

1. A Summary of the Final Report

1.1 Introduction

This Volume 1 provides an overview of Volumes 2 and 3 of our Final Report and of our special report on COVID-19, and details our approach to our inquiry. It contains a complete list of our recommendations. Volume 4 details some of what we heard in public hearings and Volume 5 contains appendices, including details of our community forums and a reproduction of our special report on COVID-19. Volumes 4 and 5 are not summarised here.

Our Final Report is generally about the future: tomorrow, a decade from now, twenty years from now, and beyond. To envisage a new aged care system, we need to understand the aged care system as it exists today, including the problems in the system. That is the purpose of Volume 2. In Volume 3 we shift our focus to solutions—our recommendations for action in response to the problems we identify. It is here that we set out our vision for the future of aged care in Australia.

1.2 The current system

1.2.1 A look at the aged care system

The Australian aged care system provides subsidised care and support to older people. It is a large and complex system that includes a range of programs and policies. It has evolved over time, including during our inquiry. Some changes to the system have been far-reaching and others incremental, but all have contributed to the piecemeal development of the aged care system.

Changing demographics

Australia's changing demographics significantly influence the demand for and provision of aged care. The aged care sector is facing an ageing population with increasing frailty. Australians are living longer than ever before. It is projected that the number of Australians aged 85 years and over will increase from 515,700 in 2018–19 (2.0% of the Australian population) to more than 1.5 million by 2058 (3.7% of the population). With advanced age comes greater frailty. Older people are more likely to have more than one health condition (comorbidity) as their life expectancy increases. As the population of older people increases, more people are expected to have memory and mobility disorders.

In 2019, there were 4.2 working age (15–64 years) people for every Australian aged 65 years or over. By 2058, this will have decreased to 3.1. This decline has implications not only for the financing of the aged care sector but also for the aged care workforce. There will be relatively fewer people of working age available to pay taxes to fund the aged care system and to meet the growing demand for services.

These changing demographics, together with changes in the patterns of disease and dependency, and in the expectations of older people and society, will impact on demand for aged care in a number of ways. These include the length of stay in residential aged care, the increase in care needs, the demand for a variety of care choices, and the desire of older people to remain in their own homes for as long as possible.

Aged care services

Aged care is not a single service. It is provided over a range of programs and services. The care ranges from low-level support to more intensive services. Aged care includes:

- assistance with everyday living activities, such as cleaning, laundry, shopping, meals and social participation
- respite
- equipment and home modifications, such as handrails
- personal care, such as help getting dressed, eating and going to the toilet
- health care, including nursing and allied health care
- accommodation.

Aged care is provided in people's homes, in the community and in residential aged care settings. People commonly think of nursing homes, or residential care, when they think about aged care. However, while most of the aged care budget is spent on residential aged care, more than two-thirds of people using aged care services do so from home.

The aged care system offers care under three main types of service: the Commonwealth Home Support Programme, Home Care Packages, and residential care.

The Commonwealth Home Support Programme is intended to provide entry-level services focused on supporting older people to maintain their health, independence and safety at home and in the community.

Home Care Packages can, and often do, contain many of the same support services that are available under the Commonwealth Home Support Programme, but they may be provided as a more structured and comprehensive bundle of services. They are delivered on a 'consumer directed care' basis. This means that people can choose the provider to deliver their services and can choose to change providers. There are four levels of assistance from basic care needs to high care needs.

Respite care provides short-term support and care services for older people and their carers. Its primary purpose is to give a carer or the person being cared for a break from the usual care arrangements.

Residential aged care provides support and accommodation for older people who are unable to continue living independently in their own homes and who need ongoing help with everyday tasks. Approved providers of residential aged care must provide a range of care and services to residents, including social care, accommodation services and help with day-to-day tasks, personal care, and clinical care.

In 2018–19, aged care services were delivered to around 1.3 million people. The most commonly used service in 2018–19 was the Commonwealth Home Support Programme (about 841,000 people), followed by residential aged care (about 243,000 people) and Home Care Packages (about 133,000 people).

Funding

The Australian Government is the main funder of aged care. In 2018–19, which is the last year for which all data is currently available, a total of \$27.0 billion was spent on aged care, including \$19.9 billion by the Australian Government. In 2019–20, the Australian Government's expenditure on aged care programs administered by the Department of Health was \$21.2 billion. Older people are required to contribute to the costs of their care and accommodation if they can afford to do so through co-payments and means tested fees. People receiving aged care services contributed \$5.6 billion to the cost of their aged care in 2018–19.

The Parliamentary Budget Office has projected that, over the next decade, Australian Government spending on aged care will increase by 4.0% a year, after correcting for inflation. This increase will mean that aged care spending will be growing significantly faster than the rate of all Australian Government spending (2.7%). By 2030–31, aged care will account for 5.0% of all Australian Government expenditure compared to 4.2% in 2018–19.

Workforce and providers

Aged care is one of Australia's largest service industries. The most recent National Aged Care Workforce Census and Survey found there were around 366,000 paid workers (84%) and 68,000 volunteers (16%) in the aged care sector in 2016. The data on the paid workforce excluded non-pay as you go workers—that is, agency, brokered and self-employed workers. During the relevant fortnight of the survey, about 28,000 non-pay as you go staff were engaged across the aged care sector.

In 2016, the majority of paid workers, 240,000 (or 66%), were in direct care roles. Registered nurses comprised 21% of the residential direct care workforce in 2003, but by 2016 this had dropped to around 15%. The proportion of enrolled nurses also dropped, from 13% to 10%. Over the same period, the proportion of the residential direct care workforce who were personal care workers increased from around 58% to around 70%.

Informal carers are a critical element of the care system for older people. They reduce the need for formal care, supplement the care provided by aged care services, and maintain critical social and community connections. In 2018, around 428,500 people were informal primary carers for someone aged 65 years or older.

The Aged Care Financing Authority reported that in 2018–19, there were over 3000 providers of aged care services. This included 873 residential aged care providers, 928 home care providers (as at 30 June 2019) and 1458 Commonwealth Home Support Programme providers.

Most aged care providers are organisations owned by community, charity or religious organisations—‘not-for-profits’, though they may or may not be run like a commercial business—or are privately owned organisations run as a commercial business. In addition, there is a smaller group of State and Territory Government and local government providers. There has been a shift towards consolidation of the aged care sector in the hands of fewer large-scale operators. In 2009–10, there were just two very large providers or groups in residential care, operating 16% of all places, whereas by 2018–19 this had grown to 10, operating 39% of all places.

According to the Aged Care Financing Authority, approximately 31% of home care providers and 42% of residential aged care providers reported an operating loss in 2018–19. Results for related parties are not accounted for in this reporting. The impact of the COVID-19 pandemic on the financial performance of aged care providers is not known at the time of writing. The Aged Care Financing Authority has suggested that the pandemic may increase pressure on the sector, particularly for providers in regional, rural and remote Australia.

Regulation of aged care

The Aged Care Quality and Safety Commissioner is the national regulator of aged care services. The Commissioner’s functions include:

- approving aged care providers to receive subsidies under the Aged Care Act
- regulating providers through accrediting aged care services, conducting quality reviews, and monitoring the quality of care
- imposing sanctions
- handling complaints
- undertaking consumer engagement
- providing education.

The Aged Care Act and the Aged Care Principles together set out providers' obligations and responsibilities. The Aged Care Act describes the quality of care approved providers must provide, including:

- providing the care and services specified in the Quality of Care Principles
- maintaining an adequate number of appropriately skilled staff to meet the care needs of people
- providing care and services of a quality that is consistent with any rights and responsibilities of people receiving care, as specified in the User Rights Principles.

Approved providers must comply with the Aged Care Quality Standards. These Standards apply to residential care, home care and flexible care. The eight Standards cover provision of care and support and the management and governance of an organisation.

1.2.2 Problems of access

It should be easy for older people to access the aged care they need. Having easy access means a person can get the information, support or care they need, when they need it. It also includes getting aged care appropriate to a person's individual needs, including care that is culturally appropriate and safe. Ineffective arrangements for older people to access aged care services mean that people may not know where to turn for help. They may have to make decisions which are difficult emotionally, financially and practically, without the benefit of accurate and timely information and support. In some cases, people do not receive the care they need, when they need it.

Entering and navigating the system

The aged care system is difficult to access and navigate. People trying to get aged care have reported the experience as time-consuming, overwhelming, frightening and intimidating. The availability of helpful and comprehensive information is critical to ensuring older people get timely access to the care they need and to empowering them to make choices about their care.

My Aged Care is the single entry point to aged care subsidised by the Australian Government. It is a contact centre and website with no local 'shopfront' or face-to-face assistance. Aged care is a personal experience, and there needs to be personalised information and support for people seeking to access and use aged care services. The current aged care system does not deliver this.

We are particularly concerned that it is difficult for people to make informed decisions about aged care services from the information available. People seeking services are not able to find out from My Aged Care whether a service will meet their specific needs. There is also very limited information available about the quality of services provided and other information which could help people meaningfully compare different services and providers.

Accessing care

There are many problems with accessing aged care services. Here we highlight problems in three key areas of care: home care, respite care and allied health care.

Most older people want to remain living in their own homes, rather than moving to residential aged care. However, in the current aged care system, older people often wait too long to get access to care at home. For example, in 2018–19, the waiting times between being assessed as eligible for a Home Care Package to being assigned a package ranged from seven months for a Level 1 package to 34 months for a Level 4 package. As at 30 June 2020, 102,081 older people were waiting for a package at their approved level. When they do eventually get access to care at home, older people may receive less care than they need, or they may not have access to specific services they need. Without access to home care services that meet their assessed needs, people face risks of declining function, preventable hospitalisation, carer burnout, premature entry to residential aged care, and even death.

Too often, older people and their informal carers do not receive quality respite care when they need it. Respite care can provide a ‘circuit breaker’ for both an older person and their carer. It can provide an opportunity for an older person’s rehabilitation, reablement or medication review. We heard of many problems with accessing respite care, including carers not knowing where to go for support, difficulty navigating between My Aged Care and the Carer Gateway, a lack of respite services generally, and a lack of access to services of the right type and duration.

People in aged care have limited access to services from allied health professionals, including dietitians, exercise physiologists, mental health workers, occupational therapists, physiotherapists, podiatrists, psychologists, speech pathologists and specialist oral and dental health professionals. A survey found that in 2018–19, only 2% of Home Care Package funding was spent on allied health. Under the Commonwealth Home Support Programme in 2018–19, while 29% of people received services categorised as allied health and therapy services, more than half of the people received fewer than five allied health services per year. Allied health care in residential aged care is also insufficient and we are concerned that the type of service provided may be influenced by funding arrangements.

Access for groups already at a disadvantage

People in aged care have diverse backgrounds and life experiences. Some groups of people have particular needs, which are too often not being met by the current aged care system. We heard of numerous access issues experienced by people with diverse backgrounds and life experiences.

We are particularly concerned about access to aged care services in regional, rural and remote areas. Older people make up a greater share of the population in these areas than in major cities. Furthermore, people in regional, rural and remote areas experience multiple disadvantages, which can magnify the need for support in older age. The data shows that the availability of aged care in outer regional and remote areas is significantly lower than in major cities, and has declined in recent years.

We are also concerned that Aboriginal and Torres Strait Islander people do not access aged care at a rate commensurate with their level of need. A combination of factors creates barriers to Aboriginal and Torres Strait Islander people's access to the aged care system. These arise from social and economic disadvantage, a lack of culturally safe care, and the ongoing impacts of colonisation and prolonged discrimination. Access issues are further compounded by Aboriginal and Torres Strait Islander people's additional vulnerability arising from higher rates of disability, comorbidities, homelessness and dementia. To feel secure and obtain culturally safe services, many Aboriginal and Torres Strait Islander people prefer to receive services from Aboriginal and Torres Strait Islander people and from Aboriginal and Torres Strait Islander organisations. However, there are currently not enough Aboriginal and Torres Strait Islander people, and other people with high levels of cultural competency, employed across the aged care system.

Many people who come from diverse backgrounds and have had varied life experiences have problems accessing aged care services that meet their particular needs. This includes people from culturally and linguistically diverse backgrounds, veterans, people who are homeless or at risk of becoming homeless, care leavers, and people from the lesbian, gay, bisexual, transgender and/or intersex (LGBTI) communities. The existing aged care system is not well equipped to provide care that is non-discriminatory and appropriate for people's identity and experience. We heard about aged care providers that do not provide culturally safe care, that is, care that acknowledges, respects and values people's diverse needs. Across the aged care system, staff are often poorly trained in culturally safe practices, with little understanding of the additional needs of people from diverse backgrounds.

Access to health care and disability services

Problems may also arise when a person's access to quality aged care is dependent on their access to another government-subsidised system. This is particularly the case where the aged care system interacts with the health care system and the National Disability Insurance Scheme.

People receiving aged care, particularly those in residential aged care, do not consistently receive the health care they need. This includes doctor visits, mental health services, oral and dental health care, and preventative and holistic care. This is a result of a number of factors. People in aged care have increasing health care needs. Their care needs are often not identified or are identified late. Older, frail people often cannot travel to access health care services and yet health care providers, particularly specialists, are reluctant to provide their services in a person's place of residence.

Some people living with disability cannot access the level of services they need. There are two key problems. First, some older people in aged care cannot receive the services they need because they are not eligible for or cannot use fully their entitlements under the National Disability Insurance Scheme. It is apparent that older people with disability do not have equitable access to disability services. Second, some younger people with disability enter residential aged care because they do not have access to the level of disability services they need. More than 1000 younger people with a disability were admitted to residential aged care in the year to 30 September 2020. Residential aged care is inherently unsuitable for younger people.

1.2.3 Uncovering substandard care

Over the course of 2019, we heard from many people about substandard care—those who experienced it, family members or loved ones who witnessed it or heard about it, aged care workers, service providers, peak bodies, advocates and experts. We heard about substandard care during hearings and community forums. We also were informed about it in public submissions. Substandard care and abuse pervades the Australian aged care system.

The accounts of substandard care were always sad and confronting. They were no doubt difficult to tell, and very difficult to hear and read. We acknowledge the courage people have shown in sharing their experiences with us. Their contributions have been essential to our inquiry and we are grateful.

What we learned about substandard care

Substandard care can occur in both routine areas of care, like food, medication management and skin care, as well as in complex care, such as the management of chronic conditions, dementia or palliation. Substandard care can also take the form of deliberate acts of harm and forms of abuse—including physical and sexual abuse and abuse from inappropriate restrictive practices. Abuse is an extreme example of substandard care and reaches into the realm of criminal behaviour.

We analysed qualitative and quantitative information and evidence from hearings, public submissions, community forums, the Service Provider Survey and research and identified 15 common areas where substandard care occurs in the provision of complex and routine care.

Abuse

The abuse of older people in residential care is far from uncommon. In 2019–20, residential aged care services reported 5718 allegations of assault under the mandatory reporting requirements of the Aged Care Act. A study conducted by consultancy firm KPMG for the Australian Department of Health estimated that, in the same year, a further 27,000 to 39,000 alleged assaults occurred that were exempt from mandatory reporting because they were resident-on-resident incidents. In our inquiry, we heard of physical and sexual abuse that occurred at the hands of staff members, and of situations in which residential aged care providers did not protect residents from abuse by other residents. This is a disgrace and should be a source of national shame. Older people receiving aged care should be safe and free from abuse at all times.

Our analysis of abuse also focused on restrictive practices, which are activities or interventions, either physical or pharmacological, that restrict a person's free movement or ability to make decisions. Where this occurs without clear justification and clinical indication, we consider this to be abuse. Restrictive practices can result in serious physical and psychological harm and, in some cases, death. Restrictive practices have been identified as a problem in aged care in Australia for more than 20 years. The inappropriate use of unsafe and inhumane restrictive practices in residential aged care has continued, despite multiple reviews and reports highlighting the problem. It must stop now.

Complex care

Many people living in residential aged care have care needs that extend beyond assistance with day-to-day self-care. Complex care needs arise when people require support that is less predictable or requires more skilful care. We heard that residential aged care providers often fail to deliver, facilitate or coordinate care to meet the complex care needs of residents. The most common areas of substandard complex care we heard about involve dementia and challenging behaviours, mental health, and palliative care.

Dementia care should be core business for aged care services, and particularly residential aged care services. Over half of people living in residential aged care have a diagnosis of dementia. Yet substandard dementia care was a persistent theme in our inquiry. We are deeply concerned that so many aged care providers do not seem to have the skills and capacity required to care adequately for people living with dementia.

We heard that the needs of older people with mental health conditions are not being adequately addressed across the aged care system. Depression is very common. Older people should have access to the same mental health support as all members of the community, but they do not. It is often difficult for people living in residential aged care to access specialist mental health services, such as psychologists and psychiatrists. Furthermore, many staff members working in aged care are not sufficiently skilled or trained to identify and support people living with mental health conditions.

Residential aged care is often a person's final place of residence before they die. Palliative and end-of-life care, like dementia care, should be considered core business for aged care providers. People at the end of their lives should be treated with care and respect. Their pain must be minimised, their dignity maintained, and their wishes respected. Their families should be supported and informed. However, throughout our inquiry we heard examples where the care provided to people in their last weeks and days of life was severely lacking and fell well short of community expectations.

Routine care

As people get older, they may require assistance to care for themselves. The types of assistance needed vary for each individual and are commonly referred to as help with the 'activities of daily living'.

The routine daily living care that older people receive should be predictable and reliable. People should be able to trust that each day they will be able to brush their teeth, eat nutritious and appetising meals, go to the toilet, and feel connected and mentally stimulated.

Care should enhance a person's health and wellbeing and avoid reasonably preventable harm. Our inquiry has shown that the routine care of older people, particularly in residential aged care, often does not meet these expectations. We have found many examples of substandard care in providing for the most basic of human needs, such as diet and nutrition, oral health, skin care, mobility, medication and prescription management, continence and incontinence, infection control, social and emotional needs, and diversity and cultural needs.

Diet, nutrition and hydration are critical to the health of older people. Food is also important to wellbeing, providing enjoyment through taste and smell. Too often we heard that residential aged care providers failed to meet the nutritional needs of people for whom they care and that they provided poor quality and unappetising food. A lack of assistance to eat and drink, leading to malnutrition and dehydration, was a common issue raised by witnesses and in submissions. Studies have revealed that as many as 68% of people receiving residential aged care are malnourished or at risk of malnutrition. The consequences of poor nutrition are significant and often irreversible for older people. Malnutrition is associated with many other health risks, including an increased incidence of falls and fractures, increased time for pressure injuries to heal, and increased risk of infection.

Poor oral health can have far reaching consequences for general health and wellbeing. We heard consistently that oral and dental health care needs of people living in residential aged care are not treated as priorities. Daily oral health care is often not undertaken and access to oral and dental health practitioners is limited. Much of what we heard about the failures in oral and dental health care focused on lack of staff time and inadequate training, as well as a lack of access to oral and dental health professionals, but there can be no excuse for failing to brush older people's teeth and clean their dentures daily.

Mobility is closely linked with people's health and their quality of life. However, we heard numerous examples of aged care providers not supporting people to maintain and improve their mobility—including limited access to allied health professionals critical to promoting mobility, such as physiotherapists. Poor mobility increases the risk of falls and fall-related injuries due to deconditioning and reduced muscle strength.

We heard horrific accounts of substandard skin care, especially about the lack of prevention, and poor treatment, of pressure injuries. It takes time and skill to care for older people's skin and to protect them from developing injuries. We heard that staff members often do not have adequate knowledge and training to prevent pressure injuries and wounds from occurring, nor for treating them effectively when they do occur. The consequences for people receiving aged care are painful, distressing and can have immense health implications, which sometimes lead to early death.

Incontinence is an intensely personal and often stigmatising condition that requires time and the right skills to manage appropriately. We were disturbed to hear that 71% of people in residential aged care have experienced incontinence. Negative effects of incontinence can include increased risk of depression, reduced quality of life and increased risk of pressure injuries and infections. The evidence indicates that some residential aged care providers unintentionally contribute to incontinence by adopting flawed approaches to its management. We also heard that staff members do not have the time needed to assist residents to go to the toilet in a timely manner. Too often there is a routine use of incontinence pads to manage workload. Where older people are reliant on incontinence aids, there may not be a sufficient supply. Not only does this risk adverse health outcomes, including creating or exacerbating incontinence, it impacts on older people's dignity, quality of life and wellbeing.

With people living longer and the increasing prevalence of multi-morbidity, older people are more likely to be taking medicines and, in some cases, more likely to be taking multiple medicines daily. Often, older people need assistance to take medicines correctly. Medicines clearly have beneficial effects and can improve health and wellbeing, but some may also have harmful unintended consequences. We heard numerous instances of inappropriate management of medication regimens. We heard about aged care staff members failing to administer medicines correctly or administering medicines but failing to ensure residents swallow them. We heard of failures to administer medicines at the correct time or in the correct dose, and of residents being administered incorrect medicines.

Infection control should be a central feature of care for aged care providers. In residential aged care, an infection outbreak has the potential to cause serious illness and death among vulnerable older people and staff. We received public submissions that raised concerns about staff training in infection control and hygiene, as well as limited access to gloves, wipes and personal protective equipment. We made recommendations to improve infection control in residential aged care homes in our special report on COVID-19. These included increased infection control expertise in all aged care homes.

We have heard about care that did not meet people's social and emotional needs. This included care that was dehumanising or that failed to recognise individual needs or to support people to make meaningful choices. We heard that the task-based focus of work in aged care does not sufficiently allow consideration for the person who is being cared for, their wants or social and emotional needs. We also heard numerous examples of what we call small oversights, such as a cup of tea placed just out of reach, a request not acknowledged or call bells unanswered. In isolation, these 'oversights' may not be considered significant instances of substandard care. But when repeated over time, they can be more than just unkind; they can amount to neglect.

People receiving aged care are not always supported to remain socially connected to the broader community. Staying actively involved in the community is an important component of helping people live at home for as long as possible. And whether a person is receiving aged care at home or in a residential setting, social connection is a key part of a fulfilled and meaningful life. The current aged care system leaves too many older people isolated and disconnected.

The aged care system often struggles to provide appropriate care to people with diverse needs. We heard evidence in this regard from people with culturally and linguistically diverse backgrounds, people who identify as part of the LGBTI communities, care leavers, Aboriginal and Torres Strait Islander people living in major cities and in rural and remote communities, veterans, and people who are experiencing, or are at risk of, homelessness. The aged care system should be equally welcoming and supportive of everyone needing care. But we heard there can be a lack of understanding and respect for people's culture, background and life experiences.

Extent of substandard care

Discovering the extent of substandard care in any human service should be quite straightforward. In Australia's aged care system, it is exceedingly difficult. 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. There has been a reluctance to measure quality.

We have considered existing data on substandard care, and we have also conducted and commissioned our own research to supplement this material. There are a number of challenges in analysing the data. The data is variable and inconsistent. It does not share a definition of substandard or high quality care. It focuses on different aspects of care, and was often gathered for an unrelated administrative purpose. In some instances, it is of poor quality.

Analysing this data has been a complex and resource-intensive task, but an important one. Viewed as a whole, the data tells a story of unacceptably high levels of substandard care.

Commissioner Briggs concludes that at least 1 in 3 people accessing residential aged care and home care services—or over 30%—have experienced substandard care. Among the data, she notes the following disturbing themes:

- the incidence of assaults may be as high as 13–18% in residential aged care
- there is a clear overuse of physical and chemical restraint in residential aged care
- in residential aged care, some 47% of people have concerns about staff, including understaffing, unanswered call bells, high rates of staff turnover, and agency staff not knowing the residents and their needs
- in home care, one-third of people have concerns about staff, including continuity of staff and staff not being adequately trained
- in respite care in residential facilities and in the Commonwealth Home Support Programme, about 30% of people have concerns about staff, including understaffing, continuity, training and communication
- substandard care has become normalised in some parts of the aged care system, such that people have low expectations of the quality of their care.

Commissioner Briggs further notes that the extent of substandard care differs across different provider types, including the organisation type—for-profit, not-for-profit, government—as well as the size and business model of the provider. In summary:

- According to a range of measures of quality and residents' outcomes, government-run residential aged care providers perform better on average than both not-for-profit and, in particular, for-profit aged care providers.
- Research indicates that quality in residential aged care services is highly correlated with size, with on average small residential care services (fewer than 30 beds) performing better than larger services.

Commissioner Pagone does not believe that it is currently possible to ascertain the precise extent of substandard care in aged care. This itself is a major deficiency in the current arrangements that must be addressed urgently. Nevertheless, it is clear from the evidence that there is too much substandard aged care. Each case of substandard care is a case that should not have happened. We both agree that there is no threshold under which the community should tolerate substandard aged care.

We consider that the extent of substandard care in Australia's aged care system is deeply concerning and unacceptable by any measure. We also consider that it is very difficult to measure precisely the extent of substandard care, and that this must change. 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 aged care providers have a responsibility to monitor, improve and be transparent about the care they provide.

The extent of substandard care in Australia's aged care system reflects both poor quality on the part of some aged care providers and fundamental systemic flaws with the way the Australian aged care system is designed and governed. People receiving aged care deserve better. The Australian community is entitled to expect better.

1.2.4 Investigating systemic problems

Systemic problems are serious and recurrent issues that stem from problems inherent in the design and operation of the aged care system. They may be funding, policy, cultural or operational issues. These systemic problems are interconnected. None of them exist in isolation and they often have a compounding effect on the quality and accessibility of aged care.

The systemic problems we have identified include inadequate funding, variable provider governance and behaviour, absence of system leadership and governance, and poor access to health care.

The common characteristic of these problems is that, in our view, they are problems that significantly and repeatedly contribute to the aged care system not providing consistently high quality care to the people who need it. The purpose of identifying the systemic problems is to inform an understanding of how the aged care system should be redesigned to ensure it provides high quality care in the future.

Systemic problems in aged care

Our investigation of systemic problems begins with those ultimately responsible for aged care in Australia—the Minister responsible for the aged care portfolio, and, through the Minister, the Australian Government. The Minister and the Government are supported by the Australian Department of Health. Over the last several decades, successive Australian Governments have brought a level of ambivalence, timidity and detachment to their approach to aged care. Responsibility for critical governing functions of setting goals, close monitoring and timely interventions has not been articulated adequately. The absence of leadership at a system level is at the heart of many of the other systemic problems we outline below.

Aged care has often been treated by the Australian Government as a lower order priority. In recent years, it has rarely been seen to merit its own Minister at Cabinet level and this has contributed to the extent of current problems. The Minister for Health often has also had responsibility for aged care, but Commissioner Pagone considers that, given the breadth of the portfolio, perhaps they necessarily paid it little notice. The Prime Minister announced the elevation of the aged care portfolio into Cabinet on 18 December 2020.

Funding for aged care is insufficient, insecure, and subject to the fiscal priorities of the Australian Government of the day. For several decades, one of the priorities for governments dealing with the aged care system has been to restrain the growth in aged care expenditure in light of demographic changes. This priority has been pursued irrespective of the level of need for care, and without sufficient regard to whether the funding is adequate to deliver high quality and safe care. The consequence of these funding arrangements for older people is that they may not be able to access care when they need it due to rationing of services, and when they do access care, funding may not be sufficient to meet the cost of providing the high quality care they need. The current state of Australia's aged care system is a predictable outcome of these measures to limit expenditure and ignore the actual cost of delivering aged care.

Commissioner Pagone considers that a continuation of the current arrangement of financing aged care through general revenue will not support a sustainable system into the future. Aged care expenditure is projected to grow at a significantly faster rate than overall Australian Government expenditure due to projected demographic changes and subsequent increasing demand for aged care services. Commissioner Pagone considers that ongoing financing of the aged care system through general revenue exposes the sector to the annual budget cycle and fiscal priorities of the government of the day. Commissioner Briggs considers that Government funding of the aged care system is the only viable option currently. In either case, we agree that funding must be based on objective and independent advice on the cost of providing care universally to those who need it.

