



**Royal
Commission
into Aged
Care Quality
and Safety**

**Final Report:
Care, Dignity
and Respect**

Volume 1
**Summary and
recommendations**



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ISBN: 978-1-921091-65-0 (print)

ISBN: 978-1-921091-66-7 (online)

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Royal Commission
into Aged Care Quality and Safety

26 February 2021

His Excellency General the Honourable David Hurley AC DSC (Retd)
Governor-General of the Commonwealth of Australia
Government House
CANBERRA ACT 2600

Your Excellency

In accordance with the Letters Patent issued on 6 December 2018,
as amended on 13 September 2019 and 25 June 2020, we have made
inquiries and now submit to you the Final Report of the Royal Commission
into Aged Care Quality and Safety.

Yours sincerely

The Hon Gaetano (Tony) Pagone QC
Chair

Ms Lynelle Briggs AO
Commissioner

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Chair's Preface

Tho' much is taken, much abides; and tho'
We are not now that strength which in old days
Moved earth and heaven, that which we are, we are;
One equal temper of heroic hearts,
Made weak by time and fate, but strong in will
To strive, to seek, to find, and not to yield.

Alfred, Lord Tennyson, *Ulysses*

These six lines from a poem written in 1833 continue to speak with force and vigour. Some have found in them inspiration in the face of adversity. These words have been used as calls for action in popular culture. The words convey the hope, vigour and commitment to life ascribed by a poet to an elderly hero whose hopes, vigour and commitment to life had diminished, but had not disappeared, with advancing age. In many ways the purpose of this Royal Commission is about how the hopes, vigour and commitment to life of ageing Australians can best be sustained and supported by the nation. Throughout our inquiry we frequently met with older people who every day lived their hopes and planned their future with the modest request for some support.

The aged care system in Australia today has many flaws. There are, no doubt, some instances of wrongful or inappropriate behaviour, but the system as a whole is a product of different elements frequently acting as expected and intended, but not producing the best outcomes for those in need.¹ The point was eloquently reiterated by Counsel Assisting at the final hearing by reference to a Cabinet Memorandum of 1997.² That paper showed the Government being advised by an independent public service about the unenviable trade-off between health for older Australians and the desire to save on public expenditure for that help. That paper, and the continued implementation of the aged care system introduced in 1997, has been part of the cause of the need for this Royal Commission.

Royal Commissions in Australia are the highest form of inquiry into matters of public importance. Commissioner Briggs has described this as a 'policy' Royal Commission and there is, no doubt, an important aspect of policy for consideration in our Terms of Reference. A fundamental aspect of all Royal Commissions, however, is that they are independent of Government to ensure that their inquiries and recommendations are not merely those that might suit Government and, if need be, for Government to be brought to account. There can be no doubt of the public importance of the Australian aged care system for every Australian of every age; nor can there be any doubt that a Royal Commission with the independence that it entails was needed to inquire into the quality and safety of the system that in the Interim Report was described generally as besieged by neglect.

Commissioner Briggs has had the benefit of having been appointed at the outset of this Royal Commission. I was appointed later, but I have had the benefit of access to the Interim Report, transcripts and recordings of oral evidence and the vast written material that was received before my appointment and, of course, many long and detailed discussions with our many advisors and those assisting us.

Each of us was charged personally with the responsibility for this report and recommendations arising from what has been a complex and difficult undertaking. We have reached different conclusions on some matters which may in part reflect our different perspectives, but it reflects also how we have differently seen and evaluated the vast amount of material we have considered and the accounts we have heard. Commissioner Briggs refers in her overview below to some of her relevant experience upon which she has drawn in developing the reforms she recommends. Naturally, I have drawn upon my experience which has come primarily from practise as a lawyer and judge, but also in chairing a number of not-for-profit organisations over many years. In the end, what matters is the force and cogency of the recommendations themselves.

