018* (Cth) need to be expanded.

Recommendation 112: Strengthened powers for the quality regulator to undertake investigations and inquiries

112.1. From 31 December 2021, the *Aged Care Quality and Safety Commission Act 2018* (Cth) should be amended to confer on the Aged Care Quality and Safety Commissioner the following additional statutory functions and powers, to be exercised in connection with, or for the purposes of, its functions conferred by that Act:

- a. the function of conducting inquiries, including into complaints (see Recommendation 114) or reported serious incidents (see Recommendation 118)
- b. a power to enter and search the premises of residential aged care facilities and other non-residential aged care workplaces without warrant or consent
- c. a power to compel the production of documents and information relevant to the performance of its functions

¹⁵⁰⁷ *Australian Charities and Not-for-profits Commission Act 2012* (Cth), Div 100; *Private Health Insurance (Prudential Supervision) Act 2015* (Cth), Part 3, Divs 6 and 8.

- d. a power to compel by notice an officer, employee or person acting on behalf of an approved provider to appear before an officer authorised by the quality regulator for examination.

112.2. The new Act should confer on the Australian Aged Care Commission responsibility for general administration of the Act. The new Act should authorise the Commission to conduct inquiries and exercise any of its powers for the purpose of the general administration of the Act.

112.3. For the avoidance of doubt, these powers should also be available to Aged Care Quality and Safety Commission and subsequently the Australian Aged Care Commission for the purposes of their prudential regulatory and financial risk monitoring functions.

Power to conduct inquiries

1481. The quality regulator should be empowered to commence an own-initiative inquiry about matters of importance relating to issues affecting the health and safety of people receiving aged care, including serious incidents and potential breaches by providers.

1482. Incident investigations are an important function for regulators to ensure they are equipped with the requisite knowledge of the aged care sector to identify and respond to problem areas.

1483. At the time of Sydney Hearing 2, which examined the response to COVID-19 in aged care, the Aged Care Quality and Safety Commission had not undertaken any investigation into the circumstances of the outbreaks at Dorothy Henderson Lodge or Newmarch House, both in New South Wales. Nor had it signalled an intention to do so. This quality regulator should be empowered and encouraged to investigate matters such as this.

1484. Guidance regarding these provisions can be drawn from the powers of inquiry given to the National Disability Insurance Scheme Quality and Safeguards Commissioner. That Commissioner is specifically empowered to authorise an inquiry:

- a. about an issue connected with a complaint, or a series of complaints, relating to the provision of support or services by a National Disability Insurance Scheme provider;¹⁵⁰⁸ and

¹⁵⁰⁸ *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth), s 29.

- b. in relation to a reportable incident, or series of reportable incidents in connection with the provision of supports or services by a National Disability Insurance Scheme provider.¹⁵⁰⁹

Such inquiries can be carried out whether or not a complaint or notification of a reportable incident has been made to the Commissioner. The Commissioner may prepare and publish a report setting out their findings in relation to the inquiry.¹⁵¹⁰

Power to enter and search premises, obtain documents and evidence

1485. The quality regulator needs to be equipped with compulsory information-gathering powers to enable it to obtain information, documents and evidence for the purposes of its functions.

1486. Currently, the Aged Care Quality and Safety Commission's limited powers include the following.

1487. Where the matter relates to a provider's responsibilities under Chapter 4 of the *Aged Care Quality and Safety Commission Act 2018* (Cth) authorised officers can only enter any premises and exercise monitoring powers if the occupier of the premises has consented to the entry, or the entry is made under a monitoring warrant.¹⁵¹¹

1488. Where the matter relates to an application for approval as a provider of aged care, complaints, accreditation and quality reviews, authorised offices can only enter a provider's premises for these purposes with the consent of the provider. Consent can be refused or withdrawn without the need to give reasons.¹⁵¹² When an authorised officer does enter a facility, any questions they ask are not required to be answered.¹⁵¹³ A person asked a question may refuse to answer it and they are not required to have a reason for doing so. Similarly, a person asked to produce a document or record may refuse to do so, and does not require a reason.¹⁵¹⁴

1489. Approved providers have a general responsibility to cooperate with any person who is performing functions or exercising monitoring powers, as well as entry and search powers relating to provider approval applications, complaints, or other specified

¹⁵⁰⁹ *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth), s 27.

¹⁵¹⁰ *National Disability Insurance Scheme (Complaints Management and Resolution) Rules 2018* (Cth), ss 29(3), (6); *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (Cth), ss 27(4), (7).

¹⁵¹¹ See *Aged Care Act 1997* (Cth), Chapter 4; *Aged Care Quality and Safety Commission Act 2018* (Cth), s 74B; *Regulatory Powers (Standard Provisions) Act 2014*, s 18.

¹⁵¹² *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 65, 66, 68 and 69.

¹⁵¹³ *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 67(3) and 70(3).

¹⁵¹⁴ *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 67 and 70.

regulatory purposes.¹⁵¹⁵ A failure to comply with this responsibility could result in the imposition of a sanction.¹⁵¹⁶

1490. Where an authorised officer of the Aged Care Quality and Safety Commission enters premises under a monitoring warrant, they have a power to compel a person on the premises to answer questions or produce documents. A failure to comply is an offence.¹⁵¹⁷ However, where an authorised officer enters a premises with consent, while the provider has a responsibility to cooperate, a person is not required to comply with such a request.¹⁵¹⁸

1491. The Commissioner also has a power to issue a written notice requiring a person it reasonably believes has information or documents relevant to whether an approved provider is complying with an aged care responsibility, to attend before an authorised officer and answer questions or give information and documents.¹⁵¹⁹ However, there is no requirement to comply with this requirement if the provider is not a corporation.¹⁵²⁰

1492. These limitations on the powers of the Aged Care Quality and Safety Commission may affect its ability to uncover and thoroughly investigate quality and safety issues in aged care.

1493. Accordingly, we submit the quality regulator should have the power, at all reasonable times, to enter and remain on any premises, as well as an entitlement to full and free access to documents, goods or other property of approved providers for performance of any of its functions under the new Act. Accompanying this power should be the ability to inspect, seize and take extracts from or make copies of any documents. It is not intended that these powers extend to a right of entry to private residences in which home care services are provided.

1494. Further, the aged care quality regulator should have a general power to require the production of documents or information from a person or an approved provider at a time and place specified in a written notice.

The people at the heart of the system must be heard

1495. The experience of people receiving care should be central to assessments of aged care quality and safety, and priority should be given to this principle in reforming the quality regulator's compliance monitoring and assessment processes.

¹⁵¹⁵ *Aged Care Act 1997* (Cth), s 63-1(1)(b).

¹⁵¹⁶ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63N.

¹⁵¹⁷ *Regulatory Powers (Standard Provisions) Act 2014*, s 24.

¹⁵¹⁸ *Aged Care Quality and Safety Commission Act 2018* (Cth), ss 67 and 70.

¹⁵¹⁹ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 74F.

¹⁵²⁰ *Aged Care Quality and Safety Commission Act 2018* (Cth), s 74F(4).

1496. To achieve this result, measures including giving greater weight to consumer experience reports, improved complaints management practices and protections for whistle blowers are required.

Consumer experience reports

Recommendation 113: Greater weight to be attached to consumer experience

113.1. From 1 July 2021 onwards, the quality regulator, whether it be the Aged Care Quality and Safety Commissioner or the Australian Aged Care Commission, should:

- a. ensure that consumer experience reports for a service are informed by consumer experience interviews with at least 20% of care recipients or services users (or their families)
- b. take consumer experience reports into account in accreditation, assessment and compliance monitoring processes
- c. publish consumer experience reports for each aged care service, informed by consumer experience interviews
- d. establish channels (including an on-line mechanism) to allow aged care recipients and their families to report their experiences of aged care and the performance of aged care providers, all year round.

1497. Consumer experience reports need to inform assessments of aged care services and approved providers and they need to be published.

1498. From May 2017 to December 2019, the Aged Care Quality and Safety Commission sought feedback through consumer experience interviews during site audits of residential aged care facilities. The results of these interviews were then published as a Consumer Experience Report for each facility and were available on the website of the Aged Care Quality and Safety Commission (from 1 January 2019) along with audit reports.