The Australian Government has undertaken little active management or shaping of the market for aged care services. The Government has control over decisions relating to entering and exiting the market, the response to changes in demand, and broader changes in market conditions. But these strategies are not being used effectively. The approach has generally been that the market will take care of itself without the need for monitoring and management by the Government. The result is that the Government has not adequately responded to the changing composition and risk profile of aged care providers. It has allowed the network of providers to become more concentrated over the last decade, with a significant expansion in very large providers. There has also been a rapid expansion in home care providers, with limited scrutiny applied to their suitability. Effective market governance requires local capacity and engagement with local networks, but aged care remains highly centralised within the Government and there is little presence at the regional and local level. This has led to gaps in planning, development and management of services.

Reform of aged care has been reactive, responding to financial, demographic or other concerns of the time. This has triggered repeated reviews, which have tended to be confined to particular areas of focus. The same issues have arisen repeatedly in these reviews without being resolved. It is clear to us that piecemeal adjustments and improvements have not been achieved, and will not achieve, the change that is required to ensure high quality care in the future.

We heard that the absence of a strong consumer voice is a notable feature of aged care in Australia. When the design and delivery of a service or system does not take account of people's needs, preferences and circumstances, it can exclude and alienate the people it seeks to assist. It can lead to a one-size-fits-all approach to program design and delivery. In overhauling the aged care system, the voices of people receiving care must be heard to ensure that the system is relevant and appropriate for the people it is intended to support.

Attitudes and assumptions about older people and aged care can affect the delivery of aged care. Assumptions about the natural process of ageing may contribute to a lack of attention to prevention and rehabilitation. When it comes to improving health, some conditions, such as back pain or feelings of depression, may be put down to 'old age'. Assumptions about an older person's cognitive capacity may lead to them being excluded from conversations, staff members talking about them as if they are not there, and their privacy not being respected. Commissioner Briggs considers that ageism is a systemic problem in the Australian community that must be addressed.

Provider governance and management directly impact on all aspects of aged care. Deficiencies in the governance and leadership of some approved providers have resulted in shortfalls in the quality and safety of care. Some boards and governing bodies lack professional knowledge about the delivery of aged care, including clinical expertise. There is a risk that they may focus on financial risks and performance, without a commensurate focus on the quality and safety of care. There is sometimes a lack of accountability, particularly when things go wrong. Poor workplace culture has also contributed to poor care. The values and behaviour of people in senior positions have a significant impact on workplace culture and the quality of care that is delivered. When these values and behaviours are poor, so may be the care that people receive.

Commissioner Pagone considers providers could do more to improve leadership and culture, while acknowledging that many providers have been exemplary in prioritising quality care within the funds available.

Commissioner Briggs considers that providers have been critical contributors to the systemic problems of the aged care system. Some approved providers' leadership and culture appear not to align with their mission and certainly not with the purpose of the aged care system. With some notable exceptions, Commissioner Briggs observes that providers have demonstrated little curiosity or ambition for care improvement, and have not prioritised enablement and allied health care. As a group, providers have not sufficiently valued nor invested in the aged care workforce. When substandard care is at inexcusably high levels, she considers that it must reflect on the providers who deliver that care.

Our inquiry has revealed that the prevailing model of care in the current aged care system is largely reactive. Aged care services are not generally geared towards people's enablement and do not maximise the maintenance and improvement of people's health. Deficits in care planning reduce the ability of care staff to deliver appropriate care. We have heard that some care plans may prioritise funding considerations over care, that they may be insufficiently detailed and rarely updated, and they may not be adhered to. The dominant models of care delivery in aged care are task-based and focused on standardised processes. The task-based approach reflects a misplaced belief that care is adequate so long as a person's medical and physical needs are met. The current system does not sufficiently recognise the importance of proactively supporting older people's social and emotional wellbeing.

We have found that Australia's aged care system is understaffed and the workforce underpaid and undertrained. Too often there are not enough staff members, particularly nurses, in home and residential aged care. In addition, the mix of staff who provide aged care is not matched to the needs of older people. Aged care workers often lack sufficient skills and training to cater for the needs of older people receiving aged care services. Inadequate staffing levels, skill mix and training are principal causes of substandard care in the current system. The sector has difficulty attracting and retaining well-skilled people due to: low wages and poor employment conditions; lack of investment in staff and, in particular, staff training; limited opportunities to progress or be promoted; and no career pathways. All too often, and despite best intentions, aged care workers simply do not have the requisite time, knowledge, skill and support to deliver high quality care.

One of the key causes of substandard care in aged care, particularly residential aged care, is that people do not consistently receive the health care they need. The reasons for poor access to health care include lack of funding for proactive health care services provided to people at their place of residence, and an unwillingness by some health care providers to attend a person at their residence. There is also poor clarity about the responsibilities of aged care providers and health care providers to deliver health care for people in aged care, and inadequate communication between them. These systemic issues are partly a result of the split in responsibilities for health care and aged care between Australian and State and Territory Governments.

Commissioner Briggs observes that a lack of transparency is a pervasive feature of the current aged care system. It has been an important contributing cause of a number of the quality problems. Useful and relevant information on aged care services and the performance of services and providers is hard to come by. It remains difficult for people to make informed decisions about aged care services they are likely to receive. Similarly, the Australian Government needs access to comprehensive data to assess the performance and impact of services provided to older people, yet the available information is often surprisingly limited. Difficulties in obtaining reliable information limits the scope for aged care providers to benchmark their performance against their peers, and prevents the community at large from holding governments and service providers to account for the quality of the care they deliver.

We both consider that the Aged Care Quality and Safety Commission and its predecessors have not demonstrated strong and effective regulation. The regulator adopted a light touch approach to regulation when a more rigorous system of continuous monitoring and investigation was required for aged care. Current regulation policies and processes have many deficiencies. The regulatory framework is overly concerned with processes, not focused enough on outcomes, and does not provide enough safeguards to protect older people and provide reassurance to their families that they will receive safe and high quality aged care. The system is insufficiently responsive to the experiences of older people. The oversight of home care is particularly underdeveloped. There is a poor track record—in both home care and residential care—on enforcement, and the approach to monitoring and compliance is overly reactive. The regulatory arrangements lack the transparency, accountability and responsiveness that would be expected of a contemporary regulatory regime. Overall, the system has not provided the assurance of high quality and safe care that older people and the community reasonably expect.

There have been many missed opportunities in research and innovation in the aged care sector. First, compared with health research, the field of aged care research struggles to compete for research funding grants. Second, there is no strategy for the translation of research outputs into evidence-based best practice and continuous improvement that benefits the whole aged care sector. Third, the current funding and service models do not support providers who wish to try new practices, products, technologies and models of care. Fourth, the absence of quality data about older people and their experiences of aged care impedes the research, evaluation and quality monitoring needed for the aged care sector to develop and safely adopt new and better care practices. Finally, the aged care system is well behind other sectors in the use and application of technology, and has no clear information and communications technology strategy. This mix of factors has resulted in an aged care sector that is behind the research, innovation and technological curves.

The complex capital financing arrangements for residential aged care accommodation can distort incentives for older people and providers, and can impose a large cost burden on older people and their families. The sector has become too reliant on Refundable Accommodation Deposits. The increasing proportion of people choosing to make Daily Accommodation Payments is increasing the difficulty for providers to secure loans. Providers in regional and remote areas are at a particular disadvantage in attracting high accommodation payments, which affects lending decisions. We have heard there is a power imbalance during payment negotiations between providers and incoming residents.

The means testing arrangements for aged care funding are insufficiently progressive, affecting equitable access to care. While means testing should ensure that services and payments are directed towards those who need them the most, the current arrangements have a disproportionate impact on people with medium-level assets compared with wealthier people. The means testing arrangements can also result in very high effective marginal tax rates for some people.

Conclusion to systematic problems

Our examination of systemic problems in the Australian aged care system cannot help but paint a gloomy picture. The current state of the aged care system is a fairly predictable outcome of the various systemic problems we have identified. This is why significant change is required. The delivery of aged care in Australia is not intended to be cruel or uncaring. Many of the people and institutions in the aged care sector want to deliver the best possible care to older people, but are overwhelmed, underfunded or out of their depth. We have not set out the problems with the current system gratuitously. We see this as a necessary part of explaining how the future aged care system can and should be so much better.

1.3 A new aged care system

1.3.1 Foundations of the new aged care system: A new Act, purpose and principles

Placing people at the centre of aged care

Much has been said during our inquiry about the need to ‘place people at the centre’ of aged care. To achieve this, we are convinced that a new Act is needed as a foundation of a new aged care system. The new Act must focus on the safety, health and wellbeing of older people and put their needs and preferences first. It should provide an entitlement to the support and care each individual needs to prevent and delay the impairment of their capacity to live independently.

Framing the reform agenda as one based on entitlement is essential. Approaching reform in this way will focus on the interests of people who need or receive aged care being embedded in all key aspects of the new system. It will guide policy development and program administration; it will govern regulatory approaches and workforce development; and it will inform the approaches taken by approved providers to their internal governance, organisational culture and care delivery.

Common themes for reform of aged care

Over the course of our inquiry, we have identified clear common themes in what the community expects from the aged care system: dignity and respect, control and choice, the importance of relationships and connections to communities, and the desire for a good quality of life and ageing at home.

We have heard repeatedly about the importance of dignity and respect in aged care. People, regardless of their age or level of frailty, want to be valued as a person and as an individual. Mr Barrie Anderson spoke movingly about Grace, his wife, and her experience of living with dementia in the palliative care stage. He said that when people asked him how to care for his wife, he replied:

It's a fairly simple message, actually, to walk in Grace's shoes, to recognise that she's had a rich past, that there's a present and that she has an evolving future.¹

Self-determination is about autonomy, and having control and choice over your own life. Choice and control, and involvement in decision-making, promote dignity.

Quality of life should be the constant and predominant aim of the aged care system. The desire for a good quality of life may change in content but does not diminish with age.

Caring, by its very nature, depends upon relationships between people. Caring relationships that leave older people feeling heard and seen and respected are essential to maintaining dignity.

It has been made plain throughout our inquiry that older people who need care want to receive it in their own homes. Ageing at home can be central to a person's sense of identity and independence.

Whether people are receiving aged care in their homes or in residential care, they are still members of our community. It is important that they remain engaged, valued and socially connected.

A new Act: a rights-based approach

A new Act is required to achieve the fundamental reforms we envisage to put older people's needs and wellbeing first. We define aged care as 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. It also includes supports for informal carers of people receiving aged care, recognising their integral role in aged care.

We propose a number of objects for the new Act, including: to provide a system of care based on a universal right to high quality, safe and timely support and care; to enable people to exercise choice and control; to ensure equity of access; and to provide for regular and independent review of the system.

The new Act must enshrine the rights of older people who are seeking or receiving aged care. This will leave no doubt to all involved in the system about the importance placed on these rights. A rights-based approach must guarantee universal access to the supports and services that an older person is assessed as needing.

The proposed rights are elements of a core human right from Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights* ratified by Australia in 1972: 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.²

For people seeking aged care, those rights include the right to equitable access to care services in accordance with needs and the right to exercise choice between available services. For people receiving aged care, they include: the right to freedom from degrading treatment, or any form of abuse; the right to liberty; the right of autonomy and to make decisions about their care; the right to fair and non-discriminatory treatment; and the right to voice opinions and make complaints. For people providing informal care, the rights include the right to reasonable access to supports in accordance with needs and to enable reasonable enjoyment of the right to social participation.

The new Act should articulate the purpose and guiding principles of the new aged care system.

Purpose of the aged care system

The purpose of the aged care system must be to ensure that older people have an entitlement to high quality aged care and support and that they must receive it. Such care and support must be safe and timely and must assist older people to live an active, self-determined and meaningful life in a safe and caring environment that allows for dignified living in old age.

This purpose should be the touchstone for the administration of the new system.

We have identified two paramount principles for the administration of the new Act: to ensure the safety, health and wellbeing of people receiving aged care, and to put older people first so that their preferences and needs drive the delivery of care. The purpose and the guiding principles should be embedded and evident in every part of the system, from aged care policy development through to on-the-ground aged care service delivery.

The principles are mandatory and provide high-level guidance to all the participants in the aged care system about what is important. Commissioner Briggs has developed a simple guide to the principles, with which Commissioner Pagone agrees. This should help everyone working in aged care to keep the principles at the centre of their thoughts on a day-to-day basis. Put simply, the aged care system should put older people first and it should be equitable, effective, ambitious, accountable and sustainable.

Supporting people to age well

The experience of ageing is different for everyone. Some people are fit and healthy well into their 80s, while others may experience cognitive decline or frailty well before then. Their experience is influenced as much by social expectations as by the biological process of ageing. There is much that can be done to help people live a more active, healthy and engaged lifestyle as they age.

The aged care system is only one component of what is needed to support people to age well. There are other government strategies and policies that can complement formal aged care to help people live a long life in good health. These strategies include designing age-friendly communities that support people to stay in their own homes into later life, age-friendly city and town design, and fostering more positive attitudes and beliefs about older people.

Beyond this, there are everyday things that all of us can do to enable older people to live their lives to the fullest extent possible, to be less isolated, and to be happier. We urge all Australians to talk to their older relatives, friends or neighbours about what they can do for them. Older people should also be encouraged to think about what it is that would make them happy, and to have some goals or objectives for each day or week that give purpose to their lives.

There is a tendency to think of ‘aged care’ in isolation rather than as part of a spectrum of supports and care that can assist older people. We consider that there should be an integrated system for the long-term support and care of older people and their ongoing community engagement.

The potential for an integrated system of supports should be the focus of a new National Cabinet Reform Committee on Ageing and Older Australians. The Australian Government’s role is clear—national leadership is required on these matters, alongside its responsibilities for age pensions and the aged care system. State and Territory Governments also have a critical role to play in helping people age well, especially through housing and health care. Placing this issue on the National Cabinet agenda will open the avenues needed for holistic attention to be given to the current patchwork of arrangements across housing, welfare, retirement incomes policy, health and aged care.

The challenges presented by forging a new aged care system for Australia extend beyond the Government to the entire community. Only the community can bring to bear the desire and will for lasting change. It is a change that sees growing older as a normal part of life—as a stage of life that holds the potential for happiness and fulfilment. We are confident that the community supports this fundamental change for aged care. That change should take as its foundation the new Act, with its purpose, outcomes and principles, and the universal rights that we propose.

All the participants in the aged care system should then adopt these aged care foundations, and take the necessary steps to transform the aged care system and deliver greatly enhanced high quality and safe aged care for older people so that they are able to live a meaningful and dignified life.

1.3.2 Governing for older Australians

Better system governance is crucial to the reform of aged care. Effective governance of the aged care system requires ongoing guidance and direction, steering the system towards long-term policy outcomes, monitoring performance, addressing emerging issues and holding players in the system accountable for performance. The overall objective of system governance must be to ensure that people receive safe and high quality aged care according to their needs.

We use the term ‘aged care system’ to describe all the entities, structures, people and processes contributing to how care to older people is provided, regulated and funded and the policies that shape that care.

The Australian aged care system has been under prolonged stress and has reached crisis point. The tragic impact of the COVID-19 pandemic highlighted weaknesses and shortcomings in the system, especially the reactive nature of its governance.

The Australian Government has policy and administrative responsibilities for aged care exclusive of the States and Territories. Responsibility for quality and safety and prudential regulation sits with the independent Aged Care Quality and Safety Commission. All other responsibilities relating to management and governance remain with the Minister for Health and Aged Care and the Australian Department of Health.

The Minister and the Department (and their predecessor Ministers and Departments) have over many years had the means available to achieve effective leadership of the aged care system, but failed to do so. The Australian Government has been the dominant funder of aged care services, but it has not funded the system adequately. It has been in a position to create mechanisms for measuring performance of the aged care system and identifying areas for improvement. It has been responsible for design of an effective regulatory system. It has failed to discharge these responsibilities adequately.

Policy developments over recent decades have aimed to encourage competition between providers of aged care services in the expectation that competitive market forces would lead to innovation and improvements in quality and safety outcomes. Consistent with a market-based perspective, the Australian Government has not taken an active system governance role. Instead, it has tended to react to adverse developments, often belatedly. There has been a vacuum in leadership of the entire aged care system and an unspoken assumption that market forces should generally be left to themselves, subject to quality regulation of the providers.

It is clear to us that a thorough systemic redesign is required to improve the aged care system. To deliver this, we recommend there should be new, robust governance arrangements, including the establishment of the institutions necessary to drive improvements to the aged care system.

We differ, however, on the institutional form that certain aspects of these governance arrangements should take. The model that Commissioner Pagone prefers involves greater independence from the Australian Government of the institutions that he proposes should govern the system. While Commissioner Briggs supports greater independence in certain areas such as quality regulation, she believes that reforming existing institutions will deliver aged care reform more quickly and effectively in an environment of greater transparency about system performance. Commissioner Pagone is concerned that the cultural issues in the current institutions that have led to the problems we have observed in the system are engrained in the nature of an organisation subject to Ministerial direction. While the models that we propose are different, they have many similarities, such as a strong regional presence and active intervention in the market to ensure the delivery of high quality and safe aged care. We both recommend stronger accountability through the establishment of an Inspector-General of Aged Care.

We recognise that the design of Australian Government institutions is a matter for the Government. We therefore offer in good faith two models for the Government to consider, together with associated changes to institutional arrangements, on many of which we agree.

Institutional arrangements: terminology

Commissioner Pagone recommends an Independent Commission model that involves greater independence from the Australian Government of the institutions to govern the system. He recommends establishing a new independent Commission—the Australian Aged Care Commission. This newly created body should perform the roles of System Governor, Quality Regulator and Prudential Regulator. Aged care pricing should be carried out by a new body—the Australian Aged Care Pricing Authority.

Commissioner Briggs recommends a Government Leadership model that supports greater independence in certain areas such as quality regulation and pricing, but maintains a strong Australian Government system leadership and stewardship role. Commissioner Briggs proposes that a reformed Department of Health and Aged Care should perform the roles of System Governor and Prudential Regulator. Quality regulation should be the responsibility of a reconstituted Aged Care Safety and Quality Authority. Aged care pricing will be included in the responsibilities of the renamed the Independent Hospital and Aged Care Pricing Authority.

To assist with readability, throughout the text of this report, unless otherwise specified, we use the shorthand terms ‘System Governor’, ‘Quality Regulator’, ‘Prudential Regulator’ and ‘Pricing Authority’ which have the meanings as set out in the following table:

Term	Independent Commission model	Government Leadership model
System Governor	Australian Aged Care Commission	Australian Department of Health and Aged Care
Quality Regulator	Australian Aged Care Commission	Aged Care Safety and Quality Authority
Prudential Regulator	Australian Aged Care Commission	Australian Department of Health and Aged Care
Pricing Authority	Australian Aged Care Pricing Authority	Independent Hospital and Aged Care Pricing Authority

Independent Commission model | Commissioner Pagone

The Australian Government should implement governance arrangements for the aged care system that are independent of Ministerial direction. An independent, dedicated statutory body should be established as system governor, administrator and regulator—the Australian Aged Care Commission. A specialist Australian Aged Care Commission can give undivided attention and focus to its task of being an effective system governor of aged care to ensure that high quality aged care reaches those who need it.

The barriers to effective governance in the current system include the concentration of powers and functions in the Minister for Health and the Department of Health. Prior to administrative arrangements changes in late 2020, the Minister for Aged Care had been junior to the Minister for Health. Aged care responsibilities were not directly represented in Cabinet but folded in amongst the wider responsibilities of the Minister for Health. This reflected the lower significance, budgetary weight and prestige that successive Australian Governments have attributed to aged care, relative to other citizen services and government priorities. The care of older Australians should not be overwhelmed by the Department of Health’s priorities, bureaucracy and budgets. Neither should it be overwhelmed by the Government’s other priorities and budget considerations. Although recent changes have given greater priority to aged care, making this a responsibility of a Commission rather than the current department will ensure a dedicated focus on aged care and single-minded attention to implementing the reforms we recommend.

The weight of evidence before me is that the current departmental arrangements fail to meet Australians’ expectations for a reliable well-governed aged care system. The extent of the problems documented in this report is such that incidental changes to the way the system is structured and governed will not be sufficient to build a better, sustainable long-term care system. Some of the issues that we have identified—including the waiting lists for care and the real reductions in the funding of care—came about because the system was working as it was designed to work and not because the system was not working. A fundamental redesign is required.

I recommend that the key functions of system management, regulation and system governance should be brought within the one organisation, the Australian Aged Care Commission:

- System management includes the approval of providers, receiving and acting on feedback and complaints, funding administration, workforce planning and development, provider capacity-building, service coverage and market evaluation, and special interventions in 'thin' markets.
- Regulatory functions include quality and safety monitoring and compliance, financial risk monitoring, and prudential regulation of providers.
- System governance involves providing overall direction in steering the system toward the achievement of long-term policy outcomes, constantly monitoring the performance of the system for emerging issues, and proactively addressing issues before they become problematic.

Currently, the Aged Care Quality and Safety Commission is independent from the Australian Department of Health. Under the Australian Aged Care Commission model, the regulatory functions would remain independent from Government but would be exercised within the same organisation as that which is responsible for system management. Conferral of discrete responsibilities for regulation, system management and other functions on different appointed commissioners within that organisation would ensure that the goals of quality and safety regulation are never compromised. The advantage in consolidating these functions in the one organisation is that many of them are interrelated and should benefit from coordinated attention.

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. Consolidation within one organisation would limit the risks of delay in identifying emerging problems or inaction in addressing them.

I propose that the Australian Aged Care Commission should have a network of regional or local offices throughout Australia. To give impetus to decentralisation of its operations, I 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 be prepared to, and be equipped to, intervene proactively in the aged care 'quasi-market'. The Commission should use its powers, including for the approval, commissioning and funding of providers, to ensure an adequate coverage of services to meet needs across Australia and an adequate number and mix of providers to enable older people seeking services to exercise an informed choice.

I propose that the Australian Aged Care Commission's operating budget should be by way of special appropriation from the Consolidated Revenue Fund. While this might not always insulate it entirely from annual budget pressures, it would create a clearly identified, separate and dedicated stream of funding, and variations to the funding would be highly visible.

The Australian Aged Care Commission should consist of a governing board, which includes its commissioners, a chief executive officer, and staff. The board would consist of a number of commissioners, one of whom (the Presiding Commissioner) would be the chair, and a small number of non-executive board members. The board should be given responsibility for: the strategic direction of the Commission; governance of the structures and processes adopted for the proper discharge of its functions; and for intervening if the performance of the Commission, or that the aged care system as a whole, is below reasonable expectations. To promote independence from the sector, members of the board must be independent of current involvement in the aged care sector. The Secretary of the Department responsible for aged care should be an *ex officio* member of the board.

The Presiding Commissioner should have an overarching role, and special responsibility for system governance. Specific responsibilities for the important functions should be assigned to the other commissioners, as follows:

- quality, safety and prudential regulation—to a Quality Commissioner
- system management functions and funding administration—to a System Commissioner
- ensuring that appropriate aged care services are widely available for Aboriginal and Torres Strait Islander people—to an Aboriginal and Torres Strait Islander Commissioner
- planning and development of the aged care workforce—to a Workforce Development and Planning Commissioner
- investigation and resolution of complaints—to a Complaints Commissioner.

The Minister should appoint an Aged Care Advisory Council to advise the System Governor on policy matters concerning the performance of the aged care system and on 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. Its membership should be 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.

Responsibility and accountability under the Australian Aged Care Commission model are important issues. At the heart of its duties, the Australian Aged Care Commission should be responsible to older people who need, or may need, aged care. Parliament should define its objectives in the new Act and hold the Australian Aged Care Commission accountable for its performance in meeting those objectives. Taxpayers expect that the funds that they provide will be handled carefully and in accordance with their wishes.

The new Act will clearly set out the principles that will guide the Australian Aged Care Commission and its operations.

The Australian Government and relevant Minister maintain ultimate accountability to the Parliament and to the public. There would continue to be a Minister responsible for aged care, supported by an Australian Government department. The Minister would be responsible for law reform, policy development and critical appointments, including making recommendations to the Governor-General about appointments to the board of the Australian Aged Care Commission, and appointing the members of the Advisory Council.

Government Leadership model | Commissioner Briggs

On receiving the Royal Commission's Final Report, the Australian Government will be faced with a very major decision which will set the scene for the most significant shift in the aged care system in decades—taking it to a rights-based and entitlement-based system, with a considerable increase in aged care expenditure and taxpayer obligations. Such a decision can only be taken responsibly by, and its implementation led by, the Australian Government.

In our Westminster system of government, responsibility for deciding on national values, interests and priorities rests with the elected government, through its Cabinet processes. Decisions about aged care involve social values and preferences. These are matters for collective consideration by the Cabinet and Parliament, as representatives of the people. They are not matters for arms-length agencies independent of the Government to determine.

I consider that aged care entitlements should be funded through a Special (Standing) Appropriation. This would mean that aged care entitlements could be paid without the need to go back to Parliament each year seeking additional funds. This requires that aged care funding be managed by a Department of State. It would not meet the Government's financial management arrangements, and it would not be acceptable to taxpayers, for more than \$30 billion of taxpayer funds to be handed over every year to non-elected individuals operating outside the direct control of Ministers to be spent as they see fit. Recent experience with the Australia Post and ASIC expenses scandals points to the difficulties with arms-length bodies in maintaining the tight controls over corporate expenses that would be expected of a Department of State.

In concluding that Ministers and their Departments should continue to be responsible for the management and delivery of aged care, I am not arguing for the status quo. Experience over the past 20 years has shown that Ministers and their Departments have not always demonstrated the compassion and concern for the interests of older people that the public would expect. It is fair to say that many people have lost confidence in the leadership and oversight of the aged care sector. There is, therefore, a great and pressing need to strengthen the current arrangements if the trust and confidence of the Australian community in the Government's stewardship of the aged care system is to be rebuilt and maintained.

It is vital that Ministerial responsibility for the aged care system should rest with a Cabinet Minister for Health and Aged Care so that the health and aged care systems can be as integrated as possible and aligned with relevant State and Territory arrangements, thereby delivering the best outcomes for older people. The Government's recent decision to make Aged Care a Cabinet-level responsibility is welcome.

In our system of government, Ministers are supported by a Department of State. This is a key part of collective decision-making. What a Department can do well, in a way that is not open to a separate agency, is to lead policy and to coordinate its work with that of other departments and State and Territory Governments. Interactions with other areas of Government policy matter to the quality of aged care. This is especially true of health, but also of other areas important to older people, such as housing, education and training, infrastructure, and transport.

Urgent reform of aged care is needed. Further delays while changes to institutional structures are rolled out would leave these urgent problems unaddressed for too long. The example of the National Disability Insurance Agency is a case in point. The Department of Health and Aged Care can hit the ground running and make an immediate start on implementing and embedding lasting reform, in a way that an off-site implementation unit will never achieve.

In the new aged care system, the Department will need to be a proactive system leader that drives reform of the sector. This will necessarily involve cultural change. I am therefore proposing an explicit and stronger role for the Department in governance of the aged care system and the establishment of an Office of Aged Care. The Department's role should be based on the concept of stewardship—the Department as steward of the public resources applied to the aged care system, with an overriding aim of ensuring that the component parts of the aged care system work together in an efficient and effective way to achieve high quality and safe care for older people.

Stewardship requires a governance system that is characterised by active engagement to ensure that the aged care system is the very best that it can be. An important part of stewardship is evaluation and continuous improvement of the delivery of aged care services. This should include building the capacity of providers, promotion and sharing of best practice, and targeted investments to support the development of workforce and provider capabilities.

Policy development happens nationally, but aged care is always delivered locally, so the Department will need a well-resourced and locally-based regional arm. Local approaches to system management are key to achieving lasting change. Through the regional network, the Department will maintain a local presence to ensure that it is able to listen to the local community, match service solutions to local needs, and provide personal support for older people.

The functions of the Department should include:

- policy advice and support to the Minister for Health and Aged Care
- program design and implementation
- funding and system financing
- oversight and management of the delivery through the network of service providers
- evaluating the performance of the system and continuous improvement of services
- prudential oversight and regulation
- workforce planning and management.