We agree that there have been many failures and shortfalls in the Australian aged care system. We agree also about many of the causes of those failures and shortfalls, and about many of the means through which to remedy them. We agree that fundamental reform to the Australian aged care system is required, but we differ sharply in our opinion on certain aspects of the arrangements necessary to give effect to our common purpose of the new aged care system, which is:

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.

Many of our recommendations and observations are made jointly, but there are some instances where we make differing recommendations and observations. We have agreed, with some misgivings and not without anxious consideration, to make some separate recommendations and to express different views where we diverge. But we both strongly conclude that fundamental change is needed. In the end, the differences between us may add to the strength of the reforms which are to be made.

I recommend, in accepting the submissions of Counsel Assisting, an Independent Commission model, whilst Commissioner Briggs recommends a Government Leadership model. Our respective reasons are set out in the chapter on governance of the new aged care system. The adoption of one model over the other will have consequences for many, but not all, of the recommendations we make. Ultimately, the Australian Government will have to determine which of the alternative models is likely to avoid the pitfalls of the past and to drive robust and genuine change. Government will also have to decide which model will best ensure high quality and safe aged care for older people now and into the future.

The role of Government, and its need to make decisions between competing governmental priorities is at the heart of the failures and shortfalls in the aged care system we have in Australia today. The role of Government in aged care in Australia goes well beyond, and must go well beyond, putting in place a framework for market forces to provide individuals with care choices matching their care needs whilst ensuring an effective safety net for those with little ability to pay. We do not have an ideal market economy for the provision of aged care in Australia and we need Government to participate fully and proactively in the provision of the care which people need and which they may obtain through the complex system that has developed over many years.

Mere adjustments and improvements to the current system will not achieve what is required to provide high quality care that is predictable, reliable and delivered through a system which is sustainable. A profound shift is required in which the people receiving care are placed at the centre of a new aged care system. In the words of one commentator, aged care does not 'need renovations, it needs a rebuild'.³ Fortunately, the rebuild that is needed has many firm foundations that can be used. The present aged care system has a workforce whose dedication to care is impressive and worthy of more praise and reward. There are informal carers whose personal connection with the person cared for is immediate and strong. What is needed is for these positive foundations to be used for a rebuilding of the aged care system needed now and for the future.

This has been an unusual Royal Commission in many ways. I was first appointed as an additional member on 13 September 2019, after the inquiry had been ongoing for nearly twelve months. My fellow Commissioner, Ms Lynelle Briggs AO, was first appointed a member of the Royal Commission on 8 October 2018, and on 12 October 2019 the then Chair, the Honourable Richard Ross Sinclair Tracey AM RFD QC, died. The work of the Royal Commission was then substantially interrupted by the outbreak of the COVID-19 pandemic which delayed our work and put unexpected pressures on governments, providers, workers, and the many others who were to assist our inquiry during 2020. Our staff and advisors throughout these difficulties deserve special thanks and mention. Amongst them, of course, as mentioned above, are the team of Counsel Assisting, upon whose submissions I have largely relied in reaching my recommendations, the team of Solicitors Assisting, and the team of dedicated policy and other advisors as well as the many support staff. Each has made a contribution and has worked with a dedication to make us proud. There are three in particular, however, that I must mention for constant assistance and counsel. The first is Peter Gray QC, who, with Peter Rozen QC, led the team of Counsel Assisting and provided me with robust, sound and well considered counsel throughout my time as Commissioner. The second is Louise Amundsen, who as Co-Solicitor Assisting with Rodger Prince, heading the Office of the Solicitor Assisting worked with tireless dedication and impeccable attention to detail. The third is Dr David Cullen, whose wealth of knowledge of the aged care system, deep conceptual and analytical skills and commitment to better outcomes were invaluable to me in forming my recommendations. There were many others who have been invaluable to our work who should not be forgotten, and whose contribution was profound, including the many direct evidence witnesses who opened their lives and their hearts to us and to the public at large. At a personal level I should also express my thanks to my fellow Commissioner, Ms Briggs, from whom I have learned much.