1499. For home care services, the Aged Care Quality and Safety Commission introduced consumer experience interviews from 1 July 2019. The home care consumer experience interviews occur in the context of a provider being assessed against the Quality Standards. Providers are required to inform people receiving care and their representatives of the upcoming assessment and give them information about how they

can participate, including via the consumer experience interviews.¹⁵²¹ Unlike in residential care, there is no set number of people receiving aged care who need to be surveyed.¹⁵²²

1500. The 2017 Carnell-Paterson review recommended that the quality and safety regulator should seek the views of 20% of older people and their representatives when conducting assessments.¹⁵²³ This recommendation was made ‘to ensure a more representative sampling of views and experiences’.¹⁵²⁴ In evidence, Professor Paterson reiterated his view that people receiving care and staff members should have online input to Consumer Experience Reports, and that 20% of residents should be interviewed in assessment visits.¹⁵²⁵ He said that ‘all sorts of reasons’ could be proffered to reject the increase to 20%, but that such reasons contributed to ‘diminishing the voices of the people who we need to hear from’.¹⁵²⁶

1501. From 9 December 2019, changes to processes relating to consumer experience interviews and Consumer Experience Reports for residential care meant the reports were no longer published.¹⁵²⁷ The Aged Care Quality and Safety Commission has advised that it is working on developing ‘appropriate sampling methodology’ to enable it to publish Consumer Experience Reports for residential aged care and home care services. It anticipates that publication will occur from 2021.¹⁵²⁸

1502. The quality regulator should publish consumer experience reports for each aged care service.

Improved complaints management

1503. In Part 3.2, we proposed that the functions of the new Australian Aged Care Commission will include responsibility for a complaints scheme relating to all aspects of aged care,

¹⁵²¹ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1713 [15].

¹⁵²² Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1714 [16]. The Aged Care Quality and Safety Commission Rules state that the assessment team must interview at least 10% of the service’s residents during site audits and review audits. See *Aged Care Quality and Safety Commission Rules 2018* (Cth), s 38(2), 74(2).

¹⁵²³ Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833, p xi.

¹⁵²⁴ Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833, p 89.

¹⁵²⁵ Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4595.1–8.

¹⁵²⁶ Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4595.30–32.

¹⁵²⁷ The Aged Care Quality and Safety Commission explained that this is because the questions asked during Consumer Experience Interviews ‘are now selected on a purposeful basis by quality assessors based on the Evidence Domain they are assessing and are not in a standardised format or sampling methodology that can be published’. See Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1717 [29].

¹⁵²⁸ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1717–1718 [30]–[31].

subject to the oversight of the Inspector-General. We now set out the features of the complaints scheme in more detail.

Recommendation 114: Improved complaints management

114.1. The new Act should provide that at all times one or more of the Assistant Commissioners of the Australian Aged Care Commission ('Complaints Commissioner') be designated to exercise and perform:

- a. the functions of:
 - i. complaints handling
 - ii. complaints referral and coordination
 - iii. promoting open disclosure and publishing information about complaints
 - iv. consideration and determination of requests to maintain confidentiality of the identity of complainants
- b. in relation to these functions, powers to:
 - i. apply enforceable undertakings, whereby the provider agrees to take certain steps or actions
 - ii. issue directions to providers
 - iii. refer complaints to a more appropriate complaints body or regulator, and to obtain information on the action taken, if any, by that complaints body or regulator
- c. before deciding to close a complaint or continue an investigation, a duty to advise complainants of the proposed outcome of complaints, and seek their views on:
 - i. the way the process has been handled by the Commission
 - ii. the provider's response to the process
 - iii. the proposed outcome of the process
- d. a duty to publish reports at least every six months on:
 - i. the number of complaints received
 - ii. the subject matter of complaints by general topic
 - iii. the number of complaints by provider and service

- iv. the outcomes of complaints
- v. the average time for conclusion of complaints
- vi. satisfaction with the outcomes of the complaints handling process.

114.2. The new Act should provide that complaints are to be made to the Australian Aged Care Commission at first instance. If a complainant is not satisfied with the Commission's handling of a complaint or the outcome, the complainant may refer the matter to the Inspector-General. The Commission should refer to the Inspector-General any complaints about the Commission itself, its performance of its functions and exercise of its powers.

114.3. The new Act should also set out the role of advocates in the complaints processes of the Commission and the Inspector-General.

1504. The above scheme is not intended in any way to diminish the importance of approved providers having effective internal complaints systems. Research commissioned by the Royal Commission from the National Ageing Research Institute, based on a survey of aged care residents, suggests that only a minority of concerns are made as formal or official complaints to approved providers, and complaints to the regulator are even rarer.¹⁵²⁹ However, the rarity of complaints to the regulator cannot be taken as a good sign: the research also indicated that about two-thirds of 'official' complaints to providers were not resolved to the satisfaction of the complainant.¹⁵³⁰

1505. It therefore appears that the current complaints processes are not working as they should. This is of great concern, because complaints are a critical source of information about not only the performance of and risks presented by particular providers. They can also shed light on systemic issues with the performance of the system overall. An ineffective complaints scheme can diminish the supply of that critical information. This represents a lost opportunity to improve the system by addressing issues at their inception, before they have become major problems.

1506. In the new aged care system, stronger processes for receiving and effectively responding to complaints must be established. As Professor Paterson said:

¹⁵²⁹ National Ageing Research Institute Ltd, *Inside the system: aged care residents' perspectives*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, pp 8-9 and 45. Of the respondents to the NARI survey, not a single resident made a complaint to the Aged Care Quality and Safety Commission, and even taking into account complaints made by another person on a resident's behalf only 1.8% of such concerns led to a complaint to the Commission.

¹⁵³⁰ National Ageing Research Institute Ltd, *Inside the system: aged care residents' perspectives*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, 2020, p 47.

Consumers and their families must be confident that there is a strong, independent complaints handling function... The Complaints Commissioner must be highly visible in the aged care sector and more broadly in the community; it must be, and be seen to be, rigorously independent from regulatory functions; its complaint handling must be skilled, timely and effective; and the lessons and trends from complaints must be well publicised (promptly and in user friendly formats) for consumers, providers and the community.¹⁵³¹

1507. There is a power imbalance between an older person and the aged care system, the provider and even workers providing care.¹⁵³² Many older people are very reluctant to complain about the people who provide their care and the system under which they receive care.¹⁵³³

1508. The Carnell-Paterson review recommended the creation of a complaints commissioner within a Quality and Safety Commission.¹⁵³⁴ This recommendation was not implemented. Currently, the Aged Care Quality and Safety Commissioner has responsibility for compliance monitoring and enforcement as well as for complaints handling. There is no distinct role of a statutory complaints commissioner. Effective complaint management requires a dedicated focus on resolving and investigating complaints. A degree of separation and independence from other functions that regulate the quality and safety of services, which may be the subject of complaints, is desirable.¹⁵³⁵

1509. The goal in the Carnell-Paterson review of designating a specialist complaints commissioner in the new aged care system will, in our submission, be fulfilled by designating to one or more of the Assistant Commissioners of the Australian Aged Care Commission the functions, powers and duties specified in this recommendation. This complaints commissioner role will be critical to addressing the power imbalance between approved providers and the people receiving care, and meeting the criteria laid out by Professor Paterson.

1510. The complaints commissioner should have appropriate powers to respond to complaints in ways that are meaningful to complainants and people receiving care. These powers should include an ability to direct providers to take specified action to remedy an issue that is the subject of a complaint. Such a power should direct the focus of the complaints commissioner to the person receiving care, and not only to the provider's compliance

¹⁵³¹ Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, 7 August 2019, RCD.9999.0143.0001 at 0003 [24].

¹⁵³² See Transcript, Adelaide Hearing 1, Ian Yates, 11 February 2019, T54.22–41; Exhibit 8-37, Brisbane Hearing, Statement of Geoffrey Francis Rowe, WIT.0319.0001.0001 at 0006; Exhibit 8-38, Brisbane Hearing, Statement of the Queensland Public Guardian, WIT.0318.0001.0001 at 0048–0049.

¹⁵³³ Exhibit 6-20, Darwin Hearing, Statement of Lisa Maree Backhouse, WIT.0221.0001.0001 at 0009 [54]; Transcript, Brisbane Hearing, Geoffrey Rowe, 8 August 2019 at T4710.5–14.

¹⁵³⁴ Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1927.

¹⁵³⁵ See Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Ron Paterson, 7 August 2019, RCD.9999.0143.0001 at 0003 [22]–[24].

with its legal responsibilities. Appropriate responses by the regulator could include issuing directives to:

- a. provide an apology
- b. provide an explanation for an incident to the complainant
- c. explain to the complainant the steps the provider has taken or will take to ensure an incident does not occur again
- d. give an enforceable undertaking in relation to an agreement reached with a complainant as part of a resolution process.