In undertaking their functions, the Minister and the Department will need to engage directly with older people to ensure aged care meets their needs. I propose that a high level and influential body, the Council of Elders, be established. The Council of Elders would speak truth to power and provide a continuing voice to Government from older people. The Council should have a wide remit to consult older Australians and advise the Minister and Department on aged care from the perspective of the quality and safety of care and the rights and dignity of older people.

The current quality regulator, the Aged Care Quality and Safety Commission, is independent from the Department of Health. This is consistent with the general practice in government that regulators should not develop the legislation they are expected to enforce. The Productivity Commission in 2011 and the Carnell-Paterson review in 2017 both recommended the separation of the quality regulator from the Department's policy and funding responsibilities.

Under my governance model, I propose that this independence is maintained and built upon. The Aged Care Quality and Safety Commission should be reconstituted and revitalised as an independent Aged Care Safety and Quality Authority. The Authority would work to an independent governing board. Its charter would be more tightly targeted to it being the 'tough cop on the beat', with responsibility for approval and accreditation of providers, monitoring and enforcing compliance, and handling complaints about provider non-performance within the regulatory framework.

Pricing Authority

One of the longstanding shortfalls in the aged care system is the absence of any firm basis on which to adequately fund the sector. Funding levels are based largely on historical precedents and ad hoc decisions, which bear little direct relevance to the actual cost of delivering care. We both agree that it is very important that an independent pricing agency should be responsible for determining the costs of providing safe and high quality aged care services.

While we both consider that a Pricing Authority should be established that is independent from the aged care sector and the Government, we differ on the detail of how this should be achieved.

Commissioner Pagone recommends the establishment of a new pricing authority specifically for aged care. The function of determining the prices and subsidies for aged care services calls for highly specialised capabilities. The Independent Hospitals Pricing Authority, even if expanded with a focus on aged care, is not the best model for aged care because there are very significant differences between the costing studies undertaken by the Independent Hospitals Pricing Authority and the type of economic regulator role that is proposed for aged care. The Australian Government should establish an Aged Care Pricing Authority and confer on it all necessary functions for determining prices for specified aged care services to meet the reasonable and efficient costs of delivering those services.

Commissioner Briggs recommends expansion of the functions of the existing Independent Hospital Pricing Authority, and renaming it as the Independent Hospital and Aged Care Pricing Authority. The Independent Hospital Pricing Authority has considerable expertise in collecting and analysing cost data and developing and refining classification systems for public hospitals. All these tasks would be involved in establishing a robust system for determining the costs of aged care, and the Authority's current expertise could be readily built upon to bring in aged care. The alternative of establishing a new agency would be inefficient, take considerable time and delay urgently needed accurate assessments of the costs of the component parts of the aged care system.

Inspector-General of Aged Care

We both recommend the establishment of an independent office of the Inspector-General of Aged Care. The primary functions of the proposed Inspector-General of Aged Care 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 System Governor 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 System Governor and Quality Regulator, and systemic issues relating to the performance of providers and treatment of people who need care. The Inspector-General of Aged Care would also perform a critical role in monitoring and reporting on progress with the implementation of our recommendations.

Conclusion to governing for older Australians

Although we differ on certain details of the institutional arrangements that we recommend for the future aged care system, we are united in urging the Australian Government to establish an enduring institutional framework that will provide proactive system governance to deliver high quality and safe care in the interests of older people.

During our last series of hearings, in September 2020, Mrs Rosemary Milkins PSM reminded us of how important it is to achieve the kind of system governance that older Australians deserve:

It should be brave, it should be innovative. It should actually fix some of the issues that people constantly talk about, rather than pointing at others: it's not me, it's yours. It needs to be more audacious than it is. It clearly is the lost land. And that really is an indictment of our values. It needs, above all, stronger leadership.³

We urge the Australian Government to take this advice to heart in its deliberations on the models we have offered, and to be brave and innovative in its response. We urge the Australian Government to implement one of our models promptly and in full, providing all the necessary resourcing and political support that will be required to achieve this, and then to continue providing the ongoing support needed to embed the reforms that our elders so richly deserve and to take them even further over time.

1.3.3 Ensuring quality and safety: the imperative

Our Terms of Reference task us with advising on what can be done to ensure that aged care services are 'high quality and safe'.⁴ This is the driving imperative for our Final Report.

We draw particular attention to the expression 'high quality'. Our recommendations are directed to establishing an aged care system that will consistently deliver high quality aged care to older people in Australia, rather than merely meeting accreditation standards.

High quality care must be the foundation of aged care. There must be a universally shared understanding by government, providers, and by older people and their family and friends of what high quality aged care means in Australia. We propose the following definition:

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 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 educated and 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. It enables people to engage in meaningful activities that provide purpose, and provides the opportunity for people to remain connected to their community.

Currently, there is no clear statement in the Aged Care Act of the basic responsibility of approved providers to ensure that the care provided to residents is safe and of high quality. This is a major gap in the legislation.

We recommend that there should be a general duty on an approved provider to ensure, so far as is reasonable, the quality and safety of its aged care services. A failure to comply with this duty where that failure exposes residents to a risk of harm, will expose a provider, and its key personnel, to a civil penalty at the suit of the Quality Regulator. The provider may also be required to compensate a resident harmed by the failure. This will send a

clear message to providers, their key personnel, the community and the regulator that the primary duty of an approved provider is to ensure the health, wellbeing and safety of its residents.

Areas for immediate attention

While the evidence before us has reflected a wide range of concerns about aged care quality and safety, we have singled out four concerns for immediate attention: food and nutrition, dementia care, the use of restrictive practices, and palliative care.

Many witnesses gave evidence about the inadequacy of the quality and quantity of food in residential care. This is an area in urgent need of improvement. A representative study of 60 Australian residential aged care services conducted in 2017 concluded that a staggering '68% of residents were malnourished or at risk of malnutrition'.⁵ Poor nutrition in aged care is related to falls, fractures, pressure injuries and unnecessary hospitalisation.

The current Aged Care Quality Standard for meals stipulates that 'where meals are provided, they are varied and of suitable quantity and quality'. 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 standard for the provision of meals in aged care facilities should be reviewed as part of the review of the Aged Care Quality Standards we are recommending. As a critical first step, increased spending to improve the quality of food can be achieved as part of an immediate conditional increase in the Basic Daily Fee of \$10 per resident per day that we recommend. The additional funds are to be spent on daily living needs, especially nutrition.

It is estimated that more than half of the people living in permanent residential aged care in 2019 had a diagnosis of one of the forms of dementia. The real percentage is likely higher, given the prevalence of undetected dementia.

Despite this, our inquiry has revealed that the quality of aged care that people living with dementia receive is, at times, abysmal. We heard time and time again that staff members do not have the time or the skills to deliver the care that is needed. The quality of dementia care in the aged care system needs significant and immediate improvement.

All mainstream aged care services should have the capacity to deliver high quality aged care for most people living with dementia—dementia care should be core business. 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. We recommend mandatory dementia training in residential aged care and in care at home.

Ensuring people living with dementia receive the support and services that they need does not begin when they access aged care services. Dementia care extends across a continuum from diagnosis through to palliative care, and includes prevention, primary care and hospital care.

We recommend that the Australian Government should establish a comprehensive and accessible post-diagnosis support pathway for people living with dementia and their carers and families. A national dementia support pathway should assist people to navigate the complex systems through which care is provided—the information, coordination, care, education and social support services.

Even with additional training on dementia and the introduction of a dementia support pathway, the aged care sector will continue to require specialist support and advice on dementia care, particularly to assist people with complex symptoms. The Australian Government has recently established the Specialist Dementia Care Program to support people exhibiting severe changed behaviours associated with dementia who are unable to be appropriately cared for in mainstream aged care services. It comprises a national network of Specialist Dementia Care Units. It is expected there will be 35 units of about eight beds each, with at least one unit operating in each of the 31 Primary Health Networks by 2022–23.

Because the Specialist Dementia Care Program was introduced as this inquiry was being conducted, we have not had the opportunity to consider its effectiveness. It is not clear if the program will be sufficient to meet demand. We therefore recommend a review of the size and effectiveness of the program, once the rollout is complete, with the Australian Government to implement any findings urgently.

The overuse of restrictive practices in aged care is a major quality and safety issue. Restrictive practices impact the liberty and dignity of people receiving aged care. Urgent reforms are necessary to protect older people from unnecessary, and potentially harmful, physical and chemical restraints.

Deficiencies in regulation of restrictive practices have been identified as a significant human rights issue in Australia. A strong and effective regulatory framework to control the use of restrictive practices should be implemented as a matter of priority. The Australian Law Reform Commission has recommended that there should be a nationally consistent approach to the regulation of restrictive practices. It has also said that a consistent approach to restrictive practices in aged care and disability services is desirable ‘both as a matter of principle and pragmatism’.⁶

Regulation of restrictive practices should be informed by respecting and supporting people’s rights, dignity and personal autonomy, while providing clarity about the circumstances in which care or treatment, including restrictive practices, may be authorised. We recommend that the Australian Government should amend *the Quality of Care Principles 2014* (Cth) to provide that the use of restrictive practices in aged care must be based on an assessment by an independent expert. It should be subject to ongoing monitoring and reporting, with a behaviour support plan lodged with the Quality Regulator. Restrictive practices should only be used where alternative strategies to meet the 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, for as long as needed to prevent significant harm.

High quality palliative care is essential to ensuring that an older person can live their life as fully and as comfortably as possible as they approach death. Compassionate, respectful and individualised support for older people approaching the end of their lives is a necessary component of aged care services.

A number of our recommendations will contribute to ensuring high quality palliative care becomes core business for aged care services. These include a right to fair, equitable and non-discriminatory access to palliative and end-of-life care, improved access to specialist palliative care services and requirements for regular staff training. Urgent consideration should also be given to how palliative care is reflected in the Aged Care Quality Standards.

Quality standards

Quality standards are a powerful tool to maintain and improve quality of aged care. They are statutory-based obligations of services, which identify the characteristics of aged care and the care environment that contribute positively to, or alternatively place at risk, the safety, health, wellbeing and quality of life of people receiving care. Such standards can motivate providers to achieve the expectations for quality. They also set the regulatory parameters for assessment of provider performance. The formulation of suitable quality standards is central to achieving and measuring high quality care.

The existing Aged Care Quality Standards do not define quality, or high quality, aged care. By their nature, they set out the minimum acceptable standards for accreditation. The Australian Department of Health develops the Standards for the Minister's consideration, in consultation with the aged care sector and the aged care regulator. While the Department consults relevant experts, the evidence suggests that the views of such experts are not always followed.

By contrast, quality standards for the health sector are set by a specialist statutory body, the Australian Commission on Safety and Quality in Health Care. The Standards prepared by that Commission appear to us to be far more comprehensive, rigorous and detailed than the existing Aged Care Quality Standards. The Chief Executive Officer of the Australian Commission on Safety and Quality in Health Care, Professor Debora Picone AO, considers that there should be 'greater harmonisation between the quality standards that apply in health care and those standards that apply in aged care'.⁷ We agree.

We recommend that the Australian Commission on Safety and Quality in Health Care should be renamed the 'Australian Commission on Safety and Quality in Health and Aged Care', and its role expanded to include formulating standards, guidelines and indicators relating to aged care safety and quality. The Commission should undertake periodic reviews of the Aged Care Quality Standards. It should also urgently review and, if it considers appropriate, amend the Standards in the areas of nutrition, dementia care, palliative care and other clinical care priorities, and provider governance. Further, the Commission should progressively review standards for staffing, diversity, aged care plans, quality of life and wellbeing.

Quality measurement and reporting

It is difficult to measure quality in the current aged care system. This is a major failing. A comprehensive approach to quality measurement and reporting has three linked elements: indicators to measure quality, benchmarking for continuous improvement, and a star rating system for comparing the performance of providers.

If the Aged Care Quality Standards set the rules for the quality of aged care, quality indicators enable that quality to be measured. As explained by Professor Picone:

Measurement of indicators...is fundamental to advancing safety and quality improvement—meaningful metrics are required to understand what the major safety issues are across the care continuum, to proactively mitigate patient safety risks and stimulate improvement.⁸

Lack of quality indicator data is a significant impediment to understanding the performance of the aged care system and providers, and ensuring accountability for that performance. As we explain above, although it is a crucial part of our Terms of Reference, we have found it very difficult to assess the extent of substandard aged care in Australia due to insufficient quality indicator data. Similarly, without quality indicators, comparing providers' performance with each other and over time is very difficult.

Quality is not adequately measured in the Australian aged care system. Until 2019, there were no mandatory quality indicators. Under the National Aged Care Mandatory Quality Indicator Program, residential aged care services are now required to report on only three indicators: pressure injuries, use of physical restraint and unplanned weight loss. There are still no quality indicators for home care.

We heard criticisms of the limited scope of the National Aged Care Mandatory Quality Indicator Program. Following a 2019 review, the Australian Government has advised that it plans to introduce two new quality indicators relating to medication management and falls and fractures.

While these are positive steps, they are not enough. We recommend that the proposed Australian Commission on Safety and Quality in Health and Aged Care should develop a more comprehensive suite of quality indicators for residential aged care and aged care in the home. This should include a quality of life assessment tool for people receiving aged care. Quality of life is a measurable outcome of good person-centred care, and good quality of life is shown to have positive impact on clinical outcomes.

Benchmarking is a powerful component of a quality measurement system. Benchmarks allow providers to compare their performance against reasonable expectations, providing an impetus for continuous improvement. They also allow the Quality Regulator to judge performance across the system.

We recommend that the Australian Government should implement reporting and benchmarking of provider performance against quality indicators. The proposed Australian Commission for Safety and Quality in Health and Aged Care should develop a methodology to enable providers to be benchmarked against similar providers. Using these

benchmarks, the System Governor should track sector and provider performance and set progressive improvement targets to raise performance against quality indicators over time. The System Governor should also publicly report on sector and provider performance against the benchmarks.

Star ratings are the third element of our proposed comprehensive approach to quality measurement and reporting. It is critical that the public has access to information about the performance of individual services, in a way that is accessible and easy to understand—a system of star ratings enables this. It is an essential tool for differentiating between aged care services.

This is particularly important for older people who are choosing an aged care provider. Equally, people who are receiving care have a right to know about the performance of their service provider and alternatives so that they can make informed decisions about whether to change providers. It is also important that families and friends of older people, advocacy organisations, policymakers, legislators and the media have access to this information.

The Service Compliance Ratings system recently introduced by the Australian Government falls well short of the system that we consider is needed. Under that system, services that meet all minimum standards, and have no current sanctions, will automatically be given the highest rating. The ratings do not differentiate between providers who just meet the standards and those who are outstanding. This is far from adequate information.

We recommend that the Australian Government should develop and publish a system of star ratings based on measurable indicators that allow older people and their families to make meaningful comparisons of the quality and safety performance of providers.

Graded assessment against the Aged Care Quality Standards should be a central part of the new star rating scheme. The scheme should also incorporate a wider range of measurable data and information to allow meaningful comparisons which reflect the elements of high quality care. This should include performance against clinical and quality indicators, staffing levels, and robust consumer experience data.

1.3.4 An entitlement to care: a new aged care program

Older Australians should have an entitlement to aged care. Alongside Medicare, the Pharmaceutical Benefits Scheme and the age pension, older Australians should be able to rely on the aged care program for support when and where they need it.

The central task of our inquiry is to recommend ways to improve aged care for Australians. This must include a redesigned program of funded services to deliver high quality and safe care to older people in their homes, in the community and in residential facilities. Our recommendations are informed by evidence about what works under the current programs and related administrative arrangements and what does not. They reflect our vision for better outcomes for older people who need care, and the beneficial impact on our communities and society when older people are supported to live independent and meaningful lives.

Putting people first: simplicity, accessibility, choice and inclusion

We have heard of the challenges posed by the current multiplicity of programs and services in aged care, each with their particular eligibility criteria, assessment processes and budget allocations. The disparate aged care programs should be consolidated and simplified in a new aged care program.

We recommend a new aged care program aimed at achieving seven essential outcomes:

- person-first—care and supports which address physical, social, psychological, cultural and spiritual needs, supporting people to function independently for as long as possible
- simplicity—one aged care program, one set of eligibility criteria and one assessment process
- accessibility—information that is easy to locate and understand with face-to-face supports
- universal entitlement—once entitled to care, guaranteed access to the care and supports assessed as needed
- timeliness—assessments and reassessments of need occur when required and services commence within one month of assessment
- choice of settings—in the home, community and residential care
- inclusiveness—recognition of a person’s diverse characteristics and delivery of culturally safe and trauma-informed care.

Access to the new aged care program should be facilitated by better information, a single avenue of assessment and personalised assistance to gain services.

Information about aged care services should be easy to understand, access and use. To ensure that people have a genuine entitlement to aged care, older people must be able to find and use the care and supports that they are assessed as needing. We recommend that the System Governor should fund and support strategies to:

- improve public awareness of the resources available to assist people to plan for ageing and potential aged care needs
- improve knowledge about aged care among health professionals with whom older people have frequent contact, particularly general practitioners
- encourage public discussion about, and consideration of, aged care needs.

The official government information service for the aged care system is My Aged Care, which provides information on aged care and helps people find care services in their local area. While the Australian Government has recently made improvements to My Aged Care, more remains to be done. To improve My Aged Care, the System Governor should include useful information about the relative performance of approved providers. This should help

people to make informed choices about the right services and the best providers to meet their needs and circumstances.

People seeking aged care should receive timely access to assessment of their needs through a streamlined, single assessment process, conducted by competent independent assessors. The assessment should be forward-looking, and promote an older person's autonomy and self-determination. It should be scalable according to the complexity of the older person's needs. It should focus on the older person's needs—social, emotional and clinical—as well as their goals in accessing aged care. It should also include an assessment of the need for services of any informal carer.

An independent assessment should establish funding for those seeking access to aged care services. Funding of a person's aged care should be driven by their individual care needs, assessed in a convenient and timely manner, and provide access to all the aged care services that the person might need.

Personalised assistance should be available to each person seeking aged care to help access aged care services in their area. People should not have to fend for themselves when starting out with aged care.

We have heard throughout this inquiry that aged care should have a much greater face-to-face presence. We agree. A workforce of personal advisers to older people, their families and carers, called 'care finders', should be established. Care finders should assist older people and their carers to receive the information they need to engage with their local assessment team, approved providers, and aged care services and supports. They should provide additional case management assistance, appropriate to each older person's circumstance and wishes.

The day-to-day coordination of care through care management can be essential to achieving good outcomes in aged care. It is especially important for people who have complex needs or needs that require multiple or intensive responses. We recommend that approved providers should assign a care manager to people receiving aged care (unless a person is receiving home care and has been assessed as not needing care management). Care management should be scaled to match the complexity of the older person's needs.

The care manager should consult with the person and, if applicable, their carer, to develop a comprehensive support and care plan that addresses their strengths, capability, aspirations and goals. The plan should include activities to enhance an older person's health and wellbeing and their ability to live or participate in the community. The plan should be regularly reviewed and adjusted as appropriate.

To deliver high quality and safe care, those providing services must respect the diverse backgrounds and life experiences of every older person, and tailor the delivery of care to meet their needs. Diversity should be core business in aged care.

We recommend measures to ensure the aged care system is designed for diversity, difference, complexity and individuality. As the foundation to wellbeing, the System Governor should require that training in cultural safety and trauma-informed service

delivery is provided for all workers who are involved in direct contact with people seeking or receiving services in the aged care system. Provision of this training should be a condition of approval of providers. Comparable training should be given to people providing care finder and assessment services.

We heard that data collection is paramount to break the ‘cycle of invisibility’ for people with diverse backgrounds and life experiences. The Australian Government acknowledged that the lack of data collection limits the understanding of how people with diverse needs access and experience the aged care system. We recommend that the System Governor should collect, monitor and analyse data about the diverse backgrounds and life experiences of older people seeking or receiving aged care.

The System Governor should also complete a national audit evaluating regional and local variation in levels of services for people from diverse backgrounds and life experiences. The findings of the audit should inform commissioning arrangements to address deficits in meeting the needs of people from diverse backgrounds on a regional and local basis. The System Governor should also report to the Inspector-General of Aged Care and the public on the extent to which the needs of diverse older people are being met by the aged care system.

Aged care service categories

The new aged care program aims to simplify the current system. The current system includes 17 Commonwealth Home Support Programme services, 11 forms of respite care, four levels of Home Care Package, and residential aged care. Our recommended system has just five service categories of care and support, which are designed to operate in a complementary way to meet an older person’s needs:

- respite supports
- social supports
- assistive technology and home modifications
- care at home
- residential care.

Respite care that is responsive to needs and circumstances is essential to maintain the wellbeing of carers and to help sustain the caring relationship. We have heard that carers’ experience of respite is mixed. People have told us that respite is difficult to access, conditions imposed upon its use are too restrictive, and it does not adequately support carers.

The failings of the aged care system to provide adequate support to informal carers must be rectified. We recommend that the Australian Government should implement a respite supports category that ensures respite is available for the carers of older people earlier and more often to provide timely assistance. It should offer people up to 63 days of respite per year with greater freedom in how the time is used, and assessors should be able to approve further days if needed. There should be a greater range of high quality respite support in people’s homes, in cottages and in purpose-built facilities.

The aged care program needs to emphasise personal, social and community connections, as well as clinical care. Our research has shown that older people place high value on belonging and a sense of community, and that they particularly value and prefer in-person interactions.

The Australian Government should implement a social supports category within the aged care program that provides supports that reduce and prevent social isolation and loneliness among older people. Services available should include social activities, transport, delivered meals and centre-based day care.

Ageing brings changes in functioning that can impact on people's ability and capacity to live independently. Small adjustments, new appliances, technologies or minor alterations to the home can enhance older people's independence, mobility and quality of life. If older people knew earlier about the availability and benefits of those supports, they might be encouraged to make decisions to adapt the home or to try new equipment or technologies, enabling them to remain at home.

The Australian Government should implement an assistive technology and home modifications category within the aged care program that provides goods, aids, equipment, technologies and services that promote a level of independence in daily living tasks and reduces risks to living safely at home.

A constant theme we have heard throughout our inquiry is that people want to remain at home. For older people to remain safely in their homes, they must have access to aged care that meets their assessed needs.

We recommend a category of care at home. The care at home category should support older people living at home to preserve and restore capacity for independent and dignified living and prevent inappropriate admission to long-term residential care. Based on assessed need, it should provide an entitlement to care at home with a personalised budget which allows for a coordinated and integrated range of care and supports. These could include: care management; living supports (for example, cleaning, preparation of meals, shopping, gardening and home maintenance); personal, clinical, enabling and therapeutic care; and palliative and end-of-life care. There should be a lead provider, chosen by the older person, who would be responsible for ensuring that services are delivered and for adjusting the care to meet the older person's changing needs.

Residential care must meet the full range of older people's physical, emotional, mental and spiritual needs. It must provide care that preserves each person's capacity for dignified living to the greatest extent possible in their circumstances, and enable each older person to have what they consider to be a good death.

The residential aged care setting has changed over the years. People now enter residential services later in their lives. Consequently, many more are frail or have chronic or complex health conditions, including high levels of dementia. Currently, however, the delivery of care in residential aged care is influenced by the funding arrangements, which are aimed at tasks and not a person's care needs. We heard complaints that funding is reactive and does not incentivise or support a preventative approach to care.

We recommend that the System Governor should implement a residential care category that provides high quality and safe care based on assessed needs. It should allow for personalised care and an integrated range of supports across these domains: care management; social supports; personal, clinical, enabling and therapeutic care and support; and palliative and end-of-life care.

Reablement and rehabilitation need to be a central focus of aged care. We recommend that care at home should include the allied health care that an older person needs to restore their physical and mental health to the highest level possible—and to maintain it at that level for as long as possible—to maximise their independence and autonomy.

Throughout our inquiry, many witnesses described the crucial role of allied health in maintaining mobility and functionality and providing restorative care in response to acute events. We also learned that many people receiving aged care services do not have sufficient access to allied health services.

We recommend that the benefits of allied health services should be considered in an assessment of a person's aged care needs, and that the person's aged care entitlement should adequately reflect those needs. For care at home, funding assigned for the older person should include an amount to meet any identified need for allied health care and the lead home care provider should be responsible for ensuring that allied health services are delivered. For residential care, we recommend that the System Governor should ensure providers provide allied health care in accordance with each older person's individual care plan, and should monitor the level of allied health services that are actually delivered. Allied health should become an intrinsic part of residential care.

Challenges of planning, transition and implementation

The Australian Government currently funds aged care subject to financial controls based on rationing of aged care residential places and Home Care Packages to a fixed proportion of the population aged 70 years and over. This creates waiting lists and means people miss out on care they need. The effect of a lengthy wait can be profound—there is a clear danger of declining function, inappropriate hospitalisation, carer burnout, premature admission to a residential facility or even death.

Wait times for the assignment of Home Care Packages have been unacceptably long for several years. According to the most recent estimate of wait times published by the Australian Government, the estimated waiting time for people entering the Home Care Packages Program at any level has not improved over the 12-month period to 30 June 2020. Older people needing care do not have the luxury of time to wait for care to be delivered. This must be addressed urgently.

We recommend that the Australian Government should clear the Home Care Package waiting list by immediately increasing the packages available. A package should be allocated to all people on the waiting list who do not have a package or do not have a package at the level they have been approved for. The Government should keep 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. Furthermore, the Government should publicly report, each quarter, on the status of the waiting list, showing progress in clearing the waiting list at a national, State or Territory, and regional level. The report should include reasons for any delays in clearing the waiting list and actions being taken to address the delay.

Under the new aged care program, older people should have a universal entitlement to high quality and safe aged care in accordance with their need. This will require a new planning and funding regime. Currently, there are population-based limits on the availability of subsidies. The new aged care program must be based on assessed need and not rationed.

The System Governor should implement a new planning regime which supports a funding allocation that is sufficient to meet people's entitlements. Funding should be based on the costs of providing high quality and safe care according to assessed need. It should not be influenced by the Australian Government's fiscal policies, or be limited to past spending levels. An important element in achieving this goal is the independent pricing process we recommend, which will determine the levels of funding for particular service types and bundles of services.

We are not confident that there is adequate capacity to supply all the services that should be funded under a needs-based system. It will be necessary for supply-side capacity to be assessed and, where necessary, grown, so that aged care services are available when and where they are needed. This requires detailed planning.

We recommend that the System Governor should develop and implement a new planning regime that replaces the current planning arrangements with planning undertaken both nationally and at the local level. The System Governor should ensure:

- an adequate coverage of services to meet the population needs for major cities, rural, regional and remote Australia
- 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
- the capacity and capability of new and existing providers to deliver more aged care services
- continuity of service for older people.

1.3.5 Giving thanks and giving back: support for informal carers and volunteers

Informal carers

Family, friends and community are a crucial part of the aged care system. They are integral to the wellbeing of older people, and to ensuring safe and high quality care. They nurture, they support, they care, they advocate, and they speak up when something's not right.

The value of informal carers to the sustainability of the aged care system is difficult to overstate, but their work is largely invisible. From the number of informal carers, the economic value they contribute, and the important care and support they provide, there is no doubt the aged care system depends on the contribution of informal carers.

Providing informal care for an ageing family member or friend can bring personal rewards and satisfaction. But we learned that a caring role can also have detrimental effects on the health, wellbeing and financial security of the carer. Over time, this can affect the quality of care an older person receives and the sustainability of the caring relationship.

The Australian Government should ensure that informal carers are properly supported. The current aged care system fails to do so and provides reactive, inadequate support. Supports are often not provided until the strain on a caring relationship has already reached crisis point.

We propose instead a preventative approach to support informal carers. A preventative approach would equip carers with skills at an early stage in their caring role, and access to timely, well-coordinated supports and respite throughout. Early access to services is critical to supporting the wellbeing of the informal carer as well as the sustainability of the caring relationship.

High quality respite is an important and highly valued support service for informal carers. It improves the emotional wellbeing and physical health of carers, as well as presenting an opportunity to benefit the person receiving care.

Carers face many challenges with accessing services. The first is that there is no formal mechanism to link carers to services. Rather, the system relies on a carer self-identifying as a 'carer' and knowing where to go for support. But many people providing care to friends, partners or parents do not identify with the term 'carer'. We recommend that informal carers are identified by My Aged Care, care finders and assessment services when an older person is assessed for aged care.