I heard evidence in my first hearing in this Commission from Uncle Brian Campbell. At the end of his evidence he asked politely if he could ask one question, which was:

I've sat with Royal Commissions into deaths in custody. I've sat with the Bringing Them Home hearing; right? And out of all of them hardly anything gets done, and is this one going to be the same?⁴

In this report we present different mechanisms through which we see how the system can be fundamentally improved. Our disagreement about the best way for improvement to be achieved is not a justification for doing nothing.

GT Pagone

Endnotes

- 1 Transcript, Sydney Hearing 2, 10 August 2020, T8365.5–8.
- 2 Exhibit 22-1, Final Hearing, Residential aged care – long term, RCD.9999.0539.0001.
- 3 S Duckett, 'Australia's aged care industry needs to be rebuilt from the ground up', *Canberra Times*, 28 December 2020, <https://www.canberratimes.com.au/story/7063604/we-need-to-rebuild-aged-care-in-australia-not-renovate/>, viewed 25 January 2021.
- 4 Transcript, Melbourne Hearing 2, Brian Campbell, 11 October 2019 at T5712.23–25.

What is to be Done— an Overview | The Hon GT Pagone QC

The very first of the matters that we were required to inquire into by our Terms of References was:

the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response.¹

Throughout this inquiry we have heard from many people about substandard care—from those who experienced it and from those who witnessed it. We have also heard from those who are responsible for regulating aged care and from many experts. We commissioned several studies and surveys that have increased the evidence base, but we do not have a complete picture of substandard care. We do know, however, that the extent of substandard care in the current aged care system is unacceptable, deeply concerning, and has been known for many years.

Old age may come upon us as something unexpected but it is a predictable phenomenon, with far-reaching implications for our social and economic future, and as a nation we cannot fail to consider the implications of ageing without provoking serious consequences.

The key to any lasting reform is understanding why the aged care system has been failing us. There have, of course, been incidents of knowing neglect and wilful failure to do the right thing; but that does not explain the problem. Frequently I heard evidence of failure where those who were failing would not have seen themselves at fault when frustrations, lack of understanding, competing demands and human failings resulted in an older person being treated badly. Collecting particulars of failings is important but so too is learning from the particular to understand the general.

We set out in Volume 2 what we have identified as systemic problems; that is, those features of the system which cause unacceptable outcomes. We have mentioned more than once the Cabinet Memorandum of 1997 but it is worth dwelling upon it once more in this outline—not to lay blame but to shed light upon how systems working well can cause harm. The Cabinet Memorandum presented options for Government to consider, including that of capping care packages: it saved public expenditure but it meant that care would be withheld from some who were in need and would cause their care needs to increase. It is instructive to revisit that memorandum because it was produced at the inception of the current form of the system. The 1997 Act was thought to provide solutions to the then increasing social need to deal with care for our ageing population. The Act was expressed with high-sounding aspirations and sought to do many of the things we say in this report

need to be done which were not done. The people given the task of implementing the changes no doubt did their best, but the system has come to its present state in an entirely foreseeable manner, given its basic structure and the constraints and influences on its governance.

We set out in Volume 2 the many systemic problems that we have identified, but I will mention five of the many in this outline.

First, too many older people are not getting the Home Care Package they need at the time and level they need it. The capping of the number of packages means that many people cannot access a package even when they are approved for one. People must, therefore, wait for the care that they need, and that has meant waiting a long time: about seven months for the lowest levels of need and about 34 months for those with the highest levels of need. Something has gone badly wrong when those most in need are forced to wait the longest for care. In any case, even seven months is simply too long for older people to wait for care. The consequences of forcing older people to wait for the care that they need are serious. Many die or have to enter residential care while waiting; and informal carers are burnt out as they struggle to fill the gap. These are results of the structure of the system as it is made to operate.