1511. People interacting with the aged care system should be able to direct complaints to one central authority. The complaints commissioner should receive all complaints relating to aged care, including complaints about approved providers and individuals who are part of the aged care system such as assessors, care finders, inspectors working for the quality regulator. It should also have the power to deal with complaints about people working in aged care.

1512. Ms Holland-Batt gave evidence about the abuse of her father by an employee of a residential aged care facility.¹⁵³⁶ Ms Holland-Batt complained to the former Aged Care Complaints Commission about the allegations. The Commission considered the allegations insofar as they related to the approved provider of the facility, but told Ms Holland-Batt that it did not have the power to investigate conduct by individual workers.¹⁵³⁷ This is unacceptable.

1513. If the complaints commissioner receives a complaint that involves allegations about the professional conduct of a health practitioner or personal care worker, it should be referred to the proposed National Board.¹⁵³⁸

1514. Complainants should be notified that, if they are not satisfied with the handling or outcome of a complaint by the Commission, the matter can be referred to the Inspector-General of Aged Care. In addition any complaint about the complaints commissioner or the Australian Aged Care Commission itself, should also be referred to the Inspector-General.

1515. The complaints commissioner should be required to publish more information about complaint outcomes than is presently available. This is required to provide greater

¹⁵³⁶ Exhibit 8-40, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0007-0008 [44]-[53].

¹⁵³⁷ Exhibit 8-40, Brisbane Hearing, Statement of Sarah Holland-Batt, WIT.0330.0001.0001 at 0011 [69] and [74].

¹⁵³⁸ See recommendation in Part 3.6 The aged care workforce.

transparency about the extent to which the complaints system is achieving satisfactory outcomes for complainants.

1516. The complaints commissioner should be required to establish an online complaints register and publish reports about complaints at least every six months. The reports should contain information about the primary areas of concern, be reported at the provider and service level, and indicate the outcome of complaints, including whether the complaint led to regulatory action. This should go beyond the sector performance reports published by the Aged Care Quality and Safety Commission on a quarterly basis, which include reports about the number of complaints received and the nature of the complaints.
1517. The conduct of the complaints scheme by the designated complaints commissioner from within the Australian Aged Care Commission should be monitored by the Inspector-General of Aged Care.
1518. In addition to the Inspector-General receiving referrals from complainants who are dissatisfied with the handling or outcome of their complaint before the Australian Aged Care Commission, there should be no restriction on the ability of the Inspector-general to receive information from any source about systemic issues affecting aged care. This may mean that some complaints will be made directly to the Inspector-General. The Inspector-General's office should consider referring complaints about non-systemic matters to the complaints scheme conducted within the Australian Aged Care Commission. Complaints raising systemic issues, and in particular complaints about the performance of the Australian Aged Care Commission or Aged Care Pricing Authority themselves, should be managed by the Inspector-General. And if the complaints commissioner receives complaints which they consider to raise such issues, they should be referred to the office of the Inspector-General.
1519. The role of advocates in the complaints process should also be clearly articulated. Currently, the role of advocates is recognised in the legislative provisions concerning user rights. Section 56-1(l) of the *Aged Care Act 1997* requires providers to allow advocates to access the service in accordance with the *User Rights Principles 2014*.¹⁵³⁹ However, in the provisions of the *Aged Care Quality and Safety Commission Act 2018* and *Aged Care Quality and Safety Commission Rules 2018* where the complaints handling process is outlined, there is no reference to advocates.
1520. The new Act should clearly direct that, where an older person and/or their family have sought support from an advocate to assist them with the complaints process, the

¹⁵³⁹ See *User Rights Principles 2014* (Cth).

advocate should be included throughout the entirety of the complaints process. A robust advocacy mechanism is critical to effective complaints handling.¹⁵⁴⁰

Recommendation 115: Protection for whistle-blowers

115.1. The new Act should contain comprehensive whistle-blower protections for:

- a. people receiving aged care, their family, carer, independent advocate or significant other
- b. an employee, officer, contractor, or member of the governing body of an approved provider

who makes complaints or reports suspected breaches of quality and safety standards or other requirements of the Act.

1521. There are limited existing protections in the *Aged Care Act 1997* for staff members who disclose information about a suspected reportable assault to police, the Aged Care Quality and Safety Commissioner or the provider.¹⁵⁴¹ Those staff members are protected from any civil or criminal liability, contractual or other remedy, victimisation, detriment or threat.¹⁵⁴² However, the protections only apply to the reportable assaults scheme. They do not apply to complaints or information about substandard care more broadly.

1522. The Charter of Aged Care Rights also provides for the right of residents to complain without reprisal, and to have complaints dealt with fairly and promptly.¹⁵⁴³

1523. Unlike the position in aged care, whistle-blower protections in the *Corporations Act 2001 (Cth)* have recently been strengthened, by amendments that commenced on 1 July 2019, with respect to certain disclosures to ASIC, APRA and specified personnel.¹⁵⁴⁴ As a result of these amendments, the protections apply to an expanded scope of disclosures, and to a broader range of individuals including past employees.¹⁵⁴⁵

1524. We submit that comprehensive whistle-blower protection provisions should be implemented in relation to aged care to protect people who make complaints or report

¹⁵⁴⁰ Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4597.4–9; Exhibit 8-38, Brisbane Hearing, Statement of the Queensland Public Guardian, WIT.0318.0001.0001 at 0016; Exhibit 8-38, Brisbane Hearing, Statement of Geoffrey Francis Rowe, WIT.0319.0001.0001 at 0022–0023 and 0027.

¹⁵⁴¹ On the definition of 'staff member' see *Aged Care Act 1997 (Cth)*, s 63-1AA(9).

¹⁵⁴² *Aged Care Act 1997 (Cth)*, s 96-8.

¹⁵⁴³ *User Rights Principles 2014 (Cth)*, Sch 1, s 2(12).

¹⁵⁴⁴ Those amendments were introduced by the *Treasury Laws Amendment (Enhanced Whistleblower Protections) Act 2019 (Cth)*. See *Corporations Act 2001 (Cth)*, Part 9.4AAA.

¹⁵⁴⁵ See *Corporations Act 2001 (Cth)*, s 1317AAA; Explanatory Memorandum, Treasury Laws Amendment (Enhancing Whistleblower Protections) Bill 2017, pp 16–18.

suspected breaches of legislative requirements to the Australian Aged Care Commission, Inspector-General of Aged Care or key personnel of an approved provider.

1525. Guidance on the form of these provisions may be drawn from the *National Disability Insurance Scheme Act 2013*, which provides broad protection to certain people who disclose information where they have a reasonable ground to suspect that the information indicates that a National Disability Insurance Scheme provider may have contravened the *National Disability Insurance Scheme Act 2013*.¹⁵⁴⁶ The protections apply to officers and employees, as well as people with a disability who are receiving a support or service from an NDIS provider, or a nominee, family member, carer, independent advocate or significant other of that person.¹⁵⁴⁷

1526. Aged care whistle-blowers should be protected from criminal prosecution, administrative action or civil litigation, such as breach of employment contract or duty of confidentiality. It should also be an offence to cause or threaten detriment to someone because they have made, may have made, or could make a whistle-blower disclosure.

Assessing provider performance

Recommendation 116: Graded assessments and performance ratings

116.1. From 1 July 2021, the Aged Care Quality and Safety Commissioner should adopt a graded assessment of service performance against the Aged Care Quality Standards.

116.2. The Australian Aged Care Commission should continue to use graded assessment from 1 July 2023 onwards.

Recommendation 117: Star ratings: performance information for people seeking care

117.1. By 1 July 2022, the Australian Government should develop and publish a system of star ratings based on objective and measurable indicators that allow older people and their families to make meaningful comparisons of the quality and safety performance of providers. The star ratings and accompanying material should be published on My Aged Care.

117.2. The star ratings should incorporate a range of measurable data and information including, at a minimum:

¹⁵⁴⁶ *National Disability Insurance Scheme Act 2013* (Cth), ss 73ZA–73ZD.

¹⁵⁴⁷ *National Disability Insurance Scheme Act 2013* (Cth), s 73ZA.

- a. graded assessment of service performance against standards
- b. performance against relevant clinical and quality indicators
- c. staffing levels
- d. robust consumer experience data, when available.

117.3. The overall star rating should be accompanied by appropriate additional information on performance and outcomes, in a readily understandable form and capable of comparison across providers. This should include all performance information that is relevant to the performance of a service provider, even if it is not reflected in the overall star rating outcome. For example, it should include:

- a. details about current and previous assessment by the quality regulator, whether it be the Aged Care Quality and Safety Commissioner or the Australian Aged Care Commission, including notices of non-compliance, sanctions, withdrawal of accreditation or approved provider status
- b. benchmarked performance for all quality indicators that are suitable for publication, including changes in performance over time
- c. consumer experience information
- d. serious incident reports data
- e. complaints data.