The second challenge with accessing support services is the assessment process. Informal carers are required to undertake separate intake and assessment processes if they are seeking supports for themselves as well as for the person they care for. This is an administrative burden for carers who have to provide information to different services and government agencies. We recommend that care finders should be able to refer informal carers to services for assessment and access to respite care and other supports.

The third challenge with access to support services is that informal carers are required to navigate complex and fragmented systems. There are currently two distinct systems in place that provide information for informal carers of older people—Carer Gateway and My Aged Care, which operate in different departments. There is no interoperability between the two systems. They are accessed through separate online portals and helplines and do not share information or data. It is left to carers to try to match availability of respite via My Aged Care with the availability of other support services via the Carer Gateway.

We recommend that My Aged Care and the Carer Gateway should be linked so that informal carers need only use one system to secure respite care and the full range of information, training and support services available on both sites. We also recommend that My Aged Care should provide accurate and up-to-date information about the range of supports locally available to informal carers, including training, education, counselling, income support, and respite. There should also be direct referral and information sharing for informal carers between My Aged Care, care finders, assessment services and the Carer Gateway.

Commissioners Tracey and Briggs heard about the benefits of shared spaces where informal carers can come together, such as the Mildura Carers Hub and the Home and Community Care Centre in Bidyadanga. Community-based carers hubs can be an important way for informal carers to access information and advice. They enable carers to talk about the challenges they face and to find practical solutions and support available locally. We recommend that the Australian Government should fund a community-based carers hub network.

The employment and working lives of informal carers are frequently affected by their caring role. Many informal carers need to make changes to their working arrangements, including reducing work hours or levels of responsibility and taking time off work to care.

In Australia there are no provisions in the National Employment Standards for an employee to take extended unpaid leave for the purpose of caring for an elderly family member or close friend. We heard evidence that an option may be to amend the *Fair Work Act 2009* (Cth) to extend an entitlement to leave to care for an older family member, on the same basis that employees are currently entitled to leave to care for a newborn or newly adopted child. We acknowledge that a change of this kind would have economy-wide impacts and would require careful evaluation. However, this change will likely be necessary as the population ages and people remain in the workforce longer, reducing the pool of available informal carers. We support further work on the potential costs, benefits and impacts of improving leave arrangements for those employees providing care to older people.

Volunteers

Volunteers are another integral part of the aged care system. For older people receiving care in their own homes, volunteers provide social support and companionship and help with household activities, transport and shopping. Older people in residential aged care receive help with the activities of daily living and companionship. Volunteers are also important connections for older people from diverse backgrounds. We heard evidence about the importance of volunteers who spoke the same language as older people from

culturally and linguistically diverse backgrounds. We also heard about the importance of LGBTI volunteers for people from LGBTI communities receiving aged care, helping reduce their isolation and maintain connection to their LGBTI identity and communities.

We consider that aged care providers should increase their support for volunteering and volunteers. For providers who operate a volunteer program, it should be a condition of their approval that a staff member is assigned to the role of volunteer coordination. Providers should provide training to volunteers and supervise their activities. Providers should also give induction and ongoing training to volunteers in caring for and supporting older people, diversity and inclusion, complaints management, and reporting abuse or neglect.

The Community Visitors Scheme, which is funded by the Australian Government, arranges visits by volunteers to older people who use aged care services to provide companionship and friendship. A recent review noted that the scheme is seen as highly successful, bringing substantial benefits to both visitors and older people alike. However, the review identified that lack of awareness is a key barrier to full use of the scheme. To address this, we recommend that the Australian Government should rename the scheme the 'Aged Care Volunteer Visitors Scheme' and promote it to increase awareness and participation. Additional funding should also be given to provide extended support for older people receiving aged care who are at risk of social isolation.

1.3.6 Designing accommodation for quality of life

Where older people live affects their sense of security and their quality of life. Accommodation that is well designed to meet people's needs can improve their lives and their wellbeing.

Most older people choose to remain at home as they age. But for some older people, it is necessary or desirable to move into residential aged care to receive the support and care that they need. It is essential that the built environment of residential aged care is suitable to meet their needs. People living with dementia are particularly sensitive to their environment because dementia can change the way in which they perceive their surroundings. The built environment can be supportive, familiar and therapeutic, or it can be a barrier to independent functioning and to a high quality of life.

In broad terms, the evidence before us is that good design in residential aged care, particularly for people living with dementia, usually involves smaller, lower-density congregate living arrangements rather than larger, more institutional settings. Smaller, lower-density congregate living arrangements generally promote better quality of life for everyone. Large, noisy institutional environments can worsen the adverse consequences of dementia.

The average size of residential aged care facilities has increased in recent years. In 2008, 39% of facilities had over 60 places; by 2019, 60% of facilities had over 60 places. We consider that, in general, residential aged care services should transition progressively away from large institutional design settings. Accessible and dementia-friendly design should be the norm for new or substantially refurbished residential aged care buildings.

To build awareness and ensure greater consistency of standards, the Australian Government should develop and publish a comprehensive set of national aged care design principles and guidelines on accessible and dementia-friendly design for residential aged care. The National Aged Care Design Principles and Guidelines should permit flexibility in their application in different circumstances. The Australian Government should actively promote and encourage their adoption by approved providers, builders, architects and others. Financial incentives should be paid to providers that demonstrate the adoption of the Design Principles and Guidelines for their residential aged care buildings.

The National Aged Care Design Principles and Guidelines should be voluntary. If, however, accessible and dementia-friendly design principles remain voluntary for an indefinite time, there is a very real risk that, without more, their adoption will not be sufficiently widespread. Class 9c of the *National Construction Code* sets out building specifications for residential aged care buildings. We have heard that those building specifications may work against the adoption of innovative models of residential aged care. The Australian Government should advance a proposal to the National Federation Reform Council for any amendments to the *National Construction Code* deemed necessary to reflect accessible and dementia-friendly design standards for 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.

Creating ‘familiar households’ facilitates the provision of person-centred care. We have heard that for residential aged care, there is significant benefit to a domestic setting instead of a traditional institutional model. Small household models usually involve housing eight to 10 people receiving aged care services, and sometimes up to 16 people, within a home-like environment. Common features include ‘a focus on domestic, homelike, familiar or normalised environment with medical equipment hidden’.⁹ Regular staff are employed and they do not wear uniforms.

Without wishing to limit innovation, we consider that the small household model is one way in which residential aged care can adopt dementia-friendly and accessible design principles.

At the same time, Commissioner Pagone considers that there may be other ways, in addition to the small household model, of providing appropriate accommodation for those who need residential aged care. The focus of planning appropriate accommodation should always be on providing the best option to meet the needs of those to be accommodated. Commissioner Pagone therefore considers that it would be wrong to substitute the current or outmoded prescriptions with other rigid prescriptions. But he nonetheless sees that the small household model is clearly established as among the models which need to be available and which require more, and immediate, attention.

Commissioner Briggs believes that small household models of design are the best option for future residential aged care and that, in the absence of government action to steer the sector toward smaller-scale accommodation, providers and developers will continue to build larger facilities. She considers that strong leadership and appropriate financial incentives will be required to encourage the construction of more appropriate residential aged care accommodation. Commissioner Briggs considers that rapid growth and development in the area of small home or household models of design would provide significant benefits for older people and deliver much-needed improvements in the quality of aged care.

We both recommend that the Australian Government should support the building or upgrading of residential aged care facilities to provide small-scale congregate living which facilitates the small household model of care. One way in which that support should be provided is through capital grants for projects of this kind. Commissioner Briggs recommends that the amount of annual grant funding should be increased to \$300 million in 2021–22, \$600 million in 2022–23 and \$1 billion in 2023–24, and should be indexed for inflation in subsequent years.

More generally, there is a need for coordinated intergovernmental policy, planning and action relating to housing and accommodation for Australia's ageing population. As a matter of priority, governments should work together to improve access to accommodation in which people can age and, as necessary, receive aged care services. Older people living in unsuitable housing face greater risk of falls, injury and immobility, and the prospect of premature entry into residential aged care.

People's accommodation should, where possible, cater to their changing needs. Accommodation with accessible and dementia-friendly design features will allow older people to remain in familiar surroundings if they become frail or if they begin to develop symptoms of dementia. Accommodation located close to shops and other amenities is not only convenient but may also help to maintain social engagement with the local community.

Older people who are at risk of not having secure and accessible accommodation are especially at risk of not being able to receive aged care services in their homes or to age in place. Special attention should be paid to the needs of these people, including through integration of the aged care and affordable housing programs, and through increased aged care support for people in insecure housing who want to remain in the community.

We note that there is currently no discernible connection between the Australian Government aged care program and any Australian or State or Territory Government housing program. This must change. We urge that the National Cabinet Reform Committee on Ageing and Older Australians, which we have recommended be established, work with housing ministers on options to provide for more integrated solutions to the housing and care needs of older people who are experiencing homelessness or are at risk of homelessness.

1.3.7 Respecting uniqueness: aged care for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people occupy a unique place in what is now known as Australia. They descend from the first inhabitants of the land we now know as Australia, having developed, over millennia, a rich, varied and unique cultural heritage. In contemporary Australia, Elders and older Aboriginal and Torres Strait Islander people are ‘cultural knowledge holders’. They provide the ‘social glue’ within their communities.¹⁰ They are central to the continuation of Aboriginal and Torres Strait Islander cultures and communities.

Aboriginal and Torres Strait Islander people who require aged care should be embraced by an aged care system that shows respect for their cultures and heritage. This Royal Commission is the opportunity to design a new national aged care system that has the capacity and flexibility to respond to the needs and aspirations of Aboriginal and Torres Strait Islander people.

We provide a blueprint for significant change to Aboriginal and Torres Strait Islander aged care. A key reason for this change is the projected rapid growth of the Aboriginal and Torres Strait Islander population aged over 50, with most of the growth in the major cities and regional areas.

Aboriginal and Torres Strait Islander people who require care are, and should continue to be, eligible for aged care from the age of 50 years because they experience earlier onset of ageing-related conditions and disability compared to the rest of the Australian population. Long-term health conditions affect 88% of Aboriginal and Torres Strait Islander people over the age of 55 years. Dementia is also more prevalent. By any objective measure, they should be receiving proportionately higher levels of aged and health care.

The current aged care system does not ensure culturally safe care for Aboriginal and Torres Strait Islander people. Unless things change, it will be unable to meet the growth in demand that will accompany the increase in the eligible population.

An Aboriginal and Torres Strait Islander aged care pathway

We propose a new approach—an Aboriginal and Torres Strait Islander aged care pathway. The pathway should incorporate the best aspects of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP), including pooled and flexible funding. Currently, however, NATSIFACP delivers services to few Aboriginal and Torres Strait Islander people, with places predominantly allocated to remote and very remote settings.

The proposed Aboriginal and Torres Strait Islander aged care pathway should be embedded in a single national system available across Australia, bringing culturally safe and flexible aged care that meets the needs of Aboriginal and Torres Strait Islander people wherever they live.

Aboriginal and Torres Strait Islander people aged between 50 and 65 years who are eligible for both the National Disability Insurance Scheme and aged care should receive funding for services from the system that best meets their needs. It is important that Aboriginal and Torres Strait Islander people in this cohort are not automatically moved straight into the aged care system. Where this happens, people miss out on the full range of assistance under the National Disability Insurance Scheme that they would otherwise be entitled to.

To achieve the necessary change and embed the pathway, we recommend the appointment of a dedicated Aboriginal and Torres Strait Islander Aged Care Commissioner, who should be an Aboriginal or Torres Strait Islander person. It is essential that the sector is supported by an Aboriginal and Torres Strait Islander person with a broad range of responsibilities to ensure that the voices of Aboriginal and Torres Strait Islander people are heard and acted upon. The Commissioner should identify the local and regional aged care needs of Aboriginal and Torres Strait Islander people and develop strategies to meet those needs in a culturally appropriate way across the country.

Embedding cultural safety

The aged care system must reflect the fact that for many Aboriginal and Torres Strait Islander people, health is grounded in connection to Country, culture, family and community. Each of these elements is capable of affecting the social, emotional and physical wellbeing of older Aboriginal and Torres Strait Islander people and, in turn, determining their health outcomes.

As the National Aboriginal Community Controlled Health Organisation put it, cultural safety ‘must be both the starting point and central to any aged care offerings for our people’.¹¹ Ms Olga Havnen, a Western Arrernte descendent and Chief Executive Officer of Danila Dilba Health Service in Darwin, described a culturally safe environment as ‘one where we feel safe and secure in our identity, culture and community’.¹² 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. The pressing need for trauma-informed care is also relevant to cultural safety.

Trauma-informed approaches are particularly important to the care of members of the Stolen Generations. By 2023, all Stolen Generations survivors will be aged over 50 years and potentially eligible for aged care services. Their childhood experiences further compromise their ability to seek services and should dictate and inform how such services should be provided.

It is essential that there are accessible pathways linking Aboriginal and Torres Strait Islanders to the care that they need. To deliver culturally safe pathways to aged care, we recommend that the Australian Government should ensure that care finders serving Aboriginal and Torres Strait Islander communities are local Aboriginal and Torres Strait Islander people.

Similarly, Aboriginal and Torres Strait Islander people need, and are entitled to receive, culturally safe aged care assessments. The Australian Government should ensure, wherever possible, that aged care assessments of Aboriginal and Torres Strait Islander people are conducted by assessors who are Aboriginal or Torres Strait Islander people, or others who have undertaken training in cultural safety and trauma-informed approaches.

The need to communicate in a language other than English can be an insurmountable barrier to accessing and using the aged care system. This can be particularly acute for Aboriginal and Torres Strait Islander people who do not speak English as their first language.

Free interpreter services are not available for older Aboriginal and Torres Strait Islander people as they are for members of culturally and linguistically diverse communities. The ability to be understood and to understand is central to a person's sense of independence and wellbeing. We recommend that Aboriginal and Torres Strait Islander people should be given access to interpreters for free when seeking or obtaining aged care services. In response to our concerns, the Australian Government advised us that a National Indigenous Interpreting Service is being progressed. This must be prioritised.

To help make culturally safe aged care a reality, we further recommend that the Australian Government should require all of its employees who are involved in the aged care system to undertake regular training about cultural safety and trauma-informed service delivery. All aged care providers that promote their services to Aboriginal and Torres Strait Islander people should also be required to train their staff in culturally safe and trauma-informed care.

Empowering Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people wish to plan, run and deliver aged care services for themselves. This extends not only to the leadership and governance of providers but also to the staff who are engaged in the face-to-face delivery of care. We support this ambition and propose ways to help achieve it.

Currently, there are insufficient numbers of Aboriginal and Torres Strait Islander aged care providers. We wish to see more Aboriginal and Torres Strait Islander organisations deliver aged care services. Services 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, particularly where those services are community controlled. 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'.¹³

Older Aboriginal and Torres Strait Islander people prefer to receive aged care services and support from other Aboriginal and Torres Strait Islander people. To respect their wishes and help deliver culturally safe aged care, the Australian Government should develop a national Aboriginal and Torres Strait Islander Aged Care Workforce Plan. There should be targets for the training and employment of Aboriginal and Torres Strait Islander people across the full range of aged care roles. The necessary funds should be available to implement the plan and meet the targets.

The new aged care system must provide for the changing and diverse needs of Aboriginal and Torres Strait Islander people. There should be 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 community.

Flexible funding

We recommend improved funding arrangements to support this approach. Funding for home and community care and for residential and respite care should be able to be pooled, recognising the flexibility that is needed by providers to deliver care in this space. Funding for capital should be available to enable the development of the infrastructure needed to deliver aged care, particularly residential aged care, and to establish respite facilities.

We also support funding to assist in the organisational development of aged care providers. Regional cooperatives would be funded to provide workforce training, career development, and integrated service delivery across health, disability, aged care and social services.

Many Aboriginal and Torres Strait Islander people have a connection to Country that is central to their ability to live, age and die well. We recommend provision of funding for retaining connection to Country to assist Aboriginal and Torres Strait Islander people to return to their Country or community if they have left to receive aged care.

The level of commitment required on the part of providers to establish infrastructure and operate in more remote locations should not be understated. We support 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 would account for the additional costs associated with providing care to Aboriginal and Torres Strait Islander people wherever they live.

We also support funding for Aboriginal and Torres Strait Islander services being provided for longer terms, with the possibility of grants of between three and seven years. This would enable aged care providers to plan effectively and build capability to establish and deliver services.

1.3.8 Fairness and flexibility: aged care in regional, rural and remote Australia

The availability of aged care in regional, rural and remote areas is poor—and it is worsening.

There are around 1.4 million people aged over 65 years living in regional, rural and remote Australia. On average, they have lower incomes, poorer education, and poorer health outcomes. These relative disadvantages can increase the need for support in older age.

Australia is a large and sparsely settled country. We heard evidence about the difficulties older people face in regional, rural and remote areas when trying to access high quality aged care. Witnesses have told us of the 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.

People living in regional, rural and remote areas should have better access to aged care than they do. Our recommendation for a universal entitlement to aged care will lay the basis for them to receive their fair share of aged care. Equitable access should be achieved through better planning, costing and funding, and more flexible, integrated service provision.

Comprehensive planning and management

The aged care system needs comprehensive planning and management. The Australian Government's projections of demand for aged care in regional, rural and remote locations are population-based and do not take into account the levels of health care needs in a community. Further, there is no targeted strategy for providing aged care in remote and very remote areas. In short, the evidence shows that 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.

There should be improved analysis of unmet need and future demand, accurate costing of the provision of care, and increased use of flexible funding to supplement gaps in services. The System Governor must better assess the aged care needs of older people in geographic areas, the services required to meet those needs, and the extent to which services are not available and needs are not being met. It should have a transparent plan to meet those unmet needs.

Proper management for the provision of aged care services also requires an understanding of the actual costs of providing services in different areas. It costs more to provide aged care services to a person living in a regional, rural or remote area than it does in a major city. Accurately costing and funding the provision of services in regional, rural and remote Australia will attract more providers to these areas by ensuring that they are paid fairly in line with their costs. The Pricing Authority should have responsibility for determining the costs of service provision in different geographical areas in Australia.

Flexible service delivery

For regional, rural and remote areas, the aged care system and funding must be flexible to account for smaller and dispersed populations and fewer aged care providers. The Multi-Purpose Services Program is an example of this flexible approach. This is a longstanding joint initiative between the Australian and State and Territory Governments which provides integrated health and aged care for regional, rural and remote communities in both residential aged care and home care settings.

The program enables health and aged care services to operate in areas that could not support a viable standalone hospital or residential aged care facility. Aged care funding from the Australian Government is pooled with funding for health care from the State or Territory Government. Through pooled funding, Multi-Purpose Services can provide innovative, flexible and integrated health and aged care services to local communities.

We have received generally positive evidence about the Multi-Purpose Services model. A 2019 evaluation identified the social and economic value of the program and concluded that it was a sound model of aged care service provision. Given the benefits of Multi-Purpose Services, we recommend that the program should be expanded and improved. New Multi-Purpose Services should be established if local needs for aged care services are not being met, even if there are existing aged care services in the region. Governments should also consider establishing new Multi-Purpose Services in areas which do not have a local public hospital.

We received evidence that the Australian Government's funding for the Multi-Purpose Services Program has failed to keep pace with need. We recommend that the Pricing Authority should develop a new funding model for Multi-Purpose Services which reflects the changing number and acuity of people receiving care and maintains certainty of funding. People accessing aged care through Multi-Purpose Services should undergo the same assessment processes and make the same co-contributions as people in mainstream aged care.

We heard that many existing buildings that house Multi-Purpose Services are outdated and need improvements, particularly for the provision of high quality residential aged care for people living with dementia. We recommend that the Australian and State and Territory Governments should together contribute to the cost of ensuring that the infrastructure is up-to-date and able to support high quality aged care.

It may not always be possible to deliver aged care services in an older person's local community. In some communities, the provision of certain aged care services may not be feasible, and an older person may have to travel or relocate to receive services. This is not desirable and should only occur when it is unavoidable. In most cases where there are few or no aged care providers, the System Governor should commission a provider of last resort.

1.3.9 Securing better access to health care

All too often, people receiving aged care miss out on access to adequate health care. This is the case even although the health care needs of people receiving aged care are, on average, greater and more complex than those of the general population. Complex needs require a coordinated, multidisciplinary response involving people from across both the health care and aged care systems.

A new primary health care model

We heard from many people that the level of service provision by general practitioners is not adequate to meet the needs of people receiving aged care. Primary health care practitioners are either not visiting people receiving aged care at their residences, or not visiting enough, or not spending enough time with them to provide the care required. Access to general practitioners will continue to be a challenge for people receiving aged care unless something significant is done to fix it.

General practitioners are primarily funded by fee-for-service. We heard evidence about the problems with the fee-for-service funding model, particularly that it creates an incentive for care that responds to an episode of ill health, rather than encouraging care that proactively attempts to reduce the risk of ill health. The fee-for-service model is considered by some to be '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'.¹⁴

We agree that part of the access problem is the amount of funding available for general practitioners providing care to people receiving aged care. Commissioner Briggs considers that another part of the problem is the way in which, and the amount that, general practitioners are funded. Commissioner Pagone agrees that the funding of general practitioners for people in aged care is insufficient and is an issue that requires consideration.

We recommend the development of a new primary care model to encourage the provision of holistic, coordinated and proactive health care for the growing complexity of the needs of people receiving aged care. Such a model would have the following characteristics:

- general practices could apply to the Australian Government to become accredited aged care general practices
- each accredited practice would enrol people receiving residential care or personal care at home who choose to be enrolled with that practice
- each accredited practice would receive an annual capitation payment for every enrolled person, based on the person's level of assessed need
- the accredited practice would be required to meet the primary health care needs of each enrolled older person, including through cooperative arrangements with other general practices to provide after-hours care
- participation would be voluntary for general practices and patients.

Commissioner Pagone recommends that the Australian Government should trial such a model for six to ten years, after which time the Australian Government should undertake a thorough evaluation of the model. He considers that a trial is necessary to determine whether it is viable to adopt a different model to improve access to health care for people receiving aged care.

Commissioner Briggs recommends that the Australian Government should implement the new voluntary primary care model for people receiving aged care. Commissioner Briggs considers that the new primary care model for older people using aged care should be adopted now as it is the only viable option to address older people's health access problems and will provide for better management of chronic and complex health conditions. She recommends that the model should be reviewed for enhancements progressively.

Multidisciplinary outreach services

Throughout our inquiry, we heard that multidisciplinary care teams are fundamental in the care of people with chronic complex health conditions.

Multidisciplinary outreach services typically work out of a hospital to deliver specialist health care in the community. Currently, most, if not all, States and Territories have some form of hospital-based outreach service into aged care facilities and older people's homes. However, outreach programs are not available to all people receiving aged care—coverage is patchy, haphazard, and subject to local funding restrictions.

We recommend that the Australian and State and Territory Governments should introduce multidisciplinary outreach services accessible to all people receiving residential care or personal care at home, based on clinical need. The services would be operated by geographically-based Local Hospital Networks responsible for managing the delivery of public hospital services and associated health services. The key features of the model would be:

- multidisciplinary teams, including nurse practitioners, allied health practitioners and pharmacists
- access to a core group of relevant specialists, including geriatricians, psychogeriatricians and palliative care specialists, and escalation to other relevant specialists
- provision of services in a person's place of residence wherever possible
- 24 hour per day on-call services
- proactive care and rehabilitation.

Older Persons Mental Health Services

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. However, the adequacy of delivery of mental health services to people living in residential aged care varies. There are differences in eligibility criteria, including whether services are provided to people in residential care and whether they are provided to people with severe changed behaviours associated with dementia. Under-funding of Older Persons Mental Health Services is also a major problem.

We recommend that the Australian and State and Territory Governments should fund older persons mental health outreach services to people receiving residential aged care or personal care at home. People receiving this care and living with dementia should also have access to the services.

A Senior Dental Benefits Scheme

Older people are far more likely to have poor oral health and be affected by its consequences, including social isolation, functional impairment, pain and discomfort, ill health and even death. Older people with a low socioeconomic status and people receiving residential aged care are at particularly high risk of experiencing oral health problems due to barriers in accessing dental care, such as public dental service wait lists and private dental costs. People often arrive in residential care with oral health problems.

Older people need improved access to the full range of oral and dental services, including those provided by oral health practitioners, general and specialist dentists, and dental prosthetists. We recommend that the Australian Government should establish a Senior Dental Benefits Scheme which would fund dental services to people who live in residential aged care and people who live in the community and receive the age pension or qualify for the Commonwealth Seniors Health Card. The scheme would cover services necessary to maintain a functional dentition—that is, 20 or more teeth—and to maintain and replace dentures.

Other health care reforms

The proposed improvements to access to primary health care, specialists and mental and dental health care will take time to develop and implement. In the short term, we recommend the Australian Government should as a matter of priority amend the Medicare Benefits Schedule to provide benefits for:

- comprehensive health assessments when a person begins to receive residential aged care or personal care at home and at six month intervals thereafter
- GP Mental Health Treatment for patients at a residential aged care facility
- 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, and subsequent reassessments or reviews
- allied mental health practitioners providing services to people in residential aged care.

The Australian Government's Rural Health Outreach Fund is intended to improve access to services provided by medical specialists, general practitioners, nurses, allied health professionals and multidisciplinary teams in regional, rural and remote areas of Australia. At present, there are four priorities: chronic disease management, eye health, maternity and paediatric health, and mental health. We recommend that the Australian Government should include geriatrician services and medical specialist services to people receiving aged care as priorities under the Fund, and increase funding accordingly.

Telehealth is a means of avoiding the potential harm and distress for frail older people caused by travel to receive medical care. The use of telehealth has become widespread as a result of the COVID-19 pandemic in 2020, and on 27 November 2020, the Australian Minister for Health announced that ‘telehealth will become a permanent part of the Medicare system’.¹⁵ Subsidised specialist telehealth services are currently available to people living in residential aged care. They are not available, however, to older people who access aged care from their homes, unless they live in remote Australia or access an Aboriginal Medical Service. We recommend that the Australian Government should expand access to subsidised specialist telehealth services to older people receiving personal care at home, and require aged care providers to have the necessary equipment and capable staff to support telehealth services.

The Australian Government subsidises Medication Management Reviews, which involve an assessment of whether the medicines that a person is taking are still necessary or appropriate, and if they are interacting with other medicines or causing potentially harmful side effects. In aged care, medication management reviews are critical to reduce chemical restraints and other inappropriate use of medications.

People living in residential aged care are entitled to only one Residential Medication Management Review every 24 months, unless there are significant changes to their medical condition or medication regimen. We recommend that the Australian Government should improve access to medication management reviews for people receiving aged care by funding pharmacists to undertake reviews on a person’s entry to residential care and annually thereafter, or more often if there has been a significant change to the person’s condition or medication regimen. Residential Medication Management Reviews should also be available to people who receive respite care or transition care in a residential aged care facility.

The Interim Report identified widespread use of chemical restraints in the purported ‘care’ of many older people in residential aged care. In its response, the Australian Government announced changes intended to address problems with medication management. These measures are commendable, but they do not go far enough to address a problem that has persisted for decades.

The Australian Government should introduce stricter requirements for prescribing antipsychotic medicines for people in residential aged care. Under the Pharmaceutical Benefits Scheme Schedule, risperidone is only subsidised for the treatment of autism in children when under the supervision of a paediatrician or psychiatrist. We recommend a similar practice should apply to residential aged care: only a psychiatrist or a geriatrician should be able to initiate treatment with antipsychotic medicines for people in residential aged care. This will ensure that every person in residential aged care is reviewed by a specialist before antipsychotic medicines are begun.

Better information and clearer responsibilities

Any breakdown in the relationship or 'interface' between the aged care and health care systems is likely to have significant, and adverse, impacts on the health of people receiving aged care. 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.

There should be improved communication and collaboration between people working in the aged care system and people working in the health care system. We have heard evidence that there is inadequate sharing of health information about older people as they move between the health and aged care systems. When older people are being transferred from hospital to residential aged care, the quality of the information provided in discharge summaries can be variable and the clinical handover processes unclear. We recommend 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.