Second, the amount funded for Home Care Packages is insufficient to meet the care needs of many. People receiving the highest level of care at home, on average, get only eight hours and 45 minutes of service a week. In other words, people who have been assessed as having care needs at least as high as those who are eligible for residential aged care are provided with slightly more than one hour of care per day. That is not enough time to provide quality care to someone who is very frail and disabled. People who need assistance with bathing, with dressing, with moving and with eating cannot reasonably be cared for in less than an hour per day. But those people may be 'the lucky ones' when compared with a person receiving a lower-level Home Care Package who, on average, receives three hours of personal care and less than 20 minutes of clinical care each week. That is, less than half an hour a day. Half an hour a day seems far too little time to provide meaningful assistance. This is particularly so when many people are forced to take a package at a lower level than they have been assessed as needing.

We have been told that the total care hours provided across all Home Care Package levels has declined, and that over a decade ago more than double the current amount of care was possible from the funding provided. That has happened because the level of funding per package provided by the Australian Government has reduced significantly in real terms. The Australian Government is providing less funding (in real terms) and so less care at the same time as older people who access aged care from home are becoming increasingly frail with higher rates of comorbidities

Third, the staffing levels are too low. Research on residential aged care staffing levels that we commissioned from the University of Wollongong found more than half of Australian aged care residents were living in facilities with unacceptable levels of staffing. One of the consequences of these low levels of staffing is that staff simply do not have time to interact meaningfully and compassionately with older people. Care therefore becomes merely transactional rather than based upon relationships. We may use different words to

describe the human face of that kind of ‘care’; some of us would see it as inhuman; but it is also inefficient. Knowing those they care for helps care staff to understand how someone would like to be cared for and what is important to them. It helps staff to care—and to care in a way that reinforces that person’s sense of self and maintains their dignity. This type of person-centred care takes time. The evidence is that current funding levels in residential aged care do not allow workers the time to provide high quality relationship-based care. There is in that context, to be sure, occasional inexcusably culpable conduct, but the root of that conduct is the system and all of the opprobrium which we might direct at the particular conduct will do little to improve the general from incubating more particulars in the future.

We have heard that there has never been an assessment of how much money is required to deliver high quality care. Moreover, as discussed below, the indexation arrangements applied to aged care payments over the last twenty years have systematically reduced the real value of the funding that is available. These limitations on funding have been a major contributor to the substandard care so many older Australians experience. In simple terms, quality care has decreased, at least in part, because we, through the Australian Government, have decreased funding levels in real terms over the last twenty years.

Fourth, the current system is largely failing those Australians who are identified by the current legislation itself as having ‘special needs’. People living in regional, rural and remote areas, for example, have significantly less access to aged care than people living in major cities. There is strong evidence that Aboriginal and Torres Strait Islander people do not access aged care at a rate commensurate with their level of need and often do not have access to culturally safe care. After a lifetime of experiencing marginalisation, discrimination, disadvantage and racism, the Elders and the older people descendent of the first inhabitants of this ancient land deserve better than this. People experiencing homelessness, and those at risk of homelessness, are also poorly served by the current arrangements—mainly because of a lack of integration between aged care and other support services.

Fifth, the aged care system is not well integrated with the health care system. People receiving aged care should have the same access to health services, such as medical services, hospital services, specialist palliative care services and subacute rehabilitation services, as other people in Australia. This does not seem to be the case. We heard evidence, for example, that older people who currently receive aged care services do not receive adequate levels of subacute rehabilitation following a major injury or illness. This seems to be particularly true for those who reside in residential aged care. One study that was brought to our attention found that of those patients who were discharged from hospital after a hip fracture, those who lived in residential aged care were far less likely to receive subacute rehabilitation than those who lived in the community (18% compared to 51%). It is in that context that there is also a need for improved communication and collaboration between people working in the aged care system and people working in the health care system. We were told much about inadequate sharing of health information about older people as they move between the health and aged care systems and of the detrimental consequences that this can have for older people.