117.4. The Australian Aged Care Commission should assume responsibility for the star ratings system from 1 July 2023 onwards.

1527. The need for better, comparable, publicly available information about the quality of care has been recognised in previous reviews of aged care in Australia.¹⁵⁴⁸ Like a number of those reviews have recommended, we submit that the Royal Commissioners should recommend a star rating system for services and providers of both home and residential aged care should be introduced.¹⁵⁴⁹

¹⁵⁴⁸ Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1830–1840; Exhibit 1-33, Adelaide Hearing 1, Productivity Commission Inquiry Report - Caring for Older Australians (Volume 2), RCD.9999.0011.1261 at 1482.

¹⁵⁴⁹ WP Hogan, *Review of Pricing Arrangements in Residential Aged Care: Final Report*, 2004, pp 283–284; Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1949; Exhibit 1-33, Adelaide Hearing 1, Productivity Commission Inquiry Report - Caring for Older Australians (Volume 2), RCD.9999.0011.1261 at 1484.

1528. From July 2020, Service Compliance Ratings of residential aged care services became available on the My Aged Care website. Providers are given an overall rating between one and four dots based on compliance with the Aged Care Quality Standards. Four dots indicates that the residential aged care service is meeting requirements, three means that some improvements are needed, two indicates that significant improvement is needed and one dot is a rating of 'inadequate', where there is an extant sanction or Notice to Agree.¹⁵⁵⁰

1529. While this Service Compliance Ratings scheme is an improvement in that it brings together some existing information about services, it still leaves a lot to be desired. Services that meet all minimum standards, and have no current sanctions, will automatically be given the highest rating.¹⁵⁵¹ The Ratings, like the assessments carried out by the quality regulator, do not recognise or assess the extent to which care exceeds the minimum standards. They do not provide incentives for providers to strive for excellence, or do more than deliver adequate care.¹⁵⁵² Nor do they permit a meaningful comparison of the performance of different services and providers, particularly in circumstances where a high percentage of providers have historically been assessed as meeting all minimum standards and outcomes.¹⁵⁵³

1530. It is critical that the public has access to information that provides a meaningful overview of the performance of individual services and providers, in a way that is accessible and easy to understand. This is particularly important for older people who need to choose an aged care provider, and those receiving care who have a right to know about the performance of their service provider and others which they may choose. It is also

¹⁵⁵⁰ See Australian Government, myagedcare, The Service Compliance Rating for aged care homes, <https://www.myagedcare.gov.au/quality/compliance#compliance-rating>, viewed 13 October 2020.

¹⁵⁵¹ See Australian Government, myagedcare, The Service Compliance Rating for aged care homes, <https://www.myagedcare.gov.au/quality/compliance#compliance-rating>, viewed 13 October 2020. Services are assessed as either having 'met' or 'not met' (or being 'compliant' or 'non-compliant' with) a Standard. See Aged Care Quality and Safety Commission, *Regulatory Strategy*, v2.1, 14 February 2020 at p 20. See for example Exhibit 13-20, Hobart Hearing, Bupa South Hobart tender bundle, tab 166, CTH.4018.2100.0296.

¹⁵⁵² Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1907–1908; Exhibit 1-3, Adelaide Hearing 1, Statement of Ian Yates, WIT.0006.0001.0001 at 0009 [33]. See also Transcript, Brisbane Hearing, 9 August 2019, John Braithwaite, T4787.29–32.

¹⁵⁵³ Under the previous accreditation standards, during 2016–17, about 98% of providers received assessments that they had 'met' all minimum standards and outcomes. In 2017–18, the equivalent figure was 95% of providers and in 2018–19 it was 93%. See Productivity Commission, Report on Government Services 2017, Table 14A.33; Report on Government Services 2018, Table 14A.33; Report on Government Services 2019, Table 14A.34. See also Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1856.

important that families and friends of older people, advocacy organisations, policy-makers, legislators and the media have access to this information.¹⁵⁵⁴

1531. A starting point is a more sophisticated approach by the quality regulator to assessments against the Standards. Rather than a pass/fail approach, a range of outcomes should be possible (for example ranging from 'very poor performance that fails to meet the standard' to 'excellent').

1532. This graded assessment against the standards should be a central part of the new star rating scheme. However, the star rating scheme should go beyond the standards, and incorporate other measurable data and information, including:

- a. performance against relevant clinical and quality indicators¹⁵⁵⁵
- b. staffing levels¹⁵⁵⁶
- c. consumer experience data.

1533. Each service (and each approved provider) should be given an overall rating, as well as ratings for the key domains underpinning that overall rating, in a way that makes it easy to compare services and providers. The star ratings should be accompanied by other information that is relevant to performance, which may include:

- a. assessment reports and information about enforcement activity
- b. consumer experience reports
- c. serious incident and complaints data.

Serious incident reporting

Recommendation 118: Serious incident reporting

118.1. The Australian Government should, in developing a new and expanded serious incident reporting scheme:

- a. ensure that the new scheme:
 - i. includes all serious incidents, including in home care, regardless of whether the alleged perpetrator has a cognitive or mental impairment

¹⁵⁵⁴ See Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0014 [73]–[76]; Transcript, Ron Paterson, Brisbane Hearing, 7 August 2019 at T4583.21–24.

¹⁵⁵⁵ See Recommendations 30 and 31.

¹⁵⁵⁶ For an outline of the evidence on the link between substandard care and staffing levels and mix, see Submissions of Counsel Assisting the Royal Commission on the future of the aged care workforce, Adelaide Hearing 3, 21 February 2020, RCD.0012.0061.0001, part 2.

- ii. supports the matching of names of individuals accused of being involved in a serious incident with previous serious incident reports
- b. require the quality regulator to publish the number of serious incident reports on a quarterly basis at a global level, at a provider level, and at a service or facility level
- c. confer a statutory power on the quality regulator to:
 - i. requisition a plan of responsive action from a provider who has reported a serious incident
 - ii. obtain evidence from the provider to satisfy itself that the responsive action has been taken and is effective
 - iii. satisfy itself as to whether or not the responsive action has been taken and is effective
 - iv. require the provider to take further or additional steps, in circumstances where the quality regulator is not satisfied with the effectiveness of the responsive action.

1534. There should be zero tolerance for neglect and abuse in aged care. The Australian Government has recognised that current arrangements for reporting serious incidents should be strengthened.

1535. Under the compulsory reporting scheme, approved providers are required to notify the police and the Aged Care Quality and Safety Commission in response to an allegation or suspicion of a reportable assault.¹⁵⁵⁷ A reportable assault is defined as unlawful sexual contact or unreasonable force or assault inflicted on a recipient of residential care.¹⁵⁵⁸

1536. Shortcomings with the scope and operation of the current compulsory reporting scheme include that:

- a. when a resident with a cognitive or mental impairment assaults another resident, and there are arrangements in place to manage that person's behaviour, this does not usually need to be reported;¹⁵⁵⁹
- b. it does not apply to home care; and

¹⁵⁵⁷ *Aged Care Act 1997* (Cth), s 63-1AA. Note that before 1 January 2020, these reports were made to and dealt with by the Department of Health.

¹⁵⁵⁸ *Aged Care Act 1997* (Cth), s63-1AA (9).

¹⁵⁵⁹ Section 53(1) of the *Accountability Principles 2014* (Cth).

- c. information about the number of serious incidents reported at the provider or service level is not made publicly available.

1537. These matters were all identified as areas requiring attention in 2017 by the Australian Law Reform Commission and also in the Carnell-Paterson review.¹⁵⁶⁰

1538. The Australian Government is currently developing a Serious Incident Response Scheme, set to commence on 1 July 2021. The scheme will require reporting of a much wider range of incidents than is currently the case. Providers will be required to report: resident-on-resident assaults, including where a resident has a cognitive impairment; physical, sexual or financial abuse; seriously inappropriate, improper, inhumane or cruel treatment; and neglect by a staff member or contractor.¹⁵⁶¹ Reforms to reporting requirements in home and community care are only 'at the feasibility study stage'.¹⁵⁶²

1539. Given that half of the people living permanently in residential aged care have a diagnosis of dementia, the cognitive impairment exemption significantly undermines the compulsory reporting scheme. As we noted earlier, a 2019 study by KPMG, commissioned by the Australian Department of Health estimated that over a 12 month period, there could be as many as between 26,960 and 38,898 serious incidents which are currently excluded from the reporting requirements as a result of the cognitive impairment exemption.¹⁵⁶³

1540. The National Disability Insurance Scheme Quality and Safeguards Commission reportable incidents scheme applies irrespective of setting; 'as long as there is a connection with the service delivery by a registered NDIS provider, then they must be notified to the Commission'.¹⁵⁶⁴ The same should occur in aged care.