There is also significant variation in the information staff at residential aged care facilities provide to paramedics or hospitals when residents are transferred to hospital. Hospitals should receive information to support safe and effective continuity of care. We recommend that staff of aged care services, when calling an ambulance for a resident, should provide the paramedics with an up-to-date summary of the resident's health status, including medications and advance care directives.

The Australian Government currently spends around \$45 billion every year on benefits for medical services and pharmaceuticals and around \$21 billion on aged care each year. Despite this significant investment, the Australian Government is unable to determine precisely how much of the spending on health care is used by people receiving aged care. Similarly, State and Territory Governments are unaware of the extent of use by people receiving aged care of the hospitals and other health services they operate. As a result, there is no proper basis for assessing whether health programs are meeting the needs of older people receiving aged care. This needs to be rectified, and we make a number of recommendations to improve data collection, reporting and analysis.

Aged care providers should be using digital care management systems. 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. In October 2019, only 247 out of a possible 1800 aged care residential and home care providers (14%) were registered for My Health Record. We recommend universal adoption by approved providers of My Health Record to ensure that multiple health care and aged care providers can access one central source of health information about people receiving aged care.

There is a lack of clarity about the respective roles and responsibilities of aged care and health care providers among staff at aged care services, people receiving aged care and their families and carers, and health care providers. 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 about where responsibility lies for different aspects of care provided to older people. We recommend that the Australian Government should amend the Quality of Care Principles to clarify the role and responsibilities of approved providers to deliver health care to people receiving aged care, including allied health services, mental health care, and dental health care.

The interface between the aged care and health care systems is complicated by Australia's federal system of government. While the Australian Government is responsible for the funding of primary care programs, including the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme, and the national aged care system, State and Territory Governments are responsible for the management of public hospitals and population health. The Australian Government and the State and Territory Governments are jointly responsible for the funding of public hospitals.

This split of responsibilities is reflected in different streams of funding for different aspects of health care and aged care. The different funding streams for particular types of care, such as general practice, aged care, mental health and public hospital care, can lead to fragmentation of care provision and service providers seeking to pass responsibility for care to other parts of the system.

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 by amending the National Health Reform Agreement to include an explicit statement of the respective roles and responsibilities of aged care providers and State and Territory health care providers to deliver health care to people receiving aged care. The Agreement should also make it clear that State and Territory health services, such as hospital services, specialist palliative care services and subacute rehabilitation services, are to be available to people receiving aged care on the same basis as they are available to other people.

Many of our recommendations directed to improving access to health care for people receiving aged care require close cooperation between the Australian and State and Territory Governments. We recommend that the Australian Health Ministers' Advisory Council should consider our recommendations related to the interface of the aged care and health care systems, and report to the Health National Cabinet Reform Committee with an approach to implementation.

The Australian Health Ministers' Advisory Council should also include an item in all future meetings on problems with the interface between the aged care system and the health care system and how those problems are to be resolved. We agree with Professor Leon Flicker when he said that:

I have no doubt that without coordination of all levels of government that we will continue to see substandard and inappropriate care for the health issues for older people and this will be manifested by completely unacceptable sentinel events.¹⁶

1.3.10 Righting a wrong: services for older people with disability

The National Disability Insurance Scheme has transformed the way in which disability services are provided for hundreds of thousands of Australians. But the National Disability Insurance Scheme by design discriminates against older people.

The National Disability Insurance Scheme does not provide supports to people who acquire a disability after they turn 65 years old. Nor does it provide supports to people with disability, whenever acquired, who had already turned 65 years old when the National Disability Insurance Scheme came into operation in their local area—including people with lifelong disability. Furthermore, the National Disability Insurance Scheme ceases to provide supports to people with disability who first receive residential or home care services, on a permanent basis, after turning 65.

Despite the landmark contribution made by the National Disability Insurance Scheme to the lives of people with disability, many people with disability aged 65 years and over are prevented from accessing the National Disability Insurance Scheme and obtaining the benefits of an individualised plan of supports. Mrs Elizabeth Karn, who was ineligible for support under the National Disability Insurance Scheme due to her age, described the effect that differences between the aged care and disability systems had on her:

As a Deaf Elder, I'm exhausted. I feel broken-hearted. So many of my friends are in the same situation as me. We feel excluded, ignored and isolated. Because of our age and our disability, we are forgotten. Where do we belong? When are we going to be included and accepted as a valued part of the Australian citizen? ¹⁷

As Australia's population ages, it is likely that a larger number of older people with disability will have to access aged care to obtain the supports and services they need. It would be manifestly unfair if those services were less adequate than what others in similar circumstances can access under the National Disability Insurance Scheme.

We have received evidence about inconsistencies between the supports and services available under the National Disability Insurance Scheme and those available in the aged care system. Compared to aged care, under the National Disability Insurance Scheme more comprehensive supports are available; there is greater access to specialised care, aids, equipment and therapy; and the average amount of available funding is often greater.

We recommend that every person receiving aged care with disability, regardless of when acquired, should receive through the aged care program living supports equivalent to those available under the National Disability Insurance Scheme to a person aged under 65 years with the same or substantially similar conditions, so that they can achieve the same outcomes. It is a matter of equity. It would also accord with one object of the proposed new Act: 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’.

We also recommend that the Australian Government should be held to account for the outcomes of the proposed changes to aged care services for people with disability. This should be part of the new National Disability Strategy being developed by the Government. The Disability Discrimination Commissioner and the Age Discrimination Commissioner should be required to report annually to the Parliament on the numbers and circumstances of all people with disability who are 65 years or older and receiving aged care. This should include reporting on the ability of older people with disability to access through the aged care program daily living supports and outcomes equivalent to those available under the National Disability Insurance Scheme.

1.3.11 Action for younger people in residential aged care

No younger person should have to live in residential aged care. Many younger people living in residential aged care experience isolation, desperation and loneliness. Australia’s Disability Discrimination Commissioner, Dr Ben Gauntlett, put it well:

younger people in Australia living in old age care institutions, because of their disability or medical condition, is a dark and inappropriate circumstance for this country to have allowed to occur. It is a significant human rights issue that we allow this position to be maintained.¹⁸

Delivering on commitments

In its November 2019 response to our Interim Report, the Australian Government committed to ensure that, apart from in exceptional circumstances:

- no person under the age of 65 years enters residential aged care from 2022
- no person under the age of 45 years lives in residential aged care from 2022
- no person under the age of 65 years lives in residential aged care from 2025.

The Australian Government has made some progress toward its commitments. Between 30 December 2019 and 30 September 2020, the number of younger people in residential aged care fell from 5297 to 4588. But still, every month, dozens of younger people continue to enter residential aged care. To fulfil its commitments, the Australian Government will be required to take decisive action, invest significant resources, and stay the course.

There can be compassionate reasons for younger people going into residential aged care. Many younger people enter residential aged care to receive necessary supports that have not been made available to them locally or in sufficient time after they leave hospital for them to avoid institutionalisation. Similarly, younger people at the end of their lives may enter residential aged care to receive palliative care unavailable elsewhere.

The National Disability Insurance Scheme offers the promise of a different world with access to accommodation, services and supports to prevent younger people having to live in residential aged care. However, there are significant gaps in National Disability Insurance Scheme coverage, including for terminally ill younger people. There is an urgent need to improve the availability of palliative care for younger people.

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 residential aged care. We agree that there may be some limited and exceptional circumstances in which a younger person enters and remains in residential aged care. For example, an adult with disability might wish to join a caregiver parent who enters residential aged care. An Aboriginal or Torres Strait Islander person, who is aged between 50 and 64 years, and therefore eligible for aged care services, might elect to live in residential aged care because of their need for care due to premature ageing or a particular aged care service's connection to community.

Safeguards will, however, be required to ensure that exceptions are limited and do not become the rule. A younger person must have choice and control about where they live, aided by informed and supported decision-making, and a clear understanding of the options and alternatives available. Regular monitoring and review of younger people living in residential aged care, recognising changes in circumstances and service availability are also essential.

We have learned that who assesses a younger person, and when, has a significant influence on whether the younger person enters residential aged care. Most younger people entering residential aged care are assessed in hospital or admitted from an inpatient setting because alternative accommodation or the necessary living supports are unavailable. Where possible, assessments should be undertaken much earlier in a younger person's treatment, so that there is time to find suitable accommodation and supports.

The gateway to aged care is the Aged Care Assessment Team. A younger person discharged from hospital is more likely to enter residential aged care if they are assessed by an Aged Care Assessment Team. Assessments of younger people with significant care needs should be undertaken by assessors with expertise and knowledge of service options. We recommend that younger people at risk of entering residential aged care should be assessed by an appropriate agency, such as the National Disability Insurance Agency, and not an Aged Care Assessment Team.

Improved accommodation options

For those eligible, the National Disability Insurance Scheme has accommodation options and supports for younger people who live in, or are at risk of entering, residential aged care. Specialist Disability Accommodation provides long-term accommodation for people who require a specialist dwelling that reduces their need for person-to-person supports, or improves the efficiency of the delivery of person-to-person supports. The Medium Term Accommodation program provides transitional accommodation for National Disability Insurance Scheme participants who are preparing to move into a more permanent home. Equally important are the services and supports available through Supported Independent Living and Assistive Technology.

Specialist Disability Accommodation is particularly important to prevent younger people living in residential aged care. However, it has limitations, with an estimated shortfall of around 9000 places in 2019. To address this problem, the Australian Government should develop a Specialist Disability Accommodation National Plan that includes strategies to build a sufficient supply of Specialist Disability Accommodation or viable alternatives in the areas of need. The plan should be updated annually.

To encourage the proper planning of services, the Australian Government should provide comprehensive information on the supply of, and demand for, Specialist Disability Accommodation. The Australian and State and Territory Governments should 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.

Many younger people living in, or at risk of entering residential aged care are not eligible for the National Disability Insurance Scheme or, if they are, they are not specifically eligible for Specialist Disability Accommodation. We therefore recommend that the Australian Government should develop, fund and implement, with State and Territory Governments, short-term, long-term and transitional accommodation and care options for this group of younger people. Social and community housing has the potential to deliver more accommodation for younger people at risk, particularly for more vulnerable younger people, including those with psychosocial disabilities or experiencing homelessness.

Advocacy and accountability

Navigation of the interfaces between the health care, aged care and disability services systems is complicated. The complexity is even more pronounced for younger people with a cognitive impairment or without a family advocate or who are struggling to come to terms with a newly acquired disability or illness. We recommend that the Australian Government should fund dedicated advocacy services for younger people who are living in, or at risk of entering residential aged care.

Improved information and data are essential to monitor the Australian Government's progress towards the achievement of its commitments to ensure that younger people are not forced to live in residential aged care. They are also essential for service planning and delivery. There has been a longstanding lack of detailed and reliable information on younger people in residential aged care. We recommend that the Australian Government should regularly collect and publish data, for each State and Territory, on the number, ages, length of stay and admissions and discharges of younger people living in residential aged care.

For public and political accountability, the responsible Minister should report biannually to the Australian Parliament. The Minister should account for the Australian Government's progress towards ensuring that younger people do not live in residential aged care.

1.3.12 A workforce to deliver quality, safe care

A highly skilled, well rewarded and valued aged care workforce is vital to the success of any future aged care system. We have heard about the dedication and passion of aged care workers. While many excellent people work in aged care, there are systemic workforce problems that must be addressed.

In a large number of residential aged care facilities there are not enough workers to provide high quality, person-centred care. In many cases the mix of staff who provide aged care is not appropriately matched to the care needs of older people. The staff in aged care are poorly paid for their difficult and important work.

The evidence is clear that the quality of care and the quality of jobs in aged care are inextricably linked. This points to the need for policies and practices to drive a 'virtuous circle', where good working conditions, supportive and visionary management, an empowering work culture, collaborative teams, relevant education and training, structured career progression, and job satisfaction among care workers underpin high quality, person-centred care.

Our recommendations seek to build on the good work of the sector-led Aged Care Workforce Industry Council. The Council was established in 2019 to implement the strategic actions in the report of the 2018 Aged Care Workforce Strategy Taskforce chaired by Professor John Pollaers AOM. A reconstituted, properly funded Council can play an important part in the implementation of our recommendations. We consider that both the Australian Government and the aged care workforce should be properly represented on the Council for it to be effective.

Strategic leadership and workforce planning

The number of older people in Australia will grow significantly in the next 30 years, resulting in a substantial increase in people needing different types of aged care. This will have a big impact on the number of people necessary to deliver that care and the required size of the aged care workforce. Australia is likely to have an undersupply of aged care workers, and measures will need to be put in place to deal with it.

Modelling by Deloitte Access Economics estimated that the number of direct care workers needed to maintain current staffing levels would be around 316,500 full-time equivalent by 2050, based on demographic trends and rates of use of aged care. This is a 70% increase—more than 130,000 additional workers—compared with the current baseline number of 186,100 full-time equivalent in 2020. The number will be significantly higher if our recommended reforms are implemented.

There is a need for strategic workforce planning to meet the medium- and long-term demand for a skilled aged care workforce. We recommend that the Australian Government should establish an Aged Care Workforce Planning Division within the System Governor. The Division should be responsible for developing workforce strategies to ensure an appropriate distribution of health professionals and care workers to meet the needs of the aged care sector, particularly in regional, rural and remote Australia. Its tasks should include: monitoring up-to-date data on the aged care workforce; long-term modelling on the supply of and demand for health professionals and care workers; consultation with tertiary education providers and State and Territory Governments; and aged care workforce planning, including taking account of immigration.

The Aged Care Workforce Planning Division should prepare an interim workforce strategy and planning framework for 2022–25 and a 10-year strategy for 2025–35. The Division should have access to an Aged Care Workforce Fund that can be used to support training, clinical placements, scholarships and other initiatives to respond to the workforce challenges.

Building an aged care profession

The Australian Council of Professions defines a ‘profession’ as:

a disciplined group of individuals who adhere to ethical standards and who hold themselves out as, and are accepted by the public as possessing special knowledge and skills in a widely recognised body of learning derived from research, education and training at a high level, and who are prepared to apply this knowledge and exercise these skills in the interest of others...¹⁹

The Australian Government, the aged care sector and unions must work together to professionalise the personal care workforce. This will require cultural change and improvements to education, training, wages and labour conditions for nurses and personal care workers.

Aged care workers should have a clear vision for career progression, and importantly, clarity about what they need to do to progress. We heard that ‘current career paths are non-existent in aged care for most direct care staff’.²⁰ We encourage a collaborative approach between the Australian Government, tertiary education providers, aged care providers and unions to consider how jobs should be valued and redesigned across the aged care sector and how roles might come together to provide career paths. The creation of rewarding career paths will be a key component in improving the attraction and retention of aged care workers. To inform this, existing job classifications should be reviewed and new career pathways mapped to facilitate opportunities for nurses, personal care workers and other workers to advance in the aged care sector. Commissioner Briggs recommends that the Aged Care Workforce Industry Council should take a leadership role in this.

As the Australian Medical Association noted, personal care workers spend proportionately more time caring for older people than any other staff type. They are ‘a crucial component to the aged care workforce and a crucial component in influencing safety and quality issues’.²¹ The Association proposes that, like health professionals, personal care workers should be subject to a regulatory scheme which features minimum education and English language proficiency requirements.

Regulation of personal care workers by registration will help to professionalise and improve the quality of the personal care workforce. We recommend that the Australian Government should establish a national registration scheme for the personal care workforce with the following key features:

- a mandatory minimum qualification of a Certificate III
- ongoing training requirements
- minimum levels of English language proficiency
- criminal history screening requirements
- a code of conduct and power for a registering body to investigate complaints into breaches of the Code of Conduct and take appropriate disciplinary action.

There are a number of ways in which such a registration scheme could be set up. Commissioner Briggs recommends that the Australian Health Practitioners Regulation Authority be asked to establish a National Board to examine the feasibility of a registration scheme under the National Registration and Accreditation Scheme for ‘personal care worker (health)’ or ‘assistant in nursing’ occupations, and advise Ministers.

There is currently no formal industry standard for an entry-level qualification to work as a personal care worker. We recommend the aged care Certificate III qualification as the mandatory minimum to ensure care workers have a broad range of knowledge and skills in varied aged care contexts and to provide a pathway for further learning. For existing personal care workers who do not meet the minimum qualification requirements, there should be transitional arrangements that allow them to apply for registration based on their experience and prior learning.

We heard harrowing stories of abuse in aged care perpetrated by care workers. We also heard of the anguish of the families of the victims that there is nothing currently in place that enables the perpetrators to be excluded from the sector. A registration scheme will enable those who are not suited to care work to be excluded from the sector.

The ability of an older person to develop quality relationships with their carers is central to high quality care. We consider that it is vital to the provision of high quality and safe care that personal care workers can communicate effectively with older people, their families and their colleagues. Minimum levels of English language proficiency should therefore be part of the registration standard for personal care workers, although we recognise having additional language capability beyond English is also helpful for Aboriginal and Torres Strait Islander people, ethnic communities and people with a hearing impairment.

Educating and training

We are keen to ensure that all care workers, but particularly personal care workers, are equipped with the skills and knowledge needed for current and future aged care needs.

Although significant numbers of personal care workers and home care workers hold a Certificate III qualification or equivalent, we have heard about inconsistency in the quality, delivery and duration of the courses leading to that qualification. The Aged Care Services Industry Reference Committee has responsibility for developing training packages to ensure that industry skill requirements are reflected in the national training system. We recommend that the Committee should review the need for specialist aged care Certificate III and IV courses. It should also regularly review the content of the Certificate III and IV courses to determine if any additional units of competency should be included in the core modules of the courses.

Commissioner Briggs observes that the Certificate III has not been changed substantively since 2015, despite aged care being a constantly changing care environment. She recommends, as part of its review, the Aged Services Industry Reference Committee should consider if the following units of competency should be included as core competencies:

- personal care modules, including trauma-informed care, cultural safety, mental health, physical health status, wound care, oral health, palliative care, falls prevention, first aid, monitoring medication, and dysphagia management
- quality of life and wellbeing, including the use of technology, interventions for older people at risk, and recognising and responding to crisis situations.

As many as 70% of people in residential aged care could be living with dementia. We have been told that many nurses and general practitioners do not have a full understanding of the symptoms and needs of people living with dementia. While this is presently of greater need in the residential aged care sector, over time it will become more important in home care.

We also heard that residential aged care staff tend to be under-skilled and under-educated in palliative care, and there is a lack of suitably qualified staff to manage palliative care adequately.

High quality dementia and palliative care should be considered core business for aged care providers. The Australian Government should implement as a condition of approval of aged care providers that all workers who are involved in direct contact with people seeking or receiving services in the aged care system undertake regular training about dementia care and palliative care.

Aged care workers should have good quality, and easily accessible, ongoing training and professional development opportunities available to them. We recommend that the Skills National Cabinet Reform Committee should fast-track the development of accredited, nationally recognised short courses, skills sets and micro-credentials for the aged care workforce. The courses should be designed to improve opportunities for learning and professional development, and upgrade the skills and knowledge of the existing workforce.

The changing profile of health and ageing within Australia presents challenges and opportunities for both undergraduate and postgraduate medical, nursing and allied health training. A paradigm shift is required. Curricula should be developed to equip the health professionals of the future with the skills and attributes they need for their core patient groups of tomorrow.

Accordingly, we recommend that the undergraduate curricula for health professionals should be reviewed by the relevant accreditation authorities. The reviews should consider changes to the knowledge, skills and professional attributes so that the care needs of older people are met by health professionals. The reviews should cover the professions of nursing, medicine, audiology, optometry, dietetics, dental practice, psychology, social work, occupational therapy, osteopathy, podiatry, physiotherapy and speech therapy.

Clinical placements are an important part of quality education programs for health care professionals. They enable students to practice their skills and learn through real life experiences, supported by other health professionals. In contrast to the health sector, aged care offers very few such experiences. This limits the number of professionals with the experience and interest to work in aged care because they are not presented with an opportunity to do so during their undergraduate training.

We recommend that the Australian Government should fund teaching aged care programs for delivery to students in both residential aged care and home care settings. The programs should facilitate clinical placements based on partnerships between aged care and tertiary education providers. This will make the programs well placed not only to build the aged care workforce, by way of placements and education, but also to support research and innovation. The programs should act as a hub for approved providers in a particular region and support training of aged care workers from surrounding aged care services.

Improving pay

A wages gap exists between aged care workers and workers performing equivalent functions in the acute health sector. Successive governments have made several failed attempts to address that gap by providing additional funds to providers in the hope that they would be passed on to aged care workers by way of increased wages. They were not.

The Aged Care Workforce Strategy Taskforce recommended in 2018 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'.²² 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, there has been no discernible increase in aged care wage rates in the more than two and a half years since the Taskforce report was published. The Taskforce's proposal of an industry-led process leading to substantial increases in aged care wages rates seems to have limited prospects of success.

In our view, the Australian Government, providers and unions must work together to improve pay for aged care workers. We put forward two recommendations to facilitate this.

First, we recommend that the Australian Government, providers and unions should collaborate on a work value case and equal remuneration application to the Fair Work Commission. We are pleased to see that the Health Services Union has already made such an application for its aged care members. If successful, such applications will increase the minimum wages payable to personal care workers and nurses in both residential and home care.

Second, wage increases should be an explicit policy objective of aged care funding. As part of the new aged care funding system we propose, we are recommending the establishment of a Pricing Authority to set prices for high quality and safe aged care. We consider that an important part of that work will be to price aged care at a level that enables workers to be remunerated to reflect what similar workers are paid in similar sectors, such as health and disability. In setting prices for aged care, the 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.

Getting staffing right

There are many ingredients that enable the provision of high quality and safe aged care, but it cannot be achieved without having enough staff with the skills and time to care.

The introduction of the Aged Care Act in 1997 removed the obligation of aged care providers to spend a dedicated portion of their government funding on direct care staffing. Since 1997, providers are free to judge for themselves what staffing numbers are 'adequate' and what skill levels are 'appropriate'. The 1997 changes effectively 'enabled cost savings through replacement of nursing staff with care workers', and has resulted in compromised care for older people in residential care.²³ There is effectively no regulation of aged care staffing levels or skill mixes.

In 2011, the Productivity Commission identified that the largely unregulated aged care sector provided an incentive to aged care providers to replace higher paid and skilled nurses with lower paid and semi-skilled personal care workers. This is what happened and the trend continues. This trend is the opposite of what should have occurred. While the capacity and capability of the residential aged care workforce have been eroded, the needs of people in their care have increased.

The status quo is unacceptable. The current requirements have not prevented inadequate staffing nor substandard care and may in fact have encouraged these outcomes.

The evidence is compelling that overall staffing levels in aged care are linked to quality of care, and that registered nurse numbers are particularly important. We were informed by a highly credentialed international nursing home expert that:

the most important policy measure for ensuring appropriate staffing levels is to adopt a regulatory requirement that establishes a minimum staffing level.²⁴

A report for us by the University of Wollongong's Centre for Health Service Development found that, on average, each resident in a residential aged care facility receives 180 minutes of care per day, of which 36 minutes are provided by registered nurses. It concluded that staffing levels within large parts of Australian residential aged care fall well short of good or even acceptable practice standards.²⁵

We recommend that the Australian Government should require approved providers of residential aged care facilities to meet a minimum quality and safety standard for staff time. The standard should set required daily minimum staff time for registered nurses, enrolled nurses and personal care workers for each resident, over two stages—with 200 minutes of care per day of which 40 minutes are provided by registered nurses by 2022, and 215 minutes of care per day by 2024, of which 44 minutes are provided by registered nurses. In addition, when fully implemented in 2024, the standard should require at least one registered nurse on site at each residential aged care facility at all times.

The standard should allow approved providers some flexibility to select the appropriate skills mix for delivering high quality care in accordance with their model of care. It should be linked to the casemix-adjusted activity based funding model for residential aged care facilities, which means that providers with a higher than average proportion of high needs residents would be expected to engage additional staff.

The standard should be phased in to give providers and government adequate time to prepare. To meet the legitimate concerns about the inability of some providers to meet the new standard and the need not to stifle innovation by being overly prescriptive, a time-limited exemption mechanism should apply in narrow circumstances.

If older people are to live well in their own homes for longer, personal care workers and health professionals need adequate time to attend to their health, social, emotional and domestic needs. This is particularly important when we consider the likely changes in future of the needs of people who access aged care services in their own homes.

The role of the personal care worker entails physical care, emotional care, housekeeping and daily living assistance, and documenting and reporting. Their work includes assisting people with personal hygiene, eating, position change and movement, exercise, leisure activities, shopping, cleaning and home maintenance.

It will be necessary to ensure that older people who are receiving care at home receive the care to which they are entitled and for which they have been assessed. We acknowledge that care time will vary significantly based on the circumstances and needs of the older person being assessed and it may well range across clinical and non-clinical care streams.

Commissioner Briggs considers that there should be processes and reporting obligations developed for checking that care being provided at home is consistent with the assessed need and care plan. Where this is not occurring, there should be a trigger for review or reassessment by the care finder and assessment service.

Commissioner Briggs notes that good quality supervision and support can improve working conditions and the performance and wellbeing of home care workers. She considers that all personal care workers providing care in the home should be supervised by a registered nurse or allied health professional. This does not mean that a registered nurse will accompany them as they work. It means that there is a health professional that they can go to for advice and support and who can provide appropriate supervision and training.

As part of our recommendations on quality and safety, we recommend that there should be an independent review of Aged Care Quality Standards. This review should consider how the Standards can be strengthened in relation to human resources to ensure that aged care providers supervise and support their employees, and in particular home care workers, for performance and health and safety outcomes.

A significant trend in recent years has been the use of ‘independent contractors’ in aged care. We consider permanent employment as a mode of engagement of the workforce is more compatible with achievement of our broad objectives of developing a skilled, career-based, stable and engaged workforce providing high quality aged care. Older people report that continuity of care provided by the same workers enables better care and improves wellbeing. Employees are, by definition, required contractually to comply with any lawful and reasonable directions they are given about the performance of their work. If a provider directs an employed care worker to provide care through a relationship-based model of care, for example, the employee is required to do so.

Leadership and culture

Good leadership and culture provide a necessary foundation for workforce development and growth—to being an employer of choice.

Leaders in aged care have a shared responsibility to help the sector emerge from what Professor Pollaers described as a state of ‘adolescence’.²⁶ We agree with his observation that the sector’s leadership capability has not kept pace with the growing size and complexity of organisations within it.

The challenge for strategic and operational leaders and managers within aged care organisations will be to lead their organisations through the reform process in the years to come with confidence. To support and drive the reforms we envisage, consistent and confident leadership at all levels of aged care organisations is essential. While this is reinforced through strategies, policies, practices and behaviours, it begins with a genuine commitment to the core values and philosophies on which high quality and safe care are built.

The Government workforce | Commissioner Briggs

The Australian Department of Health and Aged Care will need to step up to the requirements of a major hands-on service delivery agency if it is to lead and guide the aged care sector effectively through the reforms we recommend. This will necessarily require a fundamental change in the culture, leadership and management of the Department of Health and Aged Care.

Government workers are essential both to the delivery of care and to the management and oversight of the aged care system. The Government aged care workforce is a critical conduit between older Australians and their families and access to care. They are often the first point of contact for many people with the aged care system. We know from the evidence we have received that, more often than not, the first interaction with the aged care system is during an anxious or crisis time in a person's life.

The interactions between people receiving care and Australian Government aged care employees can play an important role in determining the quality of that care. It is therefore essential that the Government workforce has the experience, knowledge and skills to ensure that it plays its part in guaranteeing that the care provided by the aged care system is high quality and safe. Unfortunately, the evidence and information we received in our inquiry suggests that there are too few highly skilled and knowledgeable Government aged care workers and too much reliance on external contractors.

Throughout our Final Report, we make a number of recommendations which will affect the Australian Government workforce. Some of the recommendations will directly impact the Government's workforce, like the introduction of thousands of care finders and reforms to My Aged Care. The impact of others will be as a result of new or expanded institutional models, like the expansion of the Australian Quality and Safety Authority and the creation of a new Inspector-General for Aged Care. Others will be as a result of increased access to aged care and changes to aged care services. All these will require a professional cadre of public servants, sensitively recruited, trained and educated to meet the needs of our most vulnerable older people.