The critical issue for this report is how we as a nation are to avoid a repetition of the tragedy of the past. The task, in the words of our Terms of Reference, is what the Australian Government, aged care sector, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe.

To do this, we must ask two questions: First, why is it so: how can it be that Australia's aged care system delivers the kinds of experience that we have heard about during our investigations? Second, what is to be done: what structural reforms are necessary to transform the aged care system into one of which Australians can be justly proud? Our answers to these questions are set out in detail in Volume 3 of this report. In the remainder of this overview, I seek to highlight the fundamental building blocks of our proposed reforms—the key structural changes that are necessary if the reforms are to have the desired effect.

Context

Ageing affects every person throughout their lifespan at different rates and in different ways. It is normal and not necessarily an indication of frailty. Normal ageing slows functionality but age-related physical, emotional and social changes can be anticipated and managed by understanding the ageing process, adopting a healthy approach to ageing throughout life, and adapting to specific changes. Care available from within the community can support adaptation, but chronic conditions such as obesity, dementia, and arthritis can diminish functionality. Supportive environments and integrated care systems can help to ensure that older people whose capacity has diminished live with dignity.

Older people, like everyone, need many different types of support at different times and for differing periods. These can include income assistance, accommodation, health care, rehabilitation support, personal care, psychological or behavioural support, and social interaction. Older people needing help rarely require only one form of help; and their needs will often increase over time. Some of the conditions associated with advanced age become progressively worse—for example, Alzheimer's disease—but there are often interventions that, if made in time, can greatly benefit older people. Short-term rehabilitation and support, for example, can improve or restore independence. Ultimately, however, the emphasis in treating older people with chronic conditions is often necessarily on caring, rather than curing.

Aged care has a number of characteristics that both connect it to, and separate it from, health care. Much of aged care is about social functioning. It is providing the help needed to cope when physical and mental decline impairs the capacity to perform everyday activities such as eating, bathing, dressing, shopping and managing money. These declines can be the consequence of diseases such as osteoporosis, cardiovascular illnesses, multiple sclerosis and Alzheimer's disease, but aged care has been principally about managing and reducing functional impairments rather than managing disease processes. A great deal of aged care has tended not to involve highly technical medical services that need to be provided by specialist physicians or registered nurses. Instead, services have been provided by relatively low level-trained staff members who account for the majority of paid carers.

Aged care needs to connect with primary and acute care. People with long-term care needs are not necessarily sick and do not necessarily require intensive medical services most of the time, but they tend to see the doctor more often and are frequent users of acute care services. Consequently, coordination and integration with the medical care sector is important to meet the needs of older people. The receipt of aged care services is intensely personal and can involve intimate tasks like assistance with going to the toilet, bathing and dressing over extended periods. Such care becomes integral to how people live their lives.

From the point of view of Australia's economy, the aged care sector is already one of Australia's largest service industries. The sector accounted for about 1.4% of gross domestic product in 2018–19.² More than 3200 aged care providers delivered services to around 1.3 million people. That is, more than one in 20 people in Australia receive some assistance with aged care needs. About 3% of the Australian workforce is employed by the aged care sector.

Aged care services are funded by the Australian Government and by individuals. A small amount of top-up funding is also provided by the States and Territories to the aged care services that they operate. For the Australian Government, this includes expenditure administered by the Department of Health (home support, home care, residential aged care, flexible care) and the Department of Veterans' Affairs (Veterans' Home Care and Community Nursing). In 2018–19, which is the last year for which all relevant aged care data is currently available, a total of \$27.0 billion was spent on aged care by governments and individuals, including \$19.9 billion by the Australian Government.