1541. The anticipated changes to reporting of alleged assaults perpetrated by a resident with cognitive impairment in 2021 are likely to result in a significantly higher number of reported incidents.

¹⁵⁶⁰ Australian Law Reform Commission, *Elder Abuse: A National Legal Response*, <https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131/>, viewed 21 October 2020, pp 114, 122, 123; Exhibit 1-25, Adelaide Hearing 1, Review of National Aged Care Quality Regulatory Processes, RCD.9999.0011.1833 at 1953–1959. See also Transcript, Brisbane Hearing, Ron Paterson, 7 August 2019 at T4599.12–31.

¹⁵⁶¹ Australian Department of Health, Budget 2019-20, *More Choices for a Longer Life – serious incident response scheme*, 2019; Australian Department of Health, *Media release: Serious Incident Response Scheme*, 15 June 2020.

¹⁵⁶² Australian Department of Health, *Media release: Serious Incident Response Scheme*, 15 June 2020.

¹⁵⁶³ KPMG, *Final Report: Prevalence Study for a Serious Incident Response Scheme*, November 2019, https://www.health.gov.au/sites/default/files/documents/2020/06/prevalence-study-for-a-serious-incident-response-scheme-sirs_0.pdf, p 37.

¹⁵⁶⁴ NDIS Quality and Safeguards Commission, *Reportable Incidents: Detailed Guidance for Registered Providers*, Australian Government June 2019, <https://www.ndiscommission.gov.au/sites/default/files/documents/2019-06/detailed-guidance-reportable-incidents-detailed-guidance-registered.pdf>, viewed 9 October 2020, p 16.

1542. The regulator needs to ensure that reports of serious incidents are carefully considered, investigated, and acted upon in a meaningful way. All reports of serious incidents should be accompanied by a plan by the provider detailing what action they intend to take in response to the reported event. The regulator must consider whether this action is appropriate, and if not, may require the provider to undertake alternative remedial action.
1543. The quality regulator must also take appropriate steps to satisfy itself that the remedial action has been undertaken. Information given by providers should not be simply accepted at face value, which was the approach of the Australian Department of Health to compulsory reports previously.¹⁵⁶⁵ A Departmental officer told the Royal Commission that when the compulsory reporting scheme was operated by the Department of Health, they did not make inquiries with the family members about an incident. He said, 'We believe the service. If they tell us they've done these things, we believe what they've advised us'.¹⁵⁶⁶
1544. There was also evidence that the Department had an extremely limited ability to identify when an aged care worker was the subject of multiple allegations.¹⁵⁶⁷ Until 2018, the names of staff members alleged to have assaulted a resident could not even be recorded in the system. Since 2018, the information has been able to be recorded, but seemingly not in a manner that enables it to be readily searched, or in a form that would trigger a red flag.¹⁵⁶⁸ The Japara Case Study highlighted multiple examples of reports of serious incidents at Japara facilities where the same worker was involved in at least three incidents.
1545. The compulsory reporting functions (and team of officers in the Department previously responsible for dealing with aged care assault reports) were transferred to the Aged Care Quality and Safety Commissioner from 1 January 2020.¹⁵⁶⁹ However, the Commission has identified that the capacity to identify aged care workers who are the subject of multiple assault reports is an ongoing issue.¹⁵⁷⁰ The names of alleged offenders and their relationship to the victims have been recorded in the system only since 1 January 2020.¹⁵⁷¹

¹⁵⁶⁵ See, for example of the contrary approach taken by the Australian Department of Health, Transcript, Peter O'Brien, Brisbane Hearing, 6 August 2019 at T4453.29–4454.45.

¹⁵⁶⁶ Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4453. 29–44.

¹⁵⁶⁷ See Submissions of Counsel Assisting the Royal Commission: Department of Health's response to certain reportable assaults reported by Japara Healthcare Ltd, 26 August 2019, RCD.0012.0025.0001, particularly at 0039 [114].

¹⁵⁶⁸ Transcript, Brisbane Hearing, Peter O'Brien, 6 August 2019 at T4450.22–25.

¹⁵⁶⁹ Exhibit 22-12, Counsel Assisting's Final Submissions Hearing, ACQSC Response to NTG-0783 dated 23 September 2020, CTH.4000.0001.2842 at 2842 [3].

¹⁵⁷⁰ Exhibit 22-12, Counsel Assisting's Final Submissions Hearing, ACQSC Response to NTG-0783 dated 23 September 2020, CTH.4000.0001.2842 at 2842 [24].

¹⁵⁷¹ Exhibit 22-12, Counsel Assisting's Final Submissions Hearing, ACQSC Response to NTG-0783 dated 23 September 2020, CTH.4000.0001.2842 at 2847 [22]. The Commission has advised

1546. It is critical that the quality regulator have the systems in place to enable it to undertake this and other basic risk detection. It should have the capability to detect when a worker is the subject of multiple reports, and this should prompt action or referrals to relevant professional disciplinary bodies which will include a Board with responsibility for personal care workers.
1547. Information received through a serious incident response scheme should be used in sophisticated ways by the quality regulator. It should inform the regulator's assessment of the risk profile of a provider. It should feed into broader monitoring and compliance work.
1548. The Aged Care Quality and Safety Commission has the ability to impose a limited range of sanctions if satisfied there has been non-compliance with a provider's responsibilities with respect to reporting an alleged or suspected assault.¹⁵⁷² The Commissioner can also direct an approved provider to take specified action if satisfied that the provider is not meeting its responsibilities on the basis of information obtained through the compulsory reporting scheme.¹⁵⁷³ However, the Commissioner does not have any specific powers that would enable a flexible and targeted response to reports of assaults and other serious incidents. The Commission has identified a number of potential additional enforcement options to enable it to carry out its anticipated functions in relation to the Serious Incident Response Scheme that is being developed. These include an ability to obtain enforceable undertakings, a capacity to issue directions, and additional information gathering powers.¹⁵⁷⁴
1549. As detailed above at Recommendation 112, the quality regulator should be given additional powers to enhance the effectiveness of the Serious Incident Response Scheme once introduced. The quality regulator should be encouraged to conduct inquiries in relation to a reportable incident, or a series of such incidents that are of particular concern, or that point to a systemic issue in the safety of aged care services.

that work on improvements to its data recording and processing systems to 'enhance its risk detection capabilities' continues – see [27].

¹⁵⁷² *Aged Care Act 1997* (Cth), s 63-1AA; *Aged Care Quality and Safety Commission Act 2018* (Cth), s 63N (see definition of 'aged care responsibility' in s 7 of that Act).

¹⁵⁷³ *Aged Care Quality and Safety Commission Rules 2018* (Cth), s 19.

¹⁵⁷⁴ Exhibit 22-12, Counsel Assisting's Final Submissions Hearing, ACQSC Response to NTG-0783 dated 23 September 2020, CTH.4000.0001.2842 at 2849 [31].

Coronial reports

Recommendation 119: Responding to coroner's reports

119.1. The new Act should provide that the Australian Aged Care Commission is required to:

- a. maintain a publicly available register of reports made to the Australian Aged Care Commission or other Commonwealth entity by a State or Territory coroner that involve the death of a person in aged care
- b. publish a response to the report on the publicly available register within three months of its receipt
- c. provide annual reports to the Inspector-General of Aged Care detailing any action taken in response to coroner's reports, and assessment of the impact of such action.

1550. Reports by State and Territory coroners can be a source of significant information concerning systemic issues in aged care that the Australian Aged Care Commission should have due regard to in performing its functions.

1551. For example:

- a. The Victorian State Coroner recommended in 2012 that the Victorian Department of Health, in consultation with the then Australian Department of Health and Ageing, require aged care facilities to have a designated Infection Control Manager.¹⁵⁷⁵
- b. In 2019, the Victorian State Coroner conducted an inquest into the death of a resident who died after he fell from his wheelchair and his head became trapped in the bottom draw of his bedside draws. Coroner Jamieson concluded that the circumstances of this death 'have highlighted a concerning norm in aged care: staffing to patient ratios administered at minimalistic levels which places the delivery of appropriate care at risk', and that 'regulation has not followed minimum standards of training and ... measurement of competency levels lack benchmarks and are at the behest of facility owners'.¹⁵⁷⁶

¹⁵⁷⁵ Coroners Court of Victoria, *Finding into Death with Inquest (Broughton Hall Nursing Home) – 25 June 2012*, <https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/broughton%2Bhall%2Bpart%2B1%2Bredacted.pdf>, viewed 21 October 2020, p 57.