1.3.13 Responsibility and accountability: good provider governance

Good provider governance is essential for the delivery of high quality aged care. The evidence before us has shown that the level of substandard care in the aged care sector is unacceptably high. If all aged care providers had good governance arrangements in place, it is highly likely that the level of substandard care would reduce significantly.

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. They are set by the leaders of an organisation, in particular the board or governing body. They are implemented by executive leaders and workers who report to those executive leaders. They involve everyone in an organisation.

Culture is the key determinant of an organisation's performance and ability to meet its objectives. As the Governance Institute of Australia explains, values and behaviour determine and define organisational culture. Governance arrangements reflect and promote the culture of an organisation.

An aged care provider's most important objectives should be to enhance the wellbeing of older people by providing them with safe and high quality care, and to put the older person's wishes and needs first. Governance arrangements for aged care providers must be designed around these core objectives.

The existing governance requirements in aged care legislation do not provide a sufficiently strong basis for the governance and leadership of aged care providers. We consider that changes need to be made to improve the governance and leadership of aged care providers.

Good governance practice

Contemporary good governance practice in Australia is to have, where possible, a majority of members on an organisation's governing body who are independent of the organisation. An independent member of an organisation's governing body is one who is free of any interests that might influence, or might reasonably be perceived to influence, their capacity to bring an independent judgment to issues and to act in the best interests of the organisation.

This good governance practice should apply to approved aged care providers providing personal care services. 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. We recommend that the governing body of an organisation providing personal care must have a majority of independent non-executive members, unless an exemption has been granted.

We also have concerns about the board independence of organisations that are subsidiaries of other entities. Board members have a duty to act in good faith in the best interests of the organisation. However, the Corporations Act 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. We do not consider it appropriate that directors of an aged care provider should be permitted by law to give priority to the interests of another 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 board to act in the best interests of another entity.

While the current regulatory regime defines the key personnel of aged care providers, it does not expressly require the Quality Regulator to be kept informed of who these key personnel are. Furthermore, there is no mechanism for considering the fitness and propriety of people seeking to become key personnel. We are recommending that the Quality Regulator is kept informed of key personnel and changes to key personnel, and that key personnel are subject to a fit and proper person test.

Strengthening accountability and transparency

Accountability and transparency are critical features of good governance. They are particularly important in the case of approved providers of aged care that receive most of their funding from taxpayers and provide care to vulnerable people. Approved providers should be required to provide ready access to information about their staffing and operations to enable proper scrutiny. We recommend that approved providers should be required to provide an annual report for publication on the My Aged Care website.

Our recommendations for a new aged care system are wide-ranging and will lead to reform of the sector. This will result in major changes in policies and practices for providers and those who work in aged care. Many will find this challenging.

To support and drive the reforms that we recommend, consistent and confident leadership at all levels of aged care organisations will be essential. It begins with a genuine commitment by boards, executives and staff to the core values and philosophies on which high quality and safe care are built. This should be reinforced through strategies, policies, practices and behaviours.

We both understand the importance of leadership and culture to the delivery of high quality and safe aged care. Commissioner Pagone encourages providers to have regard to this as a matter of internal pride, governance and visibility. In his view, the values, attitudes and standards that leaders need to instil as the culture of an organisation are something for encouragement rather than imposition by obligation.

Commissioner Briggs agrees that while good providers will show such leadership, the experience of the Royal Commission is that many do not take leadership, effective staff management and culture seriously. She considers that the transformational nature of the changes envisaged will require a significant step-up in leadership quality and expectations. She recommends that the Australian Government should require that aged care providers implement arrangements to support staff in adopting a new caring culture and managing the necessary workforce changes as the aged care system is transformed.

Aged care providers need the right governance systems to support boards. The Aged Care Quality Standards in place since July 2019 include a governance standard. However, we consider there is scope for improvement. We recommend that any governance standard for aged care providers should include several key matters.

Specifically, all approved providers should have members of their governing body with the mix of skills, experience and knowledge of governance responsibilities required to ensure the safety and high quality of the care they deliver. They should have a care governance committee to monitor and ensure accountability for the quality of care delivered. They should also have effective risk management systems and practices covering care risks as well as financial and other risks, and give particular consideration to ensuring continuity of care.

Feedback mechanisms are an important means by which aged care providers can learn about day-to-day practices in their services. Any new governance standard should require approved providers to allocate resources and implement mechanisms to support regular feedback from, and engagement with, people receiving aged care, their families, their advocates, and staff. Feedback should be sought on their views on the quality and safety of the services being delivered and ways to improve the delivery of those services.

People receiving aged care, their family members and their advocates have described the powerlessness, despair, anger and frustration that they have felt when confronted with providers' resistance to feedback and complaints. Providers should have a system for receiving and dealing with complaints. This should include regular reports to the governing body about complaints and their resolution and an analysis of the patterns of and underlying reasons for complaints.

Finally, the governance standard should include a requirement that a nominated member of the governing body must attest annually, on behalf of the members of the governing body, that they are satisfied that the provider has in place the structures, systems and processes to deliver safe and high quality care. Professor Picone gave evidence that:

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.²⁷

Support for improving governance

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.

At present, there are a number of Australian Government programs available to providers to improve their operations, including governance arrangements. While these are useful, they are limited by either the range of providers that can access them or the forms of assistance that they fund. We recommend that the Australian Government should establish an ongoing program to assist approved providers to improve all aspects of their governance arrangements.

1.3.14 Lifting the bar: regulating for quality and safety

We want people who receive aged care, and their families and friends, to be at the heart of aged care regulation. We agree with the observations of Professor Ron Paterson ONZM that:

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.²⁸

The primary function of the aged care regulator is to protect and enhance the safety, health, wellbeing and quality of life of people receiving aged care. Ineffective regulation has been one of the contributing factors to the high levels of substandard care in Australia's aged care system. Regulation should seek to prevent harm to people receiving aged care services and ensure that instances of substandard care are detected and addressed. Where people have been harmed as a result of substandard care, the regulator should ensure that measures are put in place to prevent future harm, and that those responsible are held to account.

Aged care quality and safety regulation has been marked by frequent reviews and slow and piecemeal adjustments for at least a decade. If the systemic failures of Australia's aged care system are to be addressed, a meaningful shift in the regime and culture of aged care regulation is required. We are recommending changes to approval and accreditation, monitoring of quality and safety, complaints handling, serious incident reporting, enforcement powers, and regulatory capability.

Regulation of home care is particularly inadequate. This was the case when we commenced our inquiry; two years later, it remains the case. This needs to be addressed urgently, especially in light of our recommendation that there be a significant expansion of the home care sector.

Approval and accreditation

A rigorous assessment of those wanting to provide Australian Government-funded aged care services is the first and best opportunity to ensure that they are competent to provide high quality and safe care to older people. If organisations that are unlikely to be able to meet those high standards are not approved, there should be a reduced need to take corrective regulatory action in the future.

Under the new aged care program, we are recommending that all providers of subsidised aged care services should be required to be approved. In addition, all providers of residential and high-level home care should be required to be accredited. This scrutiny is essential to ensure the suitability, viability and capability of providers to deliver the kinds of services for which they receive subsidies.

Our recommendations on approval and accreditation will have significant implications for the home and community care sector. Currently, organisations providing aged care services under the Commonwealth Home Support Programme are not approved, unlike providers of

Home Care Package services. Our recommendation to integrate the Commonwealth Home Support Programme with the Home Care Packages Program as part of the new aged care program will require new approval arrangements to be put in place. In 2018–19, there were about 905 organisations that only provided services under the Commonwealth Home Support Programme, many of which are small organisations. There should be a careful transition of these organisations to the new approval process.

Given the diversity of organisations and services, a robust but flexible approval system is required. We recommend that initially home care providers should be able to seek approval for only a limited scope of services, and the regulator should be able to adjust the approval process to reflect the risk attached to different levels of service.

Unlike residential aged care services, home care services are not accredited. Although ‘home services’ are subject to a quality review at least once every three years, as at 30 June 2019, 159 approved providers had never had a quality review conducted on any of their active home care services. In 2018–19 the median time before a quality review of a new home care service was undertaken was 201 days.

We recommend accreditation for home care services that provide care management, personal care or clinical care to address this gap in the regulatory arrangements. Service-level accreditation will provide an additional level of quality assurance for higher risk services. This will become increasingly important as more older people remain at home for longer and there is a consequential increase in the frailty of people receiving more complex care at home. Accreditation periods should vary based on an analysis of performance and risk. Initial accreditation should be for no more than one year.

Monitoring quality and safety

In monitoring the quality and safety of care, an effective regulator must be able to identify risks and areas where care could be improved in a timely and effective way, drawing on all relevant sources of information. This might include information obtained from inspections, through the approvals and accreditation processes, from the complaints and serious incident reporting schemes, and from prudential regulation and financial oversight.

The Carnell-Paterson review in 2017 made a number of recommendations to improve compliance monitoring. Some of these have been or are in the process of being implemented, but overall progress in implementing the recommendations has been slow. They should be progressed as a matter of priority.

We make further recommendations to improve the monitoring and compliance of aged care services. We recommend that a general duty to provide high quality and safe care should be imposed on providers. In addition to changing the way providers work, the inclusion of such a duty in aged care legislation should provide a focus for the compliance and enforcement work of the regulator. The regulator should not only assess compliance with the specific quality standards, but should also assess whether providers are being ‘active, imaginative and flexible’ in ensuring the quality and safety of the care they provide.²⁹

The most valuable feedback on the quality and safety of care comes from people receiving aged care and their families and advocates. We make a number of recommendations to give greater weight to the voice of people receiving aged care. The regulator should report on the experience of people receiving aged care and ensure that these reports are informed by interviews with at least 20% of people receiving care at a service (or their nominated representative). The regulator should also establish channels to allow people receiving aged care and their families and advocates to report their experiences of aged care and the performance of aged care providers all year round.

There is a need for much better information about the quality of care. The Aged Care Quality and Safety Commission currently assesses providers against the Quality Standards on a binary 'met' or 'not met' basis. This does not permit a meaningful comparison of the performance of different services. A pass or fail assessment does not measure the extent to which care exceeds or fails the minimum standard. The assessments do not provide meaningful information for older people and their families or offer incentives for providers to strive for excellence, or do more than deliver adequate care.

We recommend that the regulator should adopt a more rigorous, graded assessment of service performance against the Aged Care Quality Standards. Rather than a pass or fail, there should be a range of outcomes. These outcomes could, for example, range from 'very poor performance that fails to meet the standard' to 'excellent—exceeds the standard in all respects'.

We also recommend that the powers of the regulator to enter the premises of an approved provider and obtain information, documents and evidence should be strengthened. Unannounced visits are an important tool in assessing care. While the Aged Care Quality and Safety Commission is able to conduct unannounced visits, it does not have the power to enter premises without the consent of the provider.

We consider that regulatory officials should have the power to enter the premises of an approved provider at all reasonable times without a warrant or consent. In addition, regulatory officers should have the power to enter premises at other times if the regulator reasonably believes that there is an immediate and severe risk to the safety, health and wellbeing of people receiving aged care. When on the premises, regulatory officials should have full and free access to documents, goods or other property.

Complaints handling

The importance of a transparent and effective complaints handling process cannot be overstated. A complaint can be a window into the quality and safety of care. It provides an opportunity to improve the care of an individual, address systemic issues with the provision of care, and remedy the consequences of poor care before things go badly wrong. The complaints system should be capable of providing answers and redress when there have been failures in the quality and safety of care provided.

We heard evidence of a lot of dissatisfaction with the current complaints processes. Some witnesses gave evidence about a lack of transparency in the complaints process. Others told us about being given the run-around when they tried to get a satisfactory response to

their concerns. A complaints scheme that is ineffective or that does not engender trust will diminish the supply of important information about the quality and safety of care. It is a lost opportunity to improve the system.

Effective complaints management requires a dedicated focus on resolving and investigating complaints. We recommend that the role of Complaints Commissioner should be a statutory appointment and should be operationally separate from other regulatory functions. We agree with the evidence of Professor Paterson:

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...for consumers, providers and the community.³⁰

The Complaints Commissioner should be able to deal with a broad range of complaints about aged care, including complaints about providers and their staff, and other people working in the aged care system, such as assessors, care finders, and inspectors. It is important that there is a single authority that can receive complaints from people interacting with the aged care system, including older people, their family and advocates, and workers. It must be as easy as possible for people to make a complaint about aged care, and there must be no risk of complaints falling through the cracks.

The Complaints Commissioner should be able to respond to complaints in ways that are meaningful to people receiving care and those complaining on their behalf. This should include an ability to direct providers and others to take specified action to remedy an issue that is the subject of a complaint. Other appropriate responses could include issuing directives to provide an apology or an explanation for an incident to the complainant.

The Complaints Commissioner should be required to advise a complainant of the proposed outcome of a complaint and seek their views, before deciding to close that complaint. If a complainant or a respondent is not satisfied with the Commission's handling of a complaint or the outcome, they may refer the matter to the Inspector-General of Aged Care.

The Aged Care Quality and Safety Commission currently publishes a quarterly report on sector performance. The report contains information on the number of complaints received, the nature of complaints, and the number of notices and directions issued as a result of complaints. We consider this report could be enhanced by the publication of additional information, including redress outcomes arising from complaints and service improvements implemented as a result of a complaint. We also believe that the Complaints Commissioner should publish information about the number and nature of complaints made about individual providers or services. Publishing more information about complaints will provide greater transparency about the extent to which the complaints system is achieving satisfactory outcomes for complainants.

The Aged Care Quality and Safety Commission aims to resolve 80% of complaints within 60 days. The Commission met this objective for 75% of complaints in 2019–20. However, this means that fully one-quarter of the complaints were not resolved within the targeted

timeframe. Commissioner Briggs considers that the Aged Care Safety and Quality Authority should aim to resolve all complaints within 60 days and should report on performance against this standard. Aged care services are essential to the lives of older people and their families. Older people who are expressing concerns about their care do not have the time or luxury to wait for a long drawn-out complaints process to work its way through the bureaucracy. Their concerns need to be responded to with some urgency.

We have heard that older people and their families and aged care workers may be reluctant to raise concerns due to a fear of retribution. Comprehensive whistleblower protection provisions should be implemented in aged care legislation to protect people who make complaints or report suspected breaches of legislative requirements to the Quality Regulator, the Inspector-General of Aged Care or key personnel of an approved provider.

Serious incident reporting

The level of neglect and abuse in aged care is unacceptably high. In 2018–19, the number of alleged assaults in residential aged care is estimated at between 32,193 and 44,131. The estimated number of alleged incidents of unlawful sexual contact in 2018–19 could be as high as 2520, or almost 50 per week. This is a disgrace and should be a source of national shame.

A serious incident reporting scheme is an important way to ensure that approved providers respond appropriately to incidents of abuse and neglect. The existing compulsory reporting scheme in aged care is unsatisfactory. It has a limited scope of incidents that must be reported, and information reported by approved providers is not used effectively.

In 2017, the Australian Law Reform Commission and the Carnell-Paterson review expressed similar concerns about the existing scheme and recommended that a new serious incident scheme for aged care be introduced. The Australian Government has announced a new scheme will commence on 1 July 2021. This scheme will require reporting of a much wider range of incidents than is currently the case. The expanded scope of incidents covered is a welcome development and will greatly improve the regulator's oversight of abuse and neglect in residential aged care.

However, expansion of the coverage of the scheme only addresses one of the defects in the current arrangements. Without an expansion of the scheme to home care, purposeful action on the reports of serious incidents, and greater transparency around the scheme, the abuse will continue.

Further improvements are required. The objectives of the new Serious Incident Response Scheme should be clearly set out in legislation. In our view, the central object of any serious incident reporting scheme must be to protect people receiving aged care services from harm.

The new Serious Incident Response Scheme must be extended to cover allegations of certain serious incidents perpetrated by aged care workers against people receiving aged care in home settings. It is hard to justify the lack of oversight of allegations of abuse and neglect in home settings. The need for oversight of serious incidents in home settings will increase as more people receive aged care in their homes for longer. People receiving aged care at home will also most likely have increased levels of frailty, cognitive impairment or both. Frailty is directly linked to vulnerability.

Any serious incident response scheme must have the capability to detect patterns in reports that indicate an ongoing risk to the safety of people receiving aged care services. This is a critical tool in enabling the regulator proactively to identify risk. When a new report is received by the regulator, the initial assessor should be able to identify immediately whether an aged care worker named in that report has been the subject of an earlier report. The current compulsory reporting scheme does not have this capability. The Australian Government should ensure that when the new Serious Incident Response Scheme is introduced, the regulator has the capability to undertake this and other basic risk detection.

We consider that a provider should be required to provide the regulator with a plan detailing the action it intends to take in response to a reported incident. The regulator should have powers to scrutinise a provider's response to a serious incident, including through obtaining information and imposing reporting obligations. The regulator should also be able to require a provider to take specified remedial action within a specified period.

Enforcement

Enforcement is an important part of ensuring that the regulatory system deters poor quality or unsafe care. It must be credible and effective. Existing enforcement options do not meet community expectations. Professor John Braithwaite, a leading expert in regulation, has described aged care enforcement in Australia as 'enfeebled'.³¹

In its 2011 report *Caring for Older Australians*, the Productivity Commission recommended that the aged care 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. However, there have been few substantive changes to the regulator's enforcement options since that time.

Analysis of the sanctions imposed in relation to residential aged care services between July 2015 and March 2019 reveals a remarkably uniform response to non-compliance. Such a 'one size fits all' approach to enforcement means that the regulator either lacks an appropriate range of enforcement tools or lacks the necessary flexibility and imagination to deploy the right sanction to fit an individual case.

We recommend a broader range of enforcement powers to give the regulator greater scope to impose proportionate penalties and real deterrence where needed. These include powers to accept an enforceable undertaking, impose an infringement notice, ban individuals from providing aged care services, limit the ability of a provider to expand its services, and appoint an external manager to a provider.

We also recommend the introduction of civil penalties for a breach by a provider of the general duty to provide high quality safe aged care. Civil penalty proceedings are one of the more serious forms of enforcement action available to a regulator. They are ‘primarily if not wholly protective in promoting the public interest in compliance’.³²

Individual accountability, particularly for those in positions of leadership, is important. As the Quality Standards recognise, the governing body of an aged care provider is responsible for delivering quality and safe care. We consider that the regulator should have the option of commencing civil penalty proceedings against one or more key personnel, in addition to the approved provider, in appropriate cases.

Remedies for people who have been harmed because of unsafe or poor quality care are important. We recommend that where a provider or person has been found by a court to have contravened a civil penalty provision, the court should be able to award compensation to a person receiving aged care services who has suffered harm as a result of that contravention. The regulator should be able to make an application for such compensation at the request of the person harmed. An older person who has suffered harm, or someone acting on their behalf, should also be able to make such an application.

The capability of the regulator

A competent, vigorous and well-resourced regulator is critical to the success of any regulatory regime. The systemic failures we have identified in the aged care system raise concerns about the capability, leadership and culture of the regulator.

We recommend that the regulator be given additional functions and powers, including in the areas of provider governance, serious incident reports and complaints handling. This will lead to an increase in the regulator’s workload. The introduction of civil penalties will require increased legal capacity within the regulator.

We also recommend that the Australian Government should commission an independent review of the capabilities of the Aged Care Quality and Safety Commission. Following the review, the Australian Government should provide the resources recommended to ensure the regulator can develop a skilled and dedicated compliance and enforcement workforce, with the necessary regulatory and investigatory skills and clinical knowledge to meet its mandate.

Advocacy

One of the best ways of safeguarding older people is to make sure that ‘their voices are heard and their preferences acknowledged’.³³ Advocacy services play an essential role in ensuring that this occurs. Professor Paterson described the aged care sector in Australia as being characterised by a ‘relatively weak’ consumer voice when compared with that of providers.³⁴ Advocacy services are an important mechanism for correcting this balance.

Supporting older people through the formal complaints process is an important role for advocacy services. We have heard that many people who receive aged care are fearful of making a complaint. Most complaints are made by family members or supporters on behalf of the older person. This points to the importance of access to advocates for older people who may not have family or others who are able to advocate on their behalf. The role of advocacy services in complaints handling should be formally recognised in the aged care legislation.

Advocacy should extend beyond individual advocacy to information and education programs so that older people are aware of their rights and how advocacy can help them. There should also be 'systemic advocacy' to advance the interests of older people as a group.

Older people receiving or applying for subsidised aged care are eligible to receive assistance from a formal advocacy service through the National Aged Care Advocacy Program. However, the evidence before us suggests that the funding is inadequate. In 2018–19, the Older Persons Advocacy Network supported just over 1% of the number of people receiving aged care in Australia. It reported a 67% increase in demand for information and advocacy support over the preceding two years.³⁵ We consider that the advocacy network should be strengthened to ensure that older people and their families are supported to understand their rights and to raise concerns. The advocacy network should be able to reach more older people, to undertake systemic as well as personal advocacy and to offer an expanded range of education and information services for older people, their carers and families.

We recommend that the Australian Government should complete a consultation with service providers under the National Aged Care Advocacy Program to determine the extent of unmet demand for advocacy services by people seeking or receiving aged care services. The consultation should also consider the additional funding required for the provision of education, 'systemic advocacy' and capacity-building of advocacy services.

In response to the consultation, the Australian Government should increase the funding of the National Aged Care Advocacy Program to establish a sustainable funding base. The funding should provide for increased coverage of the program to meet unmet demand for prompt advocacy services, including education and 'systemic advocacy', and the infrastructure required to support an effective national network of advocacy organisations.

In the interim, we recommend an immediate funding boost to support an expanded coverage of advocacy services. As an initial investment, we recommend an increase in funding to enable at least 5% of people receiving aged care to access advocacy services.

1.3.15 Improving aged care through data, research and technology

Understanding how the aged care system works now, and how it might work in the future, requires reliable data and careful research. Data and research will help to inform and evaluate the delivery of aged care, and to support the adoption of improved models of care and new technologies.

Aged care data

Governments, aged care providers and health professionals routinely collect data about their clients and services, but that data is not adequately integrated and analysed to inform how to achieve improvements in care.

We are concerned that reliable, accessible and comprehensive data on safety and quality is not available in the aged care sector. At a system level, there is ‘no comprehensive data on the outcomes of care’.³⁶ This cannot continue. The Australian Government cannot effectively regulate or develop responsive policy for a system about which it remains partially ignorant. The Australian public is entitled to expect comprehensive, up-to-date data to be available to help them evaluate the safety and quality of the aged care system.

The Australian Institute of Health and Welfare has acknowledged that current aged care data is fragmented and incomplete:

There is limited integration across data sets to enable a person centred view of pathways and outcomes across aged care, health and other support systems. There are also notable data gaps (e.g. workforce, finance, regular assessment of care needs, quality of life, quality of care) and no agreed common data definitions in use across the aged care sector.³⁷

It is not merely a matter of collecting missing data: all data must also be of a high quality and the capacity must be built to use it effectively. Data systems need to be able to work together and share information—also called being ‘interoperable’—and the infrastructure must be sufficient to serve the purposes of collecting data.

We recommend that the Australian Institute of Health and Welfare should undertake critical aged care data governance and management functions. It should be required to:

- collect, store and manage aged care-related information and statistics
- coordinate the collection, production and publication of that material
- oversee the development of a standard format for presentation of aged care data, including consideration of interoperability with the health care sector
- develop and publish a National Aged Care Data Asset, comprising a number of national minimum aged care datasets.

National Aged Care Data Asset

Australia does not have a national aged care data asset to inform assessment of how the aged care sector performs for the benefit of older people. We recommend that the Australian Institute of Health and Welfare should curate and make publicly available a National Aged Care Data Asset.

A National Aged Care Data Asset will provide a better understanding of the life experiences, pathways and outcomes of people receiving aged care and the operation and performance of the aged care system. It should link or be linkable with data collected on primary and acute health care as well as disability care.

The System Governor should determine the national minimum aged care datasets to be included in the National Aged Care Data Asset. The datasets should include data on:

- the demographics, clinical characteristics and care needs of people receiving aged care, and the aged and health care services they use
- the demographics, skills and wages and conditions of the aged care workforce
- the financial performance of aged care providers, the quality of care provided, and their ownership types, operating segments, size and any other relevant characteristics.

Commissioner Pagone recommends that the System Governor should establish and chair a management group to develop the national minimum aged care datasets and the strategy and agenda for aged care data. The group should include senior representatives of the Australian Institute of Health and Welfare, the Pricing Authority, the Australian Commission on Safety and Quality in Health and Aged Care, and the Australian Bureau of Statistics. Commissioner Briggs considers that the existing data management arrangements could be extended to accommodate these changes.

Data standards and approvals

We received a number of submissions supporting implementation of standardised data collection and the ‘collect once, use many times’ principle. This should be a fundamental principle for data management in aged care. To use data many times, the original collection must be high quality and reliable. This means that aged care data, and its collection, must meet minimum standards.

Data about aged care comes from several different government agencies that do not have common data standards and systems. Minimum datasets must be based on common data standards so that they yield meaningful and reliable information. The Aged Care Industry Information Technology Council stated in 2017 that:

the absence of common standards, sector-level policies and common data collection...means it is difficult for individual organisations to benchmark their performance and identify needed improvements.³⁸

An important task for aged care data management is to establish a ‘common language’ for aged care data. Attention should be paid to the intersection between aged care, health care and disability services, and the importance of common terms to enable the systems to communicate.

The Australian Government announced the ‘Aged Care Data Compare’ project in June 2020. This project aims to resolve technical difficulties with the standardisation and sharing of valuable data recorded as part of everyday practice in residential aged care. This includes the possible use of aged care data interoperability standards and protocols. The Australian Department of Health should continue this work and make sure that it is resourced adequately and given priority.

Data and information are frequently subject to statutory protections, including privacy, limiting disclosure other than for the purpose they were collected. These protections exist for a reason. However, we consider that limited exceptions should be enacted for the National Aged Care Data Asset, so that data can be made available for research and analysis in a way that does not identify individuals. The Australian Government, together with the State and Territory Governments, should work to identify and remove legislative barriers to collection and linkage of identified data about individuals by the Australian Institute of Health and Welfare.

A key issue for future research will be to ensure timely access to data. Data custodians are responsible for approving access to, and use of, the data collections for which they have authority. We heard evidence about the administrative burden of obtaining access to data from the Australian Institute of Health and Welfare, and particularly the lack of timely access to valuable data. Long delays in securing access to data can adversely affect the ability to monitor trends in care quality and to provide timely information about risks in the health and aged care sectors. Delays in accessing aged care data from the Australian Institute of Health and Welfare must be minimised in future.

Aged care research

Considering the number of people accessing aged care services and the challenges facing the aged care sector, aged care research is not given sufficient priority or funding. This needs to change. A new approach to aged care research and its funding is required.

There is no dedicated funding for research into the delivery of high quality and safe aged care. Professor Briony Dow, Director of the National Ageing Research Institute, told us that there has been a lack of investment in research into delivery of aged care due to a societal view that aged care is not ‘particularly important’. She said that the problem is circular: societal attitudes filter down, aged care research is not seen as a particularly attractive area by educators and researchers, and this is reinforced by a lack of funding.³⁹

We recommend that to ensure an enduring focus on the needs of the aged care system, a dedicated Aged Care Research and Innovation Fund should be established. It should be funded in addition to and administered independently of existing research funds.

The amount of investment in aged care research needs to reflect the Australian Government's expenditure on aged care, the importance of high quality and safe care for vulnerable people, and the research work necessary to support the new aged care system. We consider that, at least in the short to medium term, annual aged care research funding should be fixed and equal to 1.8% of the Australian Government's total expenditure on aged care.

In addition to dedicated funding, new administrative infrastructure is required to ensure that the public investment in aged care research and innovation is directed to practical and beneficial outcomes. We recommend that an Aged Care Research and Innovation Council should be established. The new Council should set the strategy and agenda for aged care research and development and should make recommendations to the System Governor on expenditure from the Aged Care Research and Innovation Fund.