Aged care is not the only form of government assistance provided to older people. In 2017–18, the Australian Government spent \$97.8 billion on care and support for older people, which represented 21.4% of all Australian Government expenditure. As well as expenditure on aged care and support for carers of older people, this includes income support and concessions for older people and expenditure on health care for older people. The Australian Government also spent a further \$36.9 billion on the needs of older people through taxation concessions, including \$33.9 billion on the concessional treatment of superannuation. Taking both direct expenditure and tax expenditure into account, aged care accounts for 15.9% of all Australian Government assistance for older people, whereas health and income support account for respectively for 25.2% and 58.9% of all Australian Government assistance for older people.

An ageing population means that more people in Australia will need aged care and that there will be relatively fewer people to pay for that care and to provide that care. These are problems that will affect all of us. Currently, about 80% of Australians use an aged care program at some stage before their death. The Australian Treasury's 2015 Intergenerational report projected that the Australian Government's expenditure on aged care would increase significantly in real terms in the four decades between 2014–15 and 2054–55 because of population ageing. At the same time, it was projected that the Australian Government's expenditure on age and service pensions would actually decrease in real terms, largely because of the increase in self-provision through superannuation. The Intergenerational Report forecast that Australian Government expenditure on health would also significantly increase in real terms, but most of this increase would be due to technological changes.

It was projected that population ageing would account for only about 10% of the real growth in Australian Government expenditure on health care per person. In other words, aged care is the part of the Australian Government's budget that is most affected by population ageing. This part of the Budget is subject to different pressures and rhythms than the rest of government expenditure and government revenue. Because of this, as I discuss in this report, it needs to be financed differently from the rest of the Budget.

Why is it so?

The Australian Government currently bears the primary burden of funding aged care, even where people receiving care are capable of meeting those costs. That funding is drawn from general revenue but the Government also extensively regulates the provision of care, including by controlling the number, composition and location of the places made available: places are rationed and access to those rationed places is controlled through a process of needs assessment and classification. The Australian Government also determines the prices that aged care providers can charge for the care that they deliver and regulates the prices that providers can levy on their residents.

Australia's aged care system, however, is failing its older people notwithstanding the extent of the Australian Government's involvement, regulation, participation and control. The flaws in the current system arise, in my view, to a significant extent from the decisions by successive governments to consider aged care as a form of welfare for the very needy, to be provided to the bare minimum extent required. As discussed in Chapter 1 of Volume 2 of this report, the history of aged care policy is a history of decisions about how much the Australian Government is willing to spend on the care of older people, and it is understandable that there has been caution about the expenditure of public funds for personal needs of a section of the public.

In the early 1960s, the Australian Government adopted the aged care program at a time of pressure to increase the age pension for older people so that those who were living in nursing homes could pay the high personal fees that were then charged. At the same time, the funding arrangements for public hospitals, which were providing free care to older people, were also drawing large numbers of chronically ill older people towards the public system so they did not have to pay the fees of private nursing homes. The Government of the time seems to have been of the view that the then standard rate for hospital care, 36 shillings a day, was a disproportionate and overgenerous subsidy for nursing home care for older people. The Commonwealth addressed the pressures at that time, in part, by introducing a new nursing home benefit of £1 (20 shillings) per day payable to approved nursing homes in respect of each qualified resident.

This same concern to control costs drove later policy developments in aged care. In 1969, the Australian Government introduced tiered nursing home benefits, with the highest payments restricted to a few residents. The Government also required that an independent assessment of need occur before payment at the higher rate could be made. In 1986, the needs-based planning arrangements were introduced to ensure a fairer distribution of services but this was designed to restrict the growth of the number of nursing home beds by rationing supply.