¹⁵⁷⁶ Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 171, RCD.9999.0231.0034 at 0064 [8].

- c. Following the death of a resident at the Oakden Older Persons Mental Health Service after an assault by another resident, the South Australian Coroner recommended: (a) South Australia adopt a register of resident to resident aggression in the aged care sector to be supported by a system of mandatory reporting of such incidents, regardless of the residents' cognitive status; and (b) the South Australian Minister for Health raise the proposition that such registers be duplicated across other States and Territories or alternatively, that there be a National register.¹⁵⁷⁷

1552. Professor Joseph Ibrahim, who has studied coronial findings in relation to aged care, gave evidence that 'studies have concluded that coroners' recommendations have the potential to reduce the incidence of fatal injury'.¹⁵⁷⁸ Yet despite their potential significance, a system for the implementation of recommendations and findings of coronial determinations does not exist.¹⁵⁷⁹ An officer of the Australian Department of Health gave evidence in August 2019 that 'a formalised protocol to consider and review coroner reports is currently being developed by the Department'.¹⁵⁸⁰

1553. Some jurisdictions, such as Victoria, require public bodies to respond to the recommendations directed to them in writing by 'specifying a 'statement of action (if any) that has or will be taken in relation to the recommendations'.¹⁵⁸¹

1554. Professor Ibrahim gave evidence that 'A centralised system that is available to RACS [residential aged care service] providers, that provides the recommendations, along with the responses to what changes have or have not been made along with a one to five year follow-up about whether the recommendation had the intended impact would be invaluable'.¹⁵⁸²

1555. Prior to the passage of the new Act, the Australian Government should establish a system of this nature, including by undertaking the recommended steps.

¹⁵⁷⁷ See Exhibit 8-25, Statement of Anthony Speed, WIT.0261.0002.0001 at 0024 [93].

¹⁵⁷⁸ Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0057–0058 [306].

¹⁵⁷⁹ See Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0022 [84]–[87].

¹⁵⁸⁰ See Exhibit 8-26, Brisbane Hearing, Statement of Anthony Speed, WIT.0261.0002.0001 at 0022 [84]–[87].

¹⁵⁸¹ *Coroners Act 2008* (Vic), s 72(3); see also Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0058 [310].

¹⁵⁸² Exhibit 3-70, Sydney Hearing 1, Statement of Joseph Ibrahim, WIT.0115.0001.0001 at 0058 [309].

Approval of providers

Recommendation 120: Approval of providers

120.1. The new Act should provide for the commencement by 1 July 2024 of new approval requirements for all aged care providers to ensure their suitability, viability and capability to deliver the kinds of services for which they receive subsidies.

120.2. Applicants for approval as a provider or existing approved providers may seek approval from the Australian Aged Care Commission to provide particular kinds of aged care services, or general approval to provide all kinds of aged care services attracting Australian Government funding.

120.3. A current approved provider should be taken to be approved to provide the kinds of services they have been regularly providing from the commencement of 12 months prior to the commencement of the new Act (or since their approval, whichever is more recent), and there should be an administrative process to record all such approved providers' scopes of approval.

1556. Properly assessing those wanting to provide government funded aged care services is the first and best opportunity to ensure that those entities are well placed to provide high quality and safe care to older people.

1557. Providers in the aged care sector range from very small community organisations to very large corporate entities. There are 'some very sophisticated organisations in the aged care sector but there are also services who are smaller and probably less able to adapt quickly'.¹⁵⁸³ A robust but flexible approval system is required.

1558. Currently applicants seeking to provide residential aged care services become 'approved providers' under the *Aged Care Act 1997* after progressing through a single assessment process conducted by the Aged Care Quality and Safety Commission.

1559. This single assessment process does not apply to providers under the Commonwealth Home Support Programme. They are engaged by the Department of Health pursuant to grant agreements without any scrutiny by the Aged Care Quality and Safety Commission.

1560. Under the new Act, we submit that a universal mechanism of approval should apply to service providers seeking Australian government funding to provide (or to continue to provide) aged care services. This will involve conversion of the status of a number of

¹⁵⁸³ See, for example, Transcript, Sydney Hearing 4, Michael Lye, 2 September 2020 at T9058.46–9059.3.

current service providers which are funded by the Commonwealth Home Support Programme to approved provider status.

1561. Providers should be permitted to seek such approval for only a limited scope of services. In the case of providers that seek only to provide relatively low risk services (such as basic domestic assistance), the Aged Care Quality and Safety Commission (and subsequently the Australian Aged Care Commission) may consider that their capacity to provide high quality services is more easily demonstrated than in the case of riskier services involving hands-on personal care, nursing or allied health.
1562. An approach of this kind at the approval stage was proposed by the Advisory Council to the Aged Care Quality and Safety Commission in a 2019 Options Paper, which recommended reforms to 'strengthen risk-based requirements for provider approval and market entry that can better differentiate the regulatory oversight to fit the type of service and level of risk to consumers'.¹⁵⁸⁴
1563. The Australian Aged Care Commission (and, prior to its establishment, the Aged Care Quality and Safety Commission) should only approve the applicant if satisfied of the capability of the applicant to deliver the specific service(s) for which it seeks approval to provide, safely and to a high standard of quality. The Commission should consider an applicant's governance arrangements, clinical systems and processes as well as its managerial capability.
1564. Where an approved provider applies to expand the scope of the services it may provide under its existing approval, it must demonstrate its capability to provide the relevant additional kinds of services safely and to a high standard of quality. In making these assessments, the Australian Aged Care Commission should take into account differences in the inherent risks associated with these additional services.
1565. Approval of the provider should be ongoing, subject to suspension or revocation by the Commission upon satisfaction that the service has failed to meet the Standards in a way that would warrant such a response.

Recommendation 121: Requirement of continuing suitability for continuing approval and certification

121.1. The new Act should provide that approvals are ongoing but subject to continuing suitability, including (in addition to the matters referred to in sections 63D and 63J of the *Aged Care Quality and Safety Commission Act 2018* (Cth)), the fitness and propriety of the provider and its key personnel, the provider's

¹⁵⁸⁴ Exhibit 20-1, Sydney Hearing 4, General Tender Bundle, tab 85, RCD0010.0001.0015 at 0138–0139.

capacity to deliver high quality and safe services within its scope of approval, and the provider's performance in delivering high quality and safe services of the kinds for which they are approved.

121.2. In cases where the Australian Aged Care Commission becomes aware the approved provider may no longer be suitable to remain a provider or to retain its current scope of services for which it is approved, the Commission must consider on notice to the provider whether to revoke the provider's approval or limit its scope of approval.

1566. Currently approved provider status is ongoing and is not reviewed. It is only withdrawn if:

- a. it is revoked by the Aged Care Quality and Safety Commission; or
- b. the approved provider requests that its approved provider status be revoked.¹⁵⁸⁵

1567. Approval should remain ongoing. Introducing a requirement to renew approval risks unnecessarily increasing the regulatory burden on providers and the Australian Aged Care Commission. Ongoing approval should also provide certainty to approved providers and encourage continued investment in the aged care sector.

1568. This recommendation will in effect place a positive obligation on the Australian Aged Care Commission to regularly consider the suitability of providers to continue providing their existing scope of services, either in part or entirely.

The capabilities of the quality regulator

Recommendation 122: Aged Care Quality and Safety Commission capability review

122.1. The Australian Government should urgently conduct a review of the capabilities of the Aged Care Quality and Safety Commission, including its assessor workforce, and should take any necessary steps to enhance the Aged Care Quality and Safety Commission's capabilities in light of the outcome of the review.

1569. The systemic failures detailed under 'inadequate governance and regulatory frameworks' in Part 2 of these submissions raise concerns about the capability of the Aged Care Quality and Safety Commission.

¹⁵⁸⁵ *Aged Care Quality and Safety Commission Act 2018 (Cth)*, Part 7A, Division 4.

1570. The evidence indicates the Aged Care Quality and Safety Commission suffers from inadequate resourcing, including deficiencies in numbers of appropriately trained and experienced staff.