The research and development strategy should not only be focused on health-related, clinical or medical matters relating to aged care. It should extend to research on, for instance, the delivery of aged care, application of technological developments in aged care, better governance of aged care providers, and the socioeconomics of ageing. It should also extend to workforce-related research, and the application of technology to improve workforce productivity and care quality, and testing innovative and creative ways to improve the quality and safety of aged care.

The Aged Care Research and Innovation Council should give priority in its recommendations on funding to research that is co-designed with older people and their families, and with aged care providers and the aged care workforce. Professor Alison Kitson advised that if the aim of research is to translate knowledge into practice, then 'involving stakeholders right at the beginning is the most important factor for success'.⁴⁰

Dr Robert Grenfell, Director of Health and Biosecurity at the Commonwealth Scientific and Industrial Research Organisation, told us that research should be for solving problems that need to be solved.⁴¹ We agree. The Aged Care Research and Innovation Council should adopt a priority-driven approach to research. The allocation of funding should be strategically directed to identified problems and gaps to ensure that funded research delivers the greatest benefit for end users. The focus on priority-driven, co-designed research will distinguish the new Aged Care Research and Innovation Council from other research bodies.

Information and communications technology

The aged care system that we envisage will need to operate in a technology-enabled environment for efficient clinical, business and operational systems. These need to be designed to identify older people's needs and preferences and to provide care tailored most effectively to their needs. Our data recommendations are dependent on information and communications systems that can harness data and information from across the aged care system and coordinate that information to support the new aged care arrangements we recommend.

The System Governor should support the development of information and communications technology capability in the aged care sector. This should include the secure use of data throughout the system and solutions to reduce the administrative burden of data collection. Real-time or near real-time data sharing should be standard within government, with the capacity for approved providers to upload data.

Information and communications systems used by approved providers of aged care should operate so that information that is routinely collected for their own purposes can assist them to meet responsibilities to provide data, including for the National Aged Care Data Asset.

We consider that the System Governor should facilitate the development of software and systems to enable automatic reporting by approved providers on mandatory reporting obligations, quality indicators, prudential arrangements and data for the Aged Care National Data Asset. It should also establish arrangements consistent with the 'collect once, use many times' principle, including:

- integrating Australian Government systems to enable sharing of aged care data
- ensuring mechanisms exist for the transfer of clinical records where required for the continuity of care
- investment in new infrastructure to support that principle being put into practice.

Arrangements should also be established by the System Governor to:

- ensure relevant administrative data, such as assessment data, is available to providers
- ensure a mechanism exists for approved providers to transfer information about an individual effectively and securely when the individual changes service providers.

Architecture and investment in technology

Commissioner Briggs highlights major problems and limitations with the current technology infrastructure and architecture for aged care. These include the variable use of digital record keeping for clinical and administrative information management, including of My Health Record. This is inefficient and often means there is duplicative record keeping. Also, the current systems that are supposed to support the aged care sector are either designed to support specific administrative and financial reporting requirements or are program-centric. They are not focused on the person. Furthermore, information and communications systems across government, aged care services, hospitals and other health care providers are not interoperable. This is not only inefficient but increases the risk of errors.

Commissioner Briggs considers that the new aged care system needs an information and communications system that is vastly evolved from that which currently exists. She recommends that the Australian Government should invest in technology, information and communications systems in three key areas.

First, the systems should be designed to enable better services for older people. This should include a new service-wide client relationship management system for care management, case monitoring and reporting systems built around older people's care. Data and information should be accessible, accurate and up-to-date, and there should be standardised systems and tools to make the user experience easy and efficient.

Second, increased investment is needed in pre-certified assistive technologies and smart technology to support care and functional needs of older people, and help manage their safety and contribute to their quality of life.

Third, there should also be investment in systems that talk to each other and allow for seamless systems for reporting. There should be interoperability of information and communications systems. This would enable the sharing of data and information about people accessing aged care between aged care and health care providers and relevant government agencies.

Commissioner Briggs also recommends that the System Governor should develop an Aged Care Information and Communications Technology Strategy in consultation with older people and various stakeholders to provide a road map to implement these and related initiatives.

1.3.16 Funding for the new aged care system

Public funding is critical to the aged care system. The Australian Government spent \$19.9 billion on aged care payments in 2018–19, and \$21.2 billion on aged care payments in 2019–20. Despite these large expenditures, the current system delivers services that are all too often substandard, and sometimes unsafe. In many instances, the current system fails to deliver services simply because there is not enough funding to meet the assessed need.

A sustainable aged care system

There is an important point of tension in the task we are required to perform. Under our Terms of Reference, we are required to inquire into actions that should be taken in response to systemic causes of substandard care, and advise what the Australian Government and others can do to ensure that the services provided are of high quality and safe. We recommend many reforms, and almost all of them have funding implications. At the same time, we are acutely conscious that under our Terms of Reference, we are also required to inquire into how best to deliver aged care services in a sustainable way.

We have carefully considered ways in which funding arrangements should be improved to ensure the economic sustainability of the aged care system. This includes the need to ensure value and accountability for public expenditure, while also ensuring that there is a sufficient number of providers to supply the increasing aged care needs of our community.

In 2019, the Aged Care Financing Authority identified what it considered to be the characteristics of ‘a viable and sustainable aged care system’. These included:

confidence and trust in policy settings; stable, predictable, efficient, equitable and effective arrangements for allocating Government funding; appropriate overall funding; funding arrangements that are flexible and adaptable to changing demographics and demands; equitable contribution to costs by consumers; effective prudential oversight; and sound management and governance arrangements.⁴²

Subject to the need to consider the principle of contributions from people receiving services in the light of the universal entitlement to aged care which we recommend, the design of the funding arrangements for a reformed aged care system should have these attributes. We also consider that funding arrangements should be transparent—the basis for funding allocations should be clear—and should support accountability for the use of funding, whether from the Government or from service users.

We recommend a revolution in the way that funding levels are determined for aged care. The funding levels payable to approved providers for aged care services should be determined by a body that is independent of both the Australian Government and the aged care sector, based on analysis of the costs of providing high quality and safe aged care. Independent pricing would provide a foundation to underpin a new form of casemix funding for residential care, appropriate staffing levels and skill mixes in residential care, and appropriately tailored forms of funding for other aged care services.

Independent Pricing Authority

The introduction of independent pricing is critical to instil and restore confidence in the funding of aged care services. The general concept of some form of independent review of costs is uncontroversial, and is supported by the Secretary of the Australian Treasury and the Department of Health, as well as eminent economists. Professor Flavio Menezes, Chair of the Queensland Competition Authority and former Head of the School of Economics at the University of Queensland, said the current arrangements involve a conflict of interest for the Australian Government because it is simultaneously trying to ensure the provision of high quality care while constraining costs. The Secretary of the Australian Treasury, Dr Steven Kennedy, gave evidence that an aged care system based on an independent assessment of costs would contribute towards all governments being able to trust and fund that system. A wide range of aged care providers and their peak representative organisations also told us that independently assessed funding levels would be important for ensuring they are adequately funded to deliver high quality care.

We recommend that the key functions of the Pricing Authority should include:

- providing expert advice to the System Governor on optimal forms for funding arrangements for particular types of aged care services and in particular market circumstances
- reviewing data and conducting studies relating to the costs of providing aged care services

- determining prices for particular aged care services based on estimates of the amounts appropriate to the provision of high quality and safe aged care services
- evaluating, or assisting the System Governor to evaluate, the extent of competition in particular areas and markets
- advising on appropriate forms of economic regulation, and implementation of such regulation where necessary.

In undertaking its functions, the Pricing Authority should be guided by the following objects:

- to ensure the availability and continuity of high quality and safe aged care services for people in need of them
- to ensure the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services
- to promote efficient investment in the supply of high quality and safe aged care services
- to promote the development and retention of a highly motivated and skilled workforce necessary for the provision of high quality and safe aged care services.

Consideration needs to be given as to whether the pricing function undertaken by the Pricing Authority should be binding on the Australian Government—and hence determine the prices for aged care services—or be advisory to it.

We both agree that the Pricing Authority should have a determinative pricing power. However, Commissioner Pagone considers that the Pricing Authority's power to determine prices should be binding on the Australian Government, and not merely advisory. In his view, a binding power on prices is necessary to insulate the funding of the aged care sector from the influence of broader fiscal considerations on the government of the day, as well as to ensure a thoroughly transparent pricing process. This will provide confidence for older people and their families and allow providers to undertake long-term planning and make the necessary investment decisions to ensure access to high quality aged care services.

Commissioner Briggs considers that a balance needs to be struck between independence in price setting and budgetary control by the government of the day by making the schedule setting out the Pricing Authority's determinations an instrument that is disallowable in Parliament. This would ensure that, in a case where the Government wishes to depart from the prices determined by the Pricing Authority, it would have to obtain a motion from either House of Parliament to disallow the schedule in an open and accountable manner.

Commissioner Briggs also recommends that a renamed Independent Hospital and Aged Care Pricing Authority assume the Pricing Authority function from 1 July 2021 so that work on these very important costing and funding issues can begin immediately. People with the expertise needed to carry out this work are in short supply, and she considers it would be inefficient to establish a new agency which would compete to obtain staff from the same limited pool of people. Commissioner Pagone does not support this recommendation. He

considers that the Pricing Authority must be free to focus on the specific challenges of aged care without any budgetary or governance pressures to adopt similar methodological approaches to those adopted in hospital funding. He also notes that the Independent Hospitals Pricing Authority has no expertise or experience in the economic regulatory functions that are proposed for the Pricing Authority.

To support the pricing function, it will be necessary for the Pricing Authority to obtain cost data from the sector. We recommend that, as a condition of approval, aged care providers should be required to provide financial information and participate in cost studies and surveys that the Pricing Authority requires to undertake its functions.

Funding arrangements for particular services

We have heard a wide range of evidence on the preferred way in which aged care services should be funded, ranging from outcomes based funding, to block funding and activity based funding. In our recommendations about funding arrangements, we have followed our principle of putting people first, and striving as far as possible for arrangements that are simple, practical, equitable, efficient, consistent, and responsive or 'agile'. We also took into account the need to create explicit relationships between people's needs, costs, prices and outcomes.

As Professor Henry Cutler told us, all funding models have their advantages and disadvantages. He argued that there are benefits in combining approaches to funding model design:

Funding models can also be combined to mitigate disadvantages or introduce further advantages associated with using only one funding model. While this increases the administrative burden, benefits associated with better targeted funding and subsequent improved outcomes can outweigh these costs.⁴³

We agree. Our view is that the primary approach for funding providers for the aged care services they deliver should be based on the volume of activity each provider performs. Activity based funding should be supplemented with block funding where required to ensure area coverage, continuity of service, and service viability. This approach combines the access, efficiency and transparency advantages of activity based funding, with the greater flexibility and confidence provided by block funding.

We are recommending funding arrangements to apply to each of the five service categories in our new program design: social supports, respite supports, assistive technologies and home modifications, care at home, and residential care.

We recommend that the Australian Government should fund social supports, respite supports and assistive technologies and home modifications in a combination of block funding and activity based funding. This is intended to achieve a number of objectives. The first objective is to ensure area coverage across Australia. Grant funding should ensure that everyone who needs to can access these supports, irrespective of how widely dispersed the population might be, or how scarce the number of organisations willing to supply services might be. While area coverage is an important consideration, ensuring there is sufficient capacity and service availability to meet demand are also significant objectives.

As part of its advisory function on funding arrangements for aged care services, the Pricing Authority should advise on the appropriate combination of block and activity based payments in the grants for social supports, respite, and assistive technologies and home modifications. The block funding component will cover the fixed costs of operating the service plus a minimum number of services that must be delivered. This will give both providers and individuals requiring care some certainty that a minimum level of services will be provided.

In relation to the care at home service category, the Australian Department of Health is currently developing a model for assessment, classification and funding within a unified home care program. We support the continuation of the Department's work on these issues. We further consider that the model should begin with a process by which the needs of older people would be assessed and classified. Each classification would be linked to an entitlement to care that would be expressed in terms of the hours of support that would be provided within specified domains: care management; living supports; personal, clinical, enabling and therapeutic care; and palliative and end-of-life care.

Older people overwhelmingly prefer to remain living in their own homes. In the current system, however, older people are not well supported in this preference. Significantly more funding will need to be available to older people to allow them to access more care in the home for longer.

While we have recommended a universal entitlement to aged care, this is not an absolute right to have that care delivered in a particular setting. Care provided to a person in a congregate setting may be more cost-effective than care provided to that person in their own home. We consider that the most appropriate limit to be placed on the funding a person should be entitled to receive for care at home is the value of the care component of the funding that the Australian Government would provide for them in a residential care setting. This level of funding may mean a person will be able to remain longer at home, and may be able to remain at home until the end of their life.

For residential aged care, we recommend a new activity based casemix funding model based on the 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. An example of the new model is the Australian National Aged Care Classification, which is currently in trials. There is a clear case, supported by the Australian Department of Health, to transition away from the Aged Care Funding Instrument. Such a transition needs to be implemented at the earliest reasonable opportunity.

The aged care system should help people to maintain independence, and the funding arrangements for residential aged care should be aligned with this goal. Currently, however, if a provider assists a person to regain some of their independence or improve their health condition, their funding is reduced after that person is reassessed. We recommend funding incentives for providers to invest in restorative care and reablement. This should include, as an incentive to restore health and wellbeing, reforms to the assessment process such that providers retain the previous level of funding if a resident becomes healthier or less dependent.

Accountability

Transparency and accountability should be embedded in the new aged care system. We make a number of recommendations to enhance accountability for the expenditure of government funding.

The current aged care system is not well designed to ensure that the care being provided meets people's needs. Residential care providers receive approximately \$11.7 billion in Australian Government care subsidies. However, there is no specific requirement on residential aged care providers to spend any portion of the money they receive on care.

We recommend that all approved providers of residential aged care should report, on a quarterly basis, the total direct care staffing hours provided each day at each facility they conduct. The report should specify the different employment categories, including personal care workers, enrolled nurses, registered nurses, and allied healthcare professionals. The System Governor should assess the reports against the minimum staffing requirements, and initiate appropriate action in cases of non-compliance.

At present, home care providers are paid subsidies for each month in advance, regardless of the services actually provided. This means the Australian Government is wholly reliant on approved providers for accurate financial reporting and reconciliation of funds. This arrangement has several undesirable effects, including the accumulation of 'unspent funds' and a lack of clarity regarding what services are delivered. To increase efficiency, transparency and accountability in the system, we recommend that home care providers should be paid from Home Care Packages on accrual for services once they have been delivered or the liability to deliver them has been incurred. Commissioner Briggs also recommends that home care providers should be required to report regularly to the Australian Government on the hours of each type of care that they deliver to people.

Immediate funding measures

The introduction of independent pricing will take some time to implement, even if the Pricing Authority starts on 1 July 2021. So, it is important to provide some immediate relief to support the aged care sector in providing safe and high quality care.

The Australian Government's approach to indexation of funding levels for aged care services has been inadequate to keep up with real cost increases over many years. We recommend short-term measures to address the inadequacy of indexation of aged care funding levels in the next few years, until the independent pricing of aged care services by the Pricing Authority can begin.

There are three further areas where we propose urgent interim action to ensure the financial viability of approved providers of residential care.

The first of these recommendations is an increase in the revenues available to providers to meet residents' ordinary living needs. The Basic Daily Fee—currently about \$52 per day—is intended to cover everyday living expenses such as food, laundry, cleaning, and utilities. The goods and services that depend on this revenue stream are essential to meet everyday living needs. A failure to provide these services at an acceptable level has an impact on the overall quality and safety of the care provided to older people living in aged care residences.

It is clear from the evidence before us that the revenue from the Basic Daily Fee is inadequate to provide these services at an adequate standard. In recommending additional interim funding, we have sought to balance urgency, simplicity, ease of administration, and accountability. Balancing these considerations, we recommend an immediate conditional increase in the Basic Daily Fee of \$10 per resident per day, to be funded by the Australian Government.

It is necessary, in our view, that approved providers who wish to receive this additional revenue should face an enhanced accountability measure. This will require reporting of the levels of expenditure they have had in the recent past on the basic living needs of residents, and the changes in expenditure resulting from the additional revenue, particularly on nutritional requirements. In short, improved accountability will be a necessary condition of receiving this increase in funding.

The second area where we propose urgent interim action is to ensure the financial viability of aged care providers in regional, rural and remote Australia. The costs of goods and services are higher in these areas. We have heard uncontested evidence that this negatively affects the financial performance and stability of providers.

Under current arrangements, the Australian Government pays a Viability Supplement to residential and home care providers in these areas. The Australian Government announced a 30% increase to this supplement in December 2018, and an additional temporary 30% increase in March 2020. We recommend the increases to the Viability Supplement should be maintained until the Pricing Authority is established and undertakes its independent cost analysis and pricing processes.

The third area for an immediate funding increase is for education and training to improve the quality of care. We recommend that the Australian Government should urgently establish a scheme 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. Eligible education and training should include Certificate III in Individual Support and Certificate IV in Ageing Support, as well as continuing education and training courses relevant to direct care skills, including dementia care, palliative care, oral health, mental health, pressure injuries and wound management.

Personal contributions and means testing

Under current arrangements, older people who use aged care services pay for about one-quarter of the total cost of those services, through a complex mix of co-contributions and means tested fees. Subject to means testing, people contribute to the costs of their care in residential aged care, and can be asked to do so in the Home Care Packages Program and by Commonwealth Home Support Programme providers. People using residential care also contribute to the cost of their accommodation and associated living expenses.

We heard a lot about the existing co-contribution and means testing arrangements during our inquiry. Witnesses described these arrangements as inequitable and confusing. Some considered that they contributed to perverse incentives around the types of aged care services people accessed. The Productivity Commission's 2011 *Caring for Older Australians* inquiry report stated that the system of co-contributions was 'often arbitrary in nature, lacking any obvious rationale and relationship to a person's capacity to pay'.⁴⁴ While a number of changes have been made since that report, problems persist and the arrangements are in need of significant reform.

Fundamental to our vision of aged care is a system of universal entitlement to high quality aged care based on assessed need. Although there are some differences between us on matters of implementation of this principle, we agree that this should guide the approach to contributions and means testing.

Guided by our principle of entitlement to aged care, we agree that, in the new aged care system, there should be no requirement to pay a co-contribution toward care (as distinct from the ordinary costs of living or accommodation costs) in any community setting or residential aged care, including respite. Like the provision of health care to public patients in public hospitals, personal care services and clinical care services should be available free of service charges in aged care. In our view, because all Australians should have an entitlement to aged care, the costs of care should be distributed equitably across the community. They should not be imposed disproportionately on the people who need and receive aged care services. This reform represents a significant departure from current arrangements.

Similarly, we do not consider that contributions or fees should be charged for social support (including transport), home modifications and assistive technologies, and domestic assistance (including cleaning and gardening) where these services are being supplied as elements of aged care provided to a person who has been assessed as needing that care.

We also consider that people should not be required to pay for the respite care they receive, nor for associated accommodation costs. Respite is intended to sustain the long-term capability of people to remain in their own home and to receive care there. Where people and their carers have been assessed as needing respite, access to respite care should be easy and affordable. This is particularly because of the important role respite can play in sustaining the care relationship and delaying or preventing entry to permanent residential aged care. Furthermore, people receiving respite care are highly likely to have accommodation-related costs to bear for their own homes which they will still incur while they are receiving respite care. They should not be required to meet two sets of accommodation costs at the same time.

In relation to residential aged care, we consider that people who receive residential aged care should not be responsible for their care costs, and we agree that they should be required to contribute to their ordinary costs of living and (under current financing arrangements) accommodation. This includes meeting costs related to food, cleaning, laundry and utilities. This would be consistent with arrangements in the general community where the ordinary costs of living and accommodation are funded by individuals who live in their own home, with any Australian Government assistance provided through the age pension.

To cover the ordinary costs of living, people who receive residential care should still be required to contribute a base fee equal to 85% of the single basic age pension. The Pricing Authority should determine the maximum amount payable for the ordinary costs of living based on an analysis of the efficient costs of delivering the required high quality goods and services. The maximum level of the fee that a resident can be asked to pay toward the ordinary costs of living should equal the base fee plus a means tested fee. The Australian Government should pay the difference between the resident contribution and the maximum amount set by the Pricing Authority.

Like the ordinary costs of living, accommodation has been regarded by many as primarily the responsibility of the person receiving care, provided they have the means to pay for it. We agree that for the time being, under current system financing arrangements people receiving residential aged care should be required to contribute to the costs of their accommodation, subject to a means test. Under the means test, fully supported residents should not be required to contribute to accommodation costs.

During our inquiry, we heard that means testing needs to be 'simplified and equitable', 'fair and sustainable' and 'robust and consistently applied'.⁴⁵ We agree. While we differ on details, we both recommend changes to means testing arrangements to make them fairer and simpler and to reduce the high effective marginal tax rates that apply to many individuals receiving residential aged care.

Commissioner Pagone sees a connection between arrangements for the long-term financing of the aged care system and the continuation of means tested contributions for ordinary costs of living and accommodation. Both of us consider that some form of aged care levy should be introduced, although we differ on the scope of the financing role to be performed by a levy and whether it should be formally hypothecated to aged care expenditures. Commissioner Pagone further considers that the Productivity Commission should be tasked with inquiring and reporting into a proposal for financing the system entirely from a hypothecated aged care levy. We address these matters in separate chapters in Volume 3 on *Financing the New Aged Care System*.

Commissioner Pagone considers that if aged care in the future is to be funded through a hypothecated levy on personal income tax, means testing arrangements should be phased out and eventually removed.

1.3.17 More sustainable capital financing for residential aged care

Current arrangements

Residential aged care providers require access to significant start-up and ongoing refurbishment capital financing. Currently, there are two main sources of capital to fund investment in residential aged care accommodation:

- equity capital, equal to \$13.5 billion, or 25.7% of total provider assets in 2018–19
- interest-free loans from residents through Refundable Accommodation Deposits, equal to \$30.2 billion or 57.4% of provider assets in 2018–19.

The revenue that approved providers receive must be able to service the costs of capital, in addition to other costs. Capital costs are not limited to the costs of establishing debt facilities and interest payable on debt financing; equity investors too will require a reasonable return on their investment.

Evaluating whether accommodation charging and funding arrangements are appropriate to meet providers' cost of capital investment is complicated by the fact that there are different arrangements for different categories of residents, depending on their eligibility to receive subsidised accommodation. The Australian Government pays all of the accommodation costs of a 'supported' resident, some of the costs of a 'partially supported' resident, and none of the costs of an 'unsupported' resident. Whether a resident is supported, partially supported or unsupported depends on a means test.

The Accommodation Supplement is the maximum amount of subsidy that the Australian Government will pay, and sets the price that may be charged for supported and partially supported residents. We recommend that the Pricing Authority should determine the Accommodation Supplement on the basis of its review of the costs of providing accommodation. This should mean that the Accommodation Supplement will be well calibrated to provide an appropriate return on capital investment in accommodation assets.

Unsupported residents are subject to different arrangements, in which Refundable Accommodation Deposits play a prominent role. Refundable Accommodation Deposits are lump sum deposits from residents to providers in return for accommodation. These deposits are refunded when people leave residential aged care, less any allowable deductions. The average value of Refundable Accommodation Deposits has steadily increased over the last six years, and was \$318,000 at 30 June 2019. The total value of all accommodation deposits has almost doubled since 2013–14.

As an alternative to a Refundable Accommodation Deposit, unsupported residents can choose to pay a Daily Accommodation Payment, or a combination of the two. Under the rate for conversion of a Refundable Accommodation Deposit to a Daily Accommodation Payment in effect in January 2021, an approved provider would receive a Daily Accommodation Payment of \$35.72 based on the average value of a Residential Accommodation Deposit of \$318,000 (as at 30 June 2019).

Phasing out Refundable Accommodation Deposits

Refundable Accommodation Deposits lower the cost of capital for residential aged care providers and appear to have supported the expansion of the residential aged care sector in recent years. However, we received evidence about problems with them and their limitations. We heard that the sustainability of the Refundable Accommodation Deposit model is questionable given the trend in people electing to pay Daily Accommodation Payments. This makes it harder for providers to attract replacement funds when required to repay Refundable Accommodation Deposits.

Refundable Accommodation Deposits are also not particularly reliable as a capital financing mechanism for certain segments of the aged care sector, such as providers operating in regional, rural and remote Australia. Furthermore, heavy reliance on Refundable Accommodation Deposits introduces risks to providers' liquidity. An event like COVID-19 potentially exacerbates the risks as it puts pressure on providers' occupancy rates and generates unpredictability about property market outcomes.

Investment in aged care accommodation infrastructure should be subject to the rigours and disciplines of the ordinary capital markets. We consider that the Australian Government should phase out Refundable Accommodation Deposits. Commissioner Briggs goes further and recommends that the Government should phase out Refundable Accommodation Deposits for new entrants from 1 July 2025. Commissioner Pagone considers that it is important to sequence the reforms recommended in this report, by allowing a period for the implementation of higher staff levels in residential aged care and the independent determination by the Pricing Authority of the prices of aged care services before commencing the phase out of Refundable Accommodation Deposits. This would allow for any initial instability caused by other reforms that we are recommending to be resolved before turning to the question of Refundable Accommodation Deposits.

Transition arrangements

The Government should implement a transitional mechanism supporting provider liquidity and viability while the sector transitions away from Refundable Accommodation Deposits. The Grattan Institute advises that without Refundable Accommodation Deposits, new forms of Government support for capital financing would be required, with transition arrangements.

The Grattan Institute proposes that the Australian Government should create a financing facility to fund capital investment in residential aged care through concessional loans, where the funds are raised through government bonds. Providers would apply to the facility for capital grants, which would finance new residential aged care services and upgrades. It would also fund providers' repayment of Refundable Accommodation Deposits to enable a smooth transition to the new model. At the same time, all new residents to residential care services would make rental payments.⁴⁶

Development of a suitable transitional mechanism is integral to the reform of capital financing. While there are various options for the transition and many details that would need to be finalised, we are inclined to support the Grattan Institute's proposal and urge the Australian Government to give it serious consideration.

Commissioner Pagone considers that an Australian Government-backed loan facility should be temporary for the transition period for the purpose of repaying Refundable Accommodation Deposits. Commissioner Pagone considers that there is a case for the Australian Government to provide loan guarantees during this transition period while providers and financial institutions adjust to the absence of Refundable Accommodation Deposits to support the construction of new, and to update existing, residential aged care services. The loan guarantees would be a temporary transitional measure to ensure continued development of residential aged care services while providers and financial institutions adjust to and develop confidence in the new capital financing arrangements.

Commissioner Briggs has an alternative view and recommends that the Australian Government should establish an ongoing aged care accommodation capital facility to support the construction of new, and to update existing, residential aged care services. Furthermore, she recommends that the capital facility's terms and conditions of assistance should be designed to create incentives for providers to develop or refurbish residential aged care services to provide lower-density congregate living or smaller-scale accommodation. She also recommends a much larger Australian Government capital grants program.

1.3.18 Strengthening prudential regulation and financial oversight

A rigorous system of prudential regulation and financial oversight of service providers should be a critical component of the Australian Government's oversight of the aged care sector. Effective financial oversight provides protection for taxpayers' investment in aged care services and a means of identifying potential risks to the quality and safety of care.

The need for reform

Under current arrangements, financial oversight in aged care is focused on managing the risk to the Australian Government associated with the Aged Care Accommodation Payment Guarantee Scheme. Refundable Accommodation Deposits, which at 30 June 2019 totalled \$30.2 billion across the sector, must be repaid to residents (or their estates) when they leave residential aged care, less any amounts they have agreed to be deducted. The repayment of Refundable Accommodation Deposits is guaranteed by the Australian Government under the Aged Care Accommodation Payment Guarantee Scheme.

The Australian Government has an interest in managing its prudential risk. It also has a broader financial oversight responsibility with respect to aged care providers. This is because the financial health of providers is crucial to the continuity of the essential aged care services they provide, and to their ability to provide those services safely and to a high quality. This is equally true for residential care and home care.