1571. For example, in March this year, the Commission advised that the program for increasing the level of compliance activity in home care services led to an increase in 2018/2019 compared to 2017/2018, but the activity level has since declined. Reasons given for this decline included a high turnover in the assessor workforce, and that the introduction of the Aged Care Quality Standards in 2019 have meant that assessment and monitoring activities have taken longer to complete.¹⁵⁸⁶

Regulation of home care

1572. It is very challenging to monitor the quality and safety of aged care provided in people's homes, a point that has been repeatedly acknowledged in the evidence, including by witnesses from the Department of Health and the Aged Care Quality and Safety Commission.¹⁵⁸⁷ In his evidence in September 2020, NSW Ageing and Disability Commissioner Robert Fitzgerald AM said that 'the highest risk for older people in the aged care system is within the home', and that 'the risks that occur at home are quite substantial because there is not the line of sight that you normally see in residential services'.¹⁵⁸⁸ One of the points Commissioner Fitzgerald made was that appropriate safeguarding should involve the identification of risks and vulnerabilities at the time that a person's needs are assessed.

1573. In post-hearing submissions, the Australian Government submitted that it 'supports strengthening regulation of home services as outlined in propositions HC6(c)(i)-(iii) to promote additional protections for consumers'.¹⁵⁸⁹

1574. Several of the proposals in these submissions seek to achieve indirect scrutiny of care in the home and to instil safeguards for people receiving aged care at home. These include proposals requiring registration of personal care workers, improving consumer feedback mechanisms and requiring the publication of consumer experience reports, instituting the system of performance ratings, and expanding the serious incident reporting regime. More 'eyes' on care in the home through expansion of the Community Visitors Scheme should also assist, although safety monitoring should in no way divert it from its primary purpose of maintaining social connection for people at risk of isolation.

¹⁵⁸⁶ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 79, CTH.4000.0001.1708 at 1712–3; Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T-9038.11–18.

¹⁵⁸⁷ See Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9032.6–12.

¹⁵⁸⁸ Transcript, Sydney Hearing 4, Robert Fitzgerald, 1 September 2020 at T8950.1–6.

¹⁵⁸⁹ Post-hearing Submission of Commonwealth, Sydney Hearing 4, 11 September 2020, RCD.0012.0072.0002 at 0006 [14].

1575. In line with Commissioner Fitzgerald's evidence, we also submit that assessments of need should continue to focus on risks and vulnerabilities of people seeking and receiving aged care. That information, currently captured on the National Screening and Assessment Form by assessment teams, should be made available to the Aged Care Quality and Safety Commission (and, in future, the Australian Aged Care Commission) so that quality and safety monitoring for people receiving care at home may be appropriately risk-informed. Further, the measures in the proposed recommendations set out above regarding the approval of particular scope of service, review of continuing suitability of approved providers and obtaining consumer experience feedback from at least 20% of people receiving care from a home care service during quality reviews should assist. These measures were supported by the Australian Government in its post-hearing submissions.¹⁵⁹⁰

1576. In light of the difficulties in monitoring the quality and safety of home care, the decline in regulatory activity in relation to home care over the period to March 2020 (documented in the evidence at Sydney Hearing 4) is of particular concern.¹⁵⁹¹ This evidence suggests that the Aged Care Quality and Safety Commission's assessor workforce are not sufficiently resourced to perform the tasks for which the Commission is currently responsible, let alone new tasks. This is of great concern, not least because the recommendations we propose will increase some aspects of the Aged Care Quality and Safety Commission's work. For example, the expansion of the range of reportable assaults, combined with the increased assessment of such reports when they are made, will significantly increase the workload of the Commission.

1577. In a submission to the Royal Commission, the Commonwealth Public Sector Union (the members of which include staff employed by the Aged Care Quality and Safety Commission) said:

...the overwhelming consensus is that the ACQSC needs greater resourcing and clearer operational policies and procedures. Current staff cannot be expected to improve outcomes with the same training, powers and staffing hours ... Although problems within the aged care sector and the ACQSC are systemic, cyclical and can seem overwhelming, the common factor relating to each failure is insufficient resourcing.¹⁵⁹²

1578. When asked whether it would be of assistance if this Royal Commission made a recommendation for a thorough capability review of the Aged Care Quality and Safety Commission, the Aged Care Quality and Safety Commissioner, Ms Janet Anderson

¹⁵⁹⁰ Post-hearing Submission of Commonwealth, Sydney Hearing 4, 11 September 2020, RCD.0012.0072.0002 at 0006 [14].

¹⁵⁹¹ Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 53, RCD.9999.0473.0001; tab 54, RCD.9999.0473.0041; tab 55, RCD.9999.0473.0051; tab 56, RCD.9999.0473.00027; tab 57, RCD.9999.0473.0011; Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9036.37–9039.24.

¹⁵⁹² Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 22, AWF.600.01806.0002 at 0012.

replied: 'I certainly would understand if the Royal Commission sought to make that recommendation'.¹⁵⁹³ We submit that such a recommendation is clearly warranted.

¹⁵⁹³ Transcript, Sydney Hearing 4, Janet Anderson, 2 September 2020 at T9044.14–15.

Part 3.18 Transition and implementation

1579. Since the enactment of the *Aged Care Act 1997* (Cth), there have been numerous inquiries and reviews into aspects of the aged care system, as documented in *Background Paper 8 – A History of Aged Care Reviews*, published on 28 October 2019. As that paper shows, government implementation of the recommendations of previous inquiries has been patchy.

1580. Government responses have, in some cases, come months or even years after the relevant review or report and some have only partially address relevant recommendations. In some instances, responses have been expressed in an ambiguous manner. In other cases, even when there has been an expressed commitment to change, actual reform has been slow to eventuate and the will for reform has cooled before implementation has been achieved.

1581. Our recommendations call for sweeping reforms to the aged care system in order to address pervasive systemic problems. Reforms of this magnitude are complex and require careful planning.¹⁵⁹⁴

1582. Reform of this nature takes genuine commitment by government. Even with such commitment, implementation of the necessary changes can be disrupted by many factors. For example, many of the recommendations are dependent on the successful implementation of others. If there is a delay in the implementation of earlier reforms, that will disrupt the implementation of later ones. It is also necessary to cater for unforeseen disruptions by building flexibility into the design for implementation of the reforms.

1583. There must be clear accountability for implementation. It must be monitored constantly, reviewed regularly and have continuous backing from government. The attention of political leadership will likely shift with crises, elections and other pressing challenges, but securing the government and ministerial engagement for seeing the change through is essential.

1584. To achieve this end, we submit the following recommendation should be made.

¹⁵⁹⁴ See, for example, Transcript, Nicholas Hartland, Adelaide Workshop 1, 11 February 2020 at T7816.6-10.

Recommendation 123: An implementation unit

123.1. Pending the establishment under the new Act of the Australian Aged Care Commission, an administrative unit or body should forthwith be established by the Australian Government (through the Australian Department of Prime Minister and Cabinet) and properly staffed and resourced to implement and direct implementation of the Royal Commission's recommendations (implementation unit).

123.2. Pending the establishment of the office of the Inspector-General of Aged Care under the new Act, an officer should be appointed to the role of Inspector-General under temporary administrative arrangements. That officer should monitor the implementation of recommendations and should report to the responsible Minister and to the Parliament at least every six months on the implementation of the recommendations.

123.3. From the commencement of the new Act, the Australian Aged Care Commission should implement and direct implementation of the recommendations of the Royal Commission. The Inspector-General of Aged Care should continue to monitor and report on the implementation of recommendations, in accordance with the requirements of that Act.

Recommendation 124: Evaluation of effectiveness

124.1. The Inspector-General of Aged Care should undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations of the Royal Commission, five and ten years after the tabling of the Final Report.

1585. The Australian Department of Health has had responsibility for formulating aged care policy over many years. In our submission, it is appropriate for another entity to be given responsibility for monitoring the implementation of the Royal Commission's recommendations.

1586. A new unit dedicated to the specific task of implementation of system-wide reform is required. The implementation unit may, in the short term, be constituted under administrative arrangements.

1587. This new authority needs a strong leader, supported by a steering committee of deputy secretaries from relevant policy agencies. These policy agencies may include:

- a. Department of the Prime Minister and Cabinet
- b. The Treasury
- c. Department of Finance
- d. Department of Health
- e. Department of Social Services
- f. Department of Education, Skills and Employment
- g. Attorney-General's Department
- h. Department of Veterans' Affairs
- i. National Indigenous Australians Agency.

1588. The implementation authority must have adequate time and resources to undertake the implementation work. It must be in a position to work quickly to identify and mobilise necessary skills, resources and systems to support implementation.

1589. In undertaking its work, the new authority should be guided by the following framework for the implementation of the recommendations of the Royal Commission.

1590. First, clear articulation of the basis for the policy is required. All of the stakeholders need to understand the objectives behind the changes. For example, people seeking or receiving aged care need to know what the benefits will be, clarity is needed for the people implementing the recommendations, providers need a level of understanding to anticipate and plan for change, the aged care market needs clear signals to maintain confidence.

1591. Secondly, the approach to implementation needs to be adaptive. It should be recognised that the policy will be shaped and reshaped at all phases of implementation and that there will be significant behavioural and cultural change required at all levels, including the broader Australian society.

1592. Thirdly, ongoing communication and collaboration is required. Attention must be paid to engaging those on the ground who will be impacted by the implementation, including older Australians and the workers who deliver care, about the best ways to achieve the necessary changes.

1593. Fourthly, ongoing political engagement is necessary to ensure the process for reform well supported, appropriately resourced and scrutinised.

1594. Finally, a phased approach should be adopted, guided by a transition and implementation plan like that found at Annexure A to these submissions. This plan needs to retain sufficient flexibility to be capable of adaptation should the need arise during implementation. These reforms will necessitate major changes in policy and operations for the entire aged care system over an extended period of time, and will need to be carefully managed. For example, the transition from the Australian Department of Health to an Australian Aged Care Commission must above all ensure continuity of aged care services for all who need them.

1595. As we have submitted on the topic of system design, we recommend the establishment of an independent statutory authority to govern the aged care system in the future, which we have been calling the Australian Aged Care Commission. In due course, the Australian Aged Care Commission should be formally established under statute, and we expect that from that point onward it would become the implementation authority and would inherit and carry on the work of implementation performed to that point in time. The Inspector-General of Aged Care should monitor and report on the work of the implementation authority.

1596. Given the significant change and the many years that it will take for some of these reforms to be embedded and then mature, the implementation process should build in independent assessments by the Inspector-General five years and ten years from the tabling of the Royal Commission's Final Report.

1597. We submit that this recommendation should be made to bring a level of focus, assurance and transparency to the implementation process. It will also prove an opportunity to check that desired outcomes are being realised and unintended consequences avoided. A process of learning and adapting is required.

PART 4 AGED CARE AND SUPPORT IN 2030 AND BEYOND

1598. The recommendations that we propose are intended to reform aged care in Australia over the coming decades. If fully implemented, those proposed recommendations should bring about significant, wide-ranging, long-lasting and beneficial changes. They should lay the groundwork for a vision for aged care in 2030 and beyond. Some core components of that vision are as follows.
1599. Aged care will always be about people – older people receiving support and care, their families and their carers, as well as the personal care workers, nurses, allied health and medical practitioners, and others who care for those older people.
1600. In 2030, there will be a statutory framework for aged care that emphasises the centrality of people and their relationships. That framework will enshrine and protect the rights of older people to high quality, safe and timely support and care to assist them to live active, self-determined and meaningful lives.
1601. The statutory framework will be administered and regulated chiefly by a strong and independent Australian Aged Care Commission. Pricing and standard setting will be undertaken by bodies removed from and independent of the Commission. The Commission's performance of its functions will be scrutinised and reviewed by an independent Inspector-General of Aged Care.
1602. Independent pricing of aged care will mean, for the first time, that funding will be set at levels designed to enable provision of high quality care. This begins with defining what is needed to raise aged care to that level, then working out what the reasonable costs of providing that will be (including staffing costs), and setting funding levels to cover those costs. This will be the principal purpose of the new Aged Care Pricing Authority, once it is established. Its pricing task will be an iterative process which will have been refined over time.
1603. The paramount consideration in the administration of the statutory framework will be the safety, health and wellbeing of people receiving aged care. The focus of aged care will be maintenance of independence, autonomy and choice.
1604. That focus will inform the delivery of aged care to older people. Support and care in the home will be the norm for aged care, through to the end of life. Wherever care is delivered, it should be personal and relationship-based rather than transactional and institutional. All aged care will be well adapted to providing safe, high quality and empathetic dementia care.
1605. Residential aged care will chiefly provide aged care services for older people with the most complex, acute and special needs, including those needing advanced subacute care, advanced palliative care, and advanced dementia care. Greater numbers of

smaller congregate living arrangements will be available for people living in residential aged care. Residential aged care facilities will meet accessible and dementia-friendly design standards.

1606. Delivery of aged care centred on the person will involve greater recognition and provision for diversity of circumstances and needs of older people. It will recognise and make culturally safe provision for the distinctive requirements of Australia's Aboriginal and Torres Strait Islander people. People receiving aged care will have access to locally-based care finders to assist with accessing aged care and other systems in accordance with their individual needs and preferences.
1607. There will be a larger, better-trained, valued and regulated aged care workforce. Residential aged care providers will have to meet mandatory staff-to-resident ratios taking into account their casemix of residents. The ratios will be adjusted to ensure they are at the level required for the delivery of high quality and safe care. Providers will be funded accordingly.
1608. Aged care staff providing personal, nursing and allied health care will be remunerated at comparable levels to their counterparts working in the health and disability services systems.
1609. Personal care workers will have mandatory minimum qualifications and undertake ongoing training and professional development activities. Nursing and allied health care staff will be subject to professional registration. All staff will receive better training in dementia care. High level infection control will be the norm in residential aged care overseen by trained infection control officers.
1610. There will be greatly improved access to allied and other health professionals in accordance with assessed need. Preventative and restorative care delivered by multidisciplinary teams will be expected. People receiving aged care will have far better access to general practitioners, specialists, dentists and pharmacists at their place of residence, whether that be at home in the community or in residential aged care.
1611. Outreach services will deliver health care to people who are unable to travel to visit health professionals. There will be system and data interoperability of information systems used by providers and the health care system to facilitate continuity of care. There will be a shared understanding of the respective (and joint) responsibilities of providers and health professionals to meet the care needs of people receiving aged care.
1612. People with disability receiving aged care will have access to services that would otherwise be available to a person with similar conditions under the National Disability Insurance Scheme. And save for very limited exceptions where it is demonstrably in the

best interests of the person receiving care, there will be no younger people in residential aged care.

1613. There will be no planning limits or rationing of entitlements to receive aged care. Wherever practicable, appropriate local aged care options will be available for all older people across Australia. Funding of aged care will be driven by individual care needs, independently assessed in a convenient and timely manner through an integrated assessment process which provides access to all aged care services a person might need.
1614. Providers will be governed accountably and skilfully by fit and proper key personnel. Providers will have a duty to provide high quality care so far as reasonable. They will have to meet clear regulatory standards for high quality care and to report on measurable performance indicators of clinical care and quality of life outcomes. Reporting on quality indicators will inform assessment by the Australian Aged Care Commission of performance of providers against benchmarks.
1615. In meeting regulatory standards, providers will provide best practice oral care, medication management, infection control, pressure injury prevention, wound management, continence care, falls prevention, and information control. A failure to meet those standards will attract timely and proportionate regulatory consequences. There will be a strong and effective regime for ensuring sound financial and prudential management by providers, in order to provide timely warning to the Australian Aged Care Commission of risks to the continuity of high quality and safe care to the people for whom a provider is responsible.
1616. The Australian Aged Care Commission will act as a proactive regulator of providers. It will have more powers and greater preparedness to use them. There will be zero tolerance for abuse and neglect. There will be effective means of redress for people receiving aged care services who are not provided with high quality care. Complaints to the Commission will be carefully considered and promptly acted on.
1617. Information on care-related spending, outcomes, provider performance and pricing will regularly be reported to the Australian Aged Care Commission, and it will be made available in appropriate form to the public, subject to individual privacy considerations. This will include a star rating system for providers, which will provide publicly available, transparent information to inform real choice.
1618. The Australian Aged Care Commission will have responsibility for aged care data collection and management, including a national aged care dataset. There will be dedicated, sizeable and ongoing research into aged care, innovation, and its translation into practice.

1619. By 2030, steps should be under way for the aged care system to be integrated with other systems administered by the Australian and State and Territory Governments for provision of health care, housing and welfare supports for older people in a comprehensive long-term care system.

Other matters

1620. Responses to these submissions are invited from any interested person. All responses are to be made on the form for responses which has been published on the Royal Commission's website. They are to be provided by 4.00pm (Australian Eastern Daylight Time) on 12 November 2020. The Royal Commissioners have indicated that no extensions to this deadline will be granted.

22 October 2020

Peter Gray QC

Peter Rozen QC

Richard Knowles SC

Paul Bolster

Erin Hill

Brooke Hutchins

Eliza Bergin

Counsel Assisting the Royal Commission into Aged Care Quality and Safety