Numerous reviews of the prudential regulatory function have been carried out in recent years. While the detailed findings and recommendations of these reviews differed, there is agreement on the need for prudential reform. In particular, there is a need for:

- more comprehensive financial reporting
- more regular and timely reporting
- liquidity and capital adequacy standards
- improved capacity within the regulator to use the information effectively.

Despite the consistent call for stronger prudential regulation and financial reporting arrangements in aged care, there has been limited prudential reform in recent years. However, in evidence to us, the Australian Government and the Department of Health accepted that the prudential framework for aged care is not currently fit for purpose and requires fundamental reform to make sure that it can meet contemporary needs.

Improving prudential regulation

We are recommending several reforms to improve prudential regulation.

The System Governor should be given responsibility as Prudential Regulator for financial oversight and prudential regulation of the aged care sector. As the aged care funding body, the System Governor is responsible for the prudent management of the Australian Government's substantial financial exposure to Refundable Accommodation Deposits under the Aged Care Accommodation Payment Guarantee Scheme. Perhaps even more importantly, the System Governor has responsibility for overall management of the aged care system and should be seeking to satisfy itself that providers have the financial strength to provide a continuity of high quality and safe aged care. If the financial position of a provider changes in ways that might present a risk to the ongoing quality and safety of care, the System Governor needs to be in a position to act quickly to safeguard the interests of older people in the provider's care.

The prudential and financial reporting objectives of the Prudential Regulator should include proactive, effective, risk-based and timely oversight of the financial sustainability of all providers. The key aim of prudential oversight should be to identify providers that are at risk of not having the financial capacity to repay their financial obligations and to provide ongoing and high quality care to older people. Prudential oversight should also inform remedial action by those responsible for system management and quality regulation. The new system of prudential regulation should apply to all providers of aged care services, including providers of home care.

The Prudential Regulator should set and enforce prudential standards that must be complied with by approved aged care providers. The new standards should address the deficiencies of the current prudential standards. They should make certain the regulator has sufficient information to assess the financial viability of providers and ensure continuity of care for people receiving aged care services. The Prudential Regulator should also be

able to impose further prudential standards if necessary. A risk-based and proportionate approach to financial oversight would imply that different requirements may apply depending upon the location, size, performance and regulatory history of aged care providers.

Improving financial reporting

Access to the right financial and corporate information of providers, the timeliness of that information, and the ability to analyse it are critical to good prudential regulation and financial oversight. The Australian Department of Health has acknowledged the inadequacy of the financial information it receives for the purposes of risk assessment. A recent review by EY Australia also found that:

The data that the Department is given is inadequate for it to assess whether or not Approved Providers comply with the Prudential Standards.⁴⁷

Prudential and financial risks occur in real time. This means that information relevant to these risks must be identified by the regulator in real time as well. 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. However, we recognise that a blanket approach in this manner could impose an unnecessary regulatory burden on providers.

We consider that the balance is to be found in establishing a continuous disclosure obligation triggered by significant events that provide a reliable indicator of impending risk. We recommend that the Prudential Regulator should have the power to designate events, facts or circumstances that may give rise to continuous disclosure obligations.

Effective financial oversight and prudential regulation require stronger information gathering powers than are currently available. 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. Despite this, the occupier of the premises can simply refuse consent to entry of the premises and any person to whom questions are directed can simply refuse to answer. Moreover, the Aged Care Quality and Safety Commission currently does not have power to conduct inquiries, which is an essential function for a prudential regulator.

The Australian Department of Health appears to agree that the Prudential Regulator needs increased powers to seek information from providers and investigate issues relating to prudential and financial management. Consistent with our recommendations for effective regulation, we recommend that the Prudential Regulator should have strengthened powers to undertake investigations and inquiries.

Improved liquidity and capital adequacy requirements

The financial oversight and prudential regulation of aged care providers should include specific and enforceable liquidity and capital requirements. These arrangements would apply to residential and home care providers. Consistent with a risk-based approach to regulation, the liquidity and capital adequacy ratios would be expected to differ between providers.

We recommend that in setting liquidity and capital adequacy requirements for residential and home care providers, the decisions of the Prudential Regulator should be based on clear and transparent criteria, including:

- the provider's business circumstances, including its capital requirements and the size of its financial liabilities
- the provider's financial risk, balance sheet strength and financial viability
- the nature of the provider's services—residential care only, home care only, residential care combined with home care, residential or home care combined with other non-aged care services.

Enforcement tools

The Prudential Regulator must be able to intervene where required to manage financial risk and safeguard the interests of people receiving aged care services. Good prudential regulation and financial oversight should be agile and responsive. The regulator should have a cascading range of powers enabling it to take corrective action promptly to deal with any breach of the new prudential standards or financial reporting requirements. Consistent with our recommendations for effective regulation, these powers should include the power to give directions, ability to issue infringement notices, accept enforceable undertakings, impose administrative penalties as well as sanctions, and apply to a court for a civil penalty.

Increasing capability

The Prudential Regulator must be adequately resourced to carry out its functions. Those resources should include well trained staff with specialised skills, and processes and systems to allow these staff to build a picture of prudential and financial risk within the sector.

A number of recent reviews, and the evidence we have heard, lead us to the conclusion that the existing aged care functional areas do not possess the capabilities or capacity to perform the level of prudential regulation and financial oversight required for this sector adequately.

The development of these capabilities will take a significant investment and a sustained management focus over a considerable period of time. While recent injections of funding are welcome, additional investment is required to ensure that the Prudential Regulator has access the people, skills, systems and other resources required to perform its functions.

1.3.19 Financing aged care: investing in an entitlement to care

Fundamental to our vision of aged care is an entitlement to high quality aged care based on need. We envisage a system in which every person can have confidence that if they need aged care, they will receive it. The aged care system requires a clear and transparent source of public funding that is adequate to deliver high quality aged care for everyone.

A new aged care financing system

The financing of aged care refers to the raising of money for the purpose of funding the provision of aged care services. For many decades, aged care in Australia has been financed by a mix of public funding, sourced through the general taxation system, private contributions in the forms of means tested fees and co-payment for certain services, and public and private capital financing.

The operating costs of the aged care system in Australia are financed on a 'pay as you go' basis from the Consolidated Revenue Fund, which includes all revenue raised by the Australian Government. In the context of financing ongoing services, pay as you go refers to arrangements whereby expenditure in any given period (for example, a year) is generally sourced from revenue raised in the same period.

Under current arrangements, the allocation of funding for aged care has been subject to decisions in the annual budget process and one-off additional top-ups or cuts agreed from time to time outside the Budget. This has provided considerable flexibility for governments. However, it has also meant that funding for aged care has been determined through a series of trade-offs and compromises between aged care and other fiscal priorities. Over time, it is clear that the availability of funding has not kept pace with the need for aged care.

We know that most people agree that there is a need for additional funding from taxpayers and the Government to improve the aged care system. A study undertaken on our behalf by Flinders University found that most current taxpayers (61%) indicated that they would be willing to pay more income tax to support a quality aged care system.

To increase the sustainable funding for high quality aged care, we both support consideration of the introduction of a levy on taxable income to finance aged care. However, we differ on the optimum design of a levy, particularly about how much of the costs of the aged care system a levy should cover, and the form of a levy, whether it should be hypothecated or non-hypothecated.

Funds raised by a hypothecated levy are paid into a dedicated account within the Consolidated Revenue Fund, established for the specific purposes for which the levy is imposed and can only be used for those purposes. Non-hypothecated levies are also paid into Consolidated Revenue. However, with non-hypothecated levies, although the funds raised are notionally 'earmarked', the Australian Government is not legally obliged to spend the funds only on the identified purpose. The Medicare Levy is an example of a non-hypothecated levy.

Commissioner Pagone recommends consideration by the Productivity Commission of a hypothecated levy for the provision of the full long-term financing of aged care services. Commissioner Briggs recommends an ongoing, non-hypothecated levy to make a significant contribution to meeting the costs of the Royal Commission's recommendations for a new aged care system. We set out the details of our respective approaches below.

A hypothecated Aged Care Levy | Commissioner Pagone

In my view, the aged care system needs a financing source that is as predictable, reliable, objective and economically sound as possible, without compromising the quality and safety of aged care, or the equity of financing arrangements. It also needs to be accountable and transparent.

Under my vision, the optimal approach is likely to be achieved by a different mechanism from the current financing approach: a hypothecated aged care levy. There are many options for the design and imposition of a hypothecated levy. One option would be to require taxpayers to pay an additional percentage of personal income tax. The additional percentage rate could be a uniform, flat levy, like the Medicare Levy, or there could be graduated rates for different taxable income brackets (a progressive levy).

It has not been possible within the time available to the Royal Commission to research, model and test the various parameters and models that would need to be considered to design a levy for the reliable and sustainable financing of aged care. For these reasons, it has not been possible to make formal recommendations for the adoption of a specific financing mechanism. Instead, I recommend that the Australian Government should commission the Productivity Commission to investigate and report on the potential benefits and risks of adoption of an appropriately designed financing scheme for the aged care system based upon the imposition of a hypothecated levy.

Potential approach

I consider that an approach based on hypothecation of revenue from a levy imposed through the tax system would have significant advantages for the long-term financing of the aged care system. The Aged Care Levy I envisage would finance an Aged Care Fund on a long-run, pay as you go basis over, say, a thirty-year horizon, based on actuarial principles. The overarching elements of my proposed approach are:

- Each individual should have a universal entitlement to receive high quality aged care based on assessed need.
- To support that entitlement, there should be unrationed provision of funding that is based on independent pricing of aged care services. The Pricing Authority will determine the levels of funding required to meet the reasonable costs of high quality aged care services.
- It will be necessary to forecast the likely aggregate funding requirements for the system for an extended period of, say, thirty years. This will be done on actuarial principles considering data on demand for relevant services and the forecast prices for them.

- It will be necessary to calculate the rate or rates of a levy that are needed to generate revenue that will meet those system funding requirements. This will be done on actuarial principles taking account of economic forecasts and tax data.
- These actuarial calculations will be constantly under review, and the levy rates will be revised every three years.

Although the calculation of levy rates should be performed independently of the Australian Government's fiscal processes, the Government would be responsible for bringing a tax Bill to Parliament to set the levy for each three-year period, and would therefore retain ultimate control over the amount of the levy.

Under this proposed approach, I envisage a greater role for contributions by each person toward the financing of the aged care system through that person's working life, and a greatly diminished or non-existent role for mandatory means tested fees and co-payments by people when they are receiving aged care later in life. Through the tax system, people will have contributed to financing the aged care system in accordance with their income over their entire lives, and so should not be required to pay means-tested fees and co-payments if and when they need aged care. 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.

There are several arguments in favour of hypothecation. The first is about accountability and trust: since hypothecated levies are directed to a specific and identifiable fund, and cannot be spent for other purposes not specified in legislation, they provide taxpayers with some assurance about how their contributions will be used. The second argument is about transparency: hypothecated levies can educate people about the cost of particular services. Taxpayers can then make better decisions about the balance between their contributions and the level of services provided. A final argument is about public support: in some cases, hypothecation can generate public support for increased contributions where the benefits gained from the increased funding are considered worthwhile.

I am satisfied that there is a persuasive case for adoption of a levy-based financing scheme for the aged care system. However, there remain many complicated issues concerning the amount of the levy and how it should be administered that the Productivity Commission has the capabilities and expertise to investigate.

In Volume 3, I set out some illustrative options to demonstrate how a hypothecated Aged Care Levy could be constructed and work in practice. I am not recommending that the levy should be constructed in these ways, but modelling of indicative options is useful because it shows that a hypothecated aged care levy is workable.

These calculations show how the current financing arrangements in aged care can be replaced with predictable, known tax levies payable during the working lives of Australians. I see a hypothecated Aged Care Levy as the best way to engender stability and confidence in the future of aged care financing. I also consider it likely to change the way the

community perceives aged care for the better so that it is seen as something valuable in which we all have a stake. This will lead to greater scrutiny and accountability in the way money is raised and spent on aged care into the future.

Financing the new aged care system | Commissioner Briggs

To date, the financing of aged care has relied on Australian Government payments funded by general taxation and other revenue supported by contributions from older people receiving care. Most of the funds have come from the Australian Government. This has proven to be a remarkably flexible and resilient means of financing the growth in aged care expenditures over the past 60 years and could be expected to continue to work effectively into the future.

Aged care services are one of the few Australian Government services universally available to everyone, irrespective of their means. Funding through the general revenue system reflects the nature of aged care as an entitlement supported by the general community, and spreads the risk of incurring aged care costs late in life across the population as a whole.

The problem with the current arrangements is not the nature of the financing arrangements or the way in which funds destined for aged care are collected, but the clarity and transparency of the arrangements for allocating those funds.

We have recommended that aged care should be established as a universal entitlement based on independent and clinically informed assessments of need and the price of the provision of that care. With appropriate legislation to ensure that funds flow in accordance with these assessments, the universal entitlement should ensure that ongoing aged care needs are fully resourced.

To complement these measures, there would also be value in an earmarked aged care levy. This would provide a clear and public commitment to the ongoing funding of Australia's aged care obligations. It would establish an important social contract for the provision of high quality aged care, consistent with the recommendations in this report.

An aged care improvement levy

I am conscious that the recommendations we make to improve the safety and quality of aged care will require a substantial increase in Australian Government expenditure. I am recommending that a substantial contribution toward the additional revenue to meet this expenditure should be raised through a non-hypothecated, earmarked levy on personal taxable income to be known as the 'aged care improvement levy'. It should be set at a sustainable rate and clearly related to the cost of the new aged care measures we have recommended. In my opinion, an appropriate rate for the new aged care improvement levy would be 1% of taxable personal income.

It is not necessary to hypothecate this levy. The Medicare levy operates effectively as a non-hypothecated levy. Taxpayers understand and appreciate the commitment made to all Australians through the Medicare levy and I am confident that they would accept an aged care improvement levy in the same spirit.

A levy of this nature would strengthen the commitment to improving the quality and safety of aged care as part of the Australian social contract. Australians are a generous people who will willingly contribute to improvements to the aged care system if they are convinced that the funds will be well directed. But they will want to see how their taxes are being used.

An aged care improvement levy of 1% designed to fund a substantial part of the improvement that we are seeking in quality and safety will provide assurance for the public that the necessary investments in aged care will be made. The Australian Government should fund the rest of the improvement we recommend in view of the need to make up for the shortfall in the level of funding it has provided over many years. Like the Medicare levy, the aged care improvement levy will provide transparency about how these funds are spent. Implementation of the levy alongside the current taxation system would retain the simplicity, flexibility and efficiency of the existing funding arrangements.

Under my proposal, the Australian Government would continue to finance aged care services from general revenue, providing additional funds to cover demographic changes, wage and cost increases and other system enhancements over time. People receiving aged care services would continue to contribute to the costs of accommodation and living expenses as their means permit.

Our recommendations are designed to deliver high quality and safe aged care. The current level of Australian Government aged care funding is inadequate and does not cover the cost of providing high quality aged care. Our research has shown that Australians understand this and are prepared to support additional funding to finance the aged care system appropriately. The most straightforward way to do this is to introduce a new aged care improvement levy.

1.3.20 Getting it done and getting it right: oversight, implementation and monitoring

Implementation of its recommendations is the primary measure of the effectiveness of a royal commission or public inquiry.

Since the enactment of the Aged Care Act in 1997, there have been numerous inquiries into the aged care system. Government implementation of the recommendations of these inquiries has been patchy and often slow. This has been caused, at least in part, by inadequate implementation and monitoring mechanisms. The public is entitled to know how the recommendations we have made as a result of our long and thorough inquiry are being implemented.

Oversight

We recommend ongoing monitoring and reporting arrangements to support the effective and transparent implementation of our recommendations. First, we recommend that the Australian Government should report by 31 May 2021 to Parliament about its response to each of the recommendations in our final report. The report should indicate whether each recommendation directed to the Government is accepted, accepted in principle, rejected or subject to further consideration. The report should also include some detail of how the recommendations that are accepted will be implemented and should explain the reasons for any rejections.

Second, we recommend that the independent Inspector-General of Aged Care which we propose should be responsible for monitoring the implementation of the recommendations. The Inspector-General should report to the responsible Minister and directly to the Parliament at least every six months.

Third, 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, especially the impact on the health, aged care and wellbeing outcomes for older people. These evaluations should occur five and 10 years after the tabling of the Final Report and should be made publicly available.

Implementation

Implementation of reform on the scale that we propose is transformational, and will take genuine commitment by aged care providers, other stakeholders and the Australian Government. The attention of political leadership will likely shift with crises, elections and other pressing challenges, but securing Government and ministerial engagement for seeing the change through is essential.

Reforms of the magnitude we propose are complex and their implementation requires careful planning. A dedicated implementation unit is vitally important. Because we propose different institutional arrangements for governance of the future aged care system, we recommend two versions of this implementation mechanism, with each approach designed to align with the respective governance model.

Commissioner Pagone proposes a new unit dedicated to the specific task of implementation of system-wide reform. To underline the importance of its work, the unit should be part of the Department of the Prime Minister and Cabinet. In due course, if the Australian Aged Care Commission is formally established, that body will carry on the work of implementation.

Consistent with Commissioner Briggs's recommendation that the Department of Health and Aged Care step up and take a much stronger leadership and stewardship role of the aged care system, she considers that an implementation taskforce should be established within the Department. The taskforce should be responsible for implementation of the recommendations and should report directly to the Cabinet Minister for Health and Aged Care.

The National Cabinet Reform Committee on Ageing and Older Australians has an important role in overseeing cross-jurisdictional implementation of our recommendations as part of developing an integrated system for the long-term support and care of older people.

We have put forward a framework to guide the implementation of our recommendations. It will be necessary for those implementing our recommendations to have a clear understanding of the evidence and policy basis for each recommendation. This understanding allows for an adaptive approach to implementation as the policy is shaped and reshaped in implementation. The Australian Government will need to communicate its intentions frequently, clearly and in a timely manner. The Australian Government must also consult with those receiving aged care, their families, their carers, their friends and their advocates, as well as with aged care and health care providers, the workforce, and State and Territory Governments.

The reforms that we recommend will require major changes in policy and operations for the entire aged care system over an extended period of time, and their implementation will need to be carefully managed. The transition to the new aged care system must, above all, ensure continuity of aged care services for all who need them. To ensure this, we consider that a phased approach should be adopted in the implementation of our recommendations. We have detailed the reforms to be implemented in four phases, beginning with the implementation of urgent reforms in 2021 in Phase 1. This phased approach should be guided by a transparent, flexible transition and implementation plan.

1.4 Aged care and COVID-19: a special report

When the Royal Commission was established in October 2018, nobody could have foreseen that the aged care sector would be in the grip of the COVID-19 pandemic in 2020. COVID-19 presents heightened risks to older people, who are particularly vulnerable to respiratory diseases. As at 31 December 2020, 685 people in Australian residential aged care had died due to COVID-19. At that time, there had been 2049 infections among residents in aged care.

The COVID-19 pandemic has been the greatest challenge Australia's aged care sector has faced. Residents, their families and aged care staff have all suffered. The suffering has not been confined to those homes which have experienced outbreaks. Thousands of residents in homes that have not suffered outbreaks have endured months of isolation which has had, and continues to have, a terrible effect on their physical, mental and emotional wellbeing.

Although the COVID-19 pandemic continues, we decided to release a special report on 1 October 2020 to take stock of the lessons that had been learned to that time. We put forward recommendations to better prepare and support the aged care sector, its staff and most importantly the residents of residential aged care. The full report is reproduced at Appendix 8 of Volume 5.

To inform our report, we held a dedicated hearing into the impact of COVID-19 on aged care. We are greatly indebted to the many people—including people receiving aged care services and their loved ones, some of whom were recently bereaved—who shared with us their stories and experiences, both at the hearing and by making written submissions. We also heard evidence of the effect of the pandemic on those working in aged care. Care workers develop close relationships with residents. Many are grieving for residents who have died after contracting COVID-19. Others are anxious about bringing the virus into their workplace or home. We pay tribute to aged care workers and to the vital work they do.

1.4.1 Recommendations

We made six recommendations in our report. The first recommendation emphasised the importance of accountability to the public for implementation.

Recommendation 1 – The Australian Government should report to Parliament by no later than 1 December 2020 on the implementation of these recommendations.

Australian Government response: On 30 November 2020, the Australian Government tabled its response in Parliament, and accepted all the recommendations.⁴⁸

We welcome the Government's response.

The other five recommendations addressed four areas for immediate action to support the aged care sector. We set them out below and include the Australian Government's response, while noting that we have not had a chance to assess the measures taken by the Government.

Visitors and quality of life

We focused a lot in our report on the measures necessary to restore physical connection between older people in aged care homes and their families and friends. Older people must always be at the heart of the aged care sector and of any response to any event affecting their physical and mental wellbeing. The understandable restriction of visits to older people due to the pandemic has had tragic, irreparable and lasting effects which must immediately be addressed. Visits from family and friends are critical to the physical, mental and emotional health and wellbeing of people living in residential aged care, and also to the health and wellbeing of family and friends.

Recommendation 2 – The Australian Government should immediately fund providers to ensure there are adequate staff available to allow continued visits to people living in residential aged care by their families and friends.

Australian Government response: The Australian Government accepted this recommendation. The Government advised that it delivered \$450 million in 2020 to residential aged care providers to support preparedness and response to COVID-19, including visitation to aged care facilities by families and friends. On 14 October 2020, the Minister for Aged Care and Senior Australians, Minister Colbeck, wrote to all providers reinforcing expectations with regard to visitation, noting that the Australian Government

agrees with our emphasis on ensuring aged care residents are able to see their loved ones. In addition, updated Australian Health Protection Principal Committee *Visitation Guidelines for Residential Aged Care Facilities* were issued on 20 November 2020.

Allied health

Levels of depression, anxiety, confusion, loneliness and suicide risk among aged care residents have increased since March 2020. Some of this can be attributed to missing family, changed routines, concern about catching the virus or fear of being isolated in their rooms. In some cases, people are no longer doing the incidental exercise they were previously doing. We urged additional measures for aged care residents to prevent deterioration in physical and mental health.

Recommendation 3—The Australian Government should urgently create Medicare Benefits Schedule items to increase the provision of allied health services, including mental health services, to people in aged care during the pandemic.

Australian Government response: The Australian Government accepted the recommendation and created two new Medicare Benefits Schedule items at a cost of \$47.6 million for mental health and allied health services for residential aged care residents. The items commenced from 10 December 2020.

National advisory body and plan

Confused and inconsistent messaging from providers, the Australian Government, and State and Territory Governments emerged as themes in the submissions we received on COVID-19. All too often, providers, people receiving care and their families, and health workers did not have an answer to the critical question: who is in charge? At a time of crisis, such as this pandemic, clear leadership, direction and lines of communication are essential.

In our report, we argued that there was a need for a defined, consolidated, national aged care COVID-19 plan. Advice for government about the response to the pandemic must be given by a dedicated national aged care advisory body. Such a body must have members with expertise in aged care, health care, infection control, the operational requirements of aged care settings, and the characteristics of the aged care workforce.

Recommendation 4 – We recommended that the Australian Government should establish a national aged care plan for COVID-19 through the National Cabinet in consultation with the aged care sector.

Australian Government response: The Australian Government accepted the recommendation. The *Updated National COVID-19 Aged Care Plan* was endorsed by the Australian Health Protection Principal Committee and noted at National Cabinet on 13 November 2020. The Aged Care Advisory Group was made a permanent advisory body to the Australian Health Protection Principal Committee on 1 October 2020. The Aged Care Advisory Group's membership includes people with critical expertise about the aged care sector, infection control and emergency preparedness, consumer advocacy, and public health response.

Infection control expertise and personal protective equipment

There is nothing more important to help providers prepare for, and respond to, COVID-19 outbreaks than access to high-level infection prevention and control expertise. This is especially so given the challenges associated with infection control in aged care homes for COVID-19, including its high transmissibility. Infection control is important not only for the health, safety and wellbeing of residents, but also for those who work in aged care.

Based on the findings of expert reports, it is apparent that high-level infection control expertise is needed by aged care homes:

- to assist with the preparation and implementation of outbreak management plans
- to provide training to staff on the use of personal protective equipment and infection prevention and control
- to provide assistance on day one of an outbreak.

Recommendation 5—All residential aged care homes should have one or more trained infection control officers as a condition of accreditation. The training requirements for these officers should be set by the aged care advisory body.

Australian Government response: The Australian Government accepted the recommendation. The Government provided funding of \$217.6 million to residential aged care providers in October 2020 to be used for COVID-19 preparedness and response, including to support the costs of engaging an Infection, Prevention Control lead. The Government also agreed that residential aged care providers will be required to demonstrate, as part of the accreditation process, evidence relating to Infection, Prevention Control leads. The Aged Care Advisory Group advised on training parameters.

Recommendation 6 – The Australian Government should arrange with the States and Territories to deploy accredited infection prevention and control experts into residential aged care homes to provide training, assist with the preparation of outbreak management plans and assist with outbreaks.

Australian Government response: the Australian Government accepted the recommendation. The Government increased its contribution under the National Partnership on COVID-19 Response from 50% to 100% for activity by the States and Territories to support aged care services, particularly infection and prevention control training, and co-ordinated preparedness and response.

Endnotes

- 1 Transcript, Adelaide Hearing 1, Barrie Anderson, 21 February 2019 at T639.31–33.
- 2 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), Article 12.
- 3 Transcript, Sydney Hearing 4, Rosemary Milkins, 1 September 2020 at T8931.10–14.
- 4 Commonwealth of Australia, *Letters Patent*, 6 December 2018, paragraph (d).
- 5 Exhibit 6-47, Darwin and Cairns Hearing, Statement of Sandra Iuliano, WIT.0204.0001.0001 at 0001–0002 [9]–[10]; S Iuliano et al., ‘Dairy food supplementation may reduce malnutrition risk in institutionalised elderly’, *British Journal of Nutrition*, 2017, Vol 117, 1, pp 142–147.
- 6 Australian Law Reform Commission, *Elder Abuse—A National Legal Response*, 2017, p 147.
- 7 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0020 [107].
- 8 Exhibit 8-41, Brisbane Hearing, Statement of Debora Picone, WIT.0290.0001.0001 at 0032 [153].
- 9 Flinders University, Bolton Clarke Research Institute, SAHMRI and Stand Out Report, *Review of Innovative Models of Aged Care*, A report for the Royal Commission into Aged Care Quality and Safety, Research Paper 3, 2020, p 8.
- 10 Exhibit 4-16, Broome Hearing, Statement of Venessa Curnow, WIT.0243.0001.0001 at 0005 [31].
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- 12 Exhibit 6-6, Darwin and Cairns Hearing, Statement of Olga Havnen concurred in by Sarah Giles, WIT.0263.0001.0001 at 0003 [15].
- 13 Darwin Community Legal Service, Public submission, AWF.001.02120.02 at 0013.
- 14 Report of the Primary Health Care Advisory Group, *Better Outcomes for People with Chronic and Complex Health Conditions*, December 2015, p 36.
- 15 The Hon Greg Hunt MP, Minister for Health and Aged Care, Transcript, *Doorstop interview on 27 November 2020*, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/doorstop-interview-on-27-november-2020>, viewed 28 November 2020.
- 16 Exhibit 14-25, Canberra Hearing, Statement of Leon Flicker, WIT.0616.0001.0001 at 0009–0010 [43].
- 17 Transcript, Melbourne Hearing 2, Elizabeth Karn, 11 October 2019 at T5734.42–46.
- 18 Transcript, Melbourne Hearing 1, Ben Gauntlett, 11 September 2019 at T5152.21–25.
- 19 Australian Council of Professions, *What is a profession?* 2003, <https://www.professions.org.au/what-is-a-professional/>, viewed 9 June 2020.
- 20 Exhibit 1-52, Adelaide Hearing 1, Statement of Melissa Coad, WIT.0018.0001.0001 at 0006 [32].
- 21 Exhibit 14-1, Canberra Hearing, general tender bundle, tab 45, AMA.9999.0001.0001 at 0013.
- 22 Aged Care Workforce Strategy Taskforce, *A Matter of Care - Australia’s Aged Care Workforce Strategy*, 2018, p 95 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 205, ACW.9999.0001.0022).
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