The current Aged Care Act is focused on the financial relationship between the Australian Government and the providers, and, in particular, on restraining expenditure rather than on the rights of older people to the care that they need. The significance of budgetary policy was evident from the commencement of the 1997 Act in the advice that was provided to Government by the Australian Department of Health and Family Services and the Australian Department of Finance in the Cabinet Memorandum of 1997. The memorandum is not primarily concerned with the quality of care or with ensuring that older people can access the care that they need, but identifies the ‘billions’ in savings that had been achieved to that time by ‘capping service provision’ and the ‘risks’ to the Government’s budgetary position presented by the new arrangements which might, if not carefully managed, undo some of the longstanding fiscal constraints that were operating in aged care.

Staff of the Royal Commission have carefully studied the impact of the decisions that were made by the Australian Government to apply an efficiency dividend to aged care funding and to ration care. They estimate that because of the efficiency dividend, the level of Australian Government expenditure on aged care is 22.4% lower than it would have been if the efficiency dividend had not been applied. On top of this, they estimate that the rationing of places has further reduced Australian Government expenditure on aged care by 25.7% from what it would have been if demand had been met by an unrationed supply of places. In total, it appears that the collective decisions of successive governments have cut more than \$9.8 billion from the budget for aged care in 2018–19. It is no wonder that there are waiting lists for home care and serious deficiencies in the quality of care.

I do not criticise the officials for providing the advice they gave to Government, nor do I critique the Government for seeking this advice. But it is essential in understanding why the system has developed as it has to realise that decisions made by Government, when working as it should, are influenced by costs. It is natural for Government to seek to have as much control over costs as it can and that governments will have many competing priorities that need to be balanced. But the consequences of these decisions can be serious, especially for the marginalised and disadvantaged. This is why I argue that aged care must have an independent champion for high quality and safe care so that the key decisions are not made by the very people who must compromise between competing Government and political priorities.

What is to be done?

The three key building blocks of the reforms proposed in this report to address the current situation, in my view, are:

- a rights foundation for high quality aged care
- independence from Government
- a secure source of funding

We have made other reform recommendations, but I consider that these are the key changes necessary to create a bedrock for an aged care system of which we can be proud.

A rights foundation for high quality aged care

We recommend that the new system for aged care should be based on the protection and promotion of the rights of the people who require support and care. The rights of older people who are seeking or receiving aged care should be enshrined in legislation so as to leave no doubt about the importance placed on these rights. We propose that this rights-based approach should guarantee universal access to the supports and services that an older person is assessed as needing based on the core human right described in the *International Covenant on Economic, Social and Cultural Rights* ‘of everyone to the enjoyment of the highest attainable standard of physical and mental health’.

We intend that the rights that we propose should be enshrined in the new Act may be invoked by individuals seeking protection from neglect, and its effects, by providers or governments in the implementation of the new system. This is in line with the *International Covenant on Economic, Social and Cultural Rights*, which provides that governments must use ‘all appropriate means’ to work towards the stated ends, ‘particularly the adoption of legislative measures’, and opens avenues for their enforcement.

We envisage a system of aged care that is based on a universal right to high quality, safe and timely support and care. A system that ensures that all older people can, without prejudice, receive high quality care in a safe and caring environment. A system that protects older people from mistreatment and neglect, and that protects them from harm. Such a system will provide older people with agency—with choice and control; and it will provide advocacy and complaint mechanisms to support them in exercising their rights. We also envisage a system that is dynamic rather than static. A system that promotes innovation in aged care based on research and that is subject to regular and independent review so that it continues to be fit for purpose.

Recognising that older people have a right to aged care raises other issues of inequality. This is why we have also recommended that older people with disability should have access to the same level of supports in aged care as would be available under the National Disability Insurance Scheme to a person under the age of 65 years, regardless of when a person acquired disability. This change is necessary to remedy a grossly unfair gap in access to supports for older people with disability.

Duties

Rights are, of course, of little use if they are not enforceable. We have therefore also recommended that the new Act should impose a general, positive and non-delegable statutory duty on approved providers of aged care to ensure that the nursing and personal care they provide is safe and of high quality so far as is reasonable. This will require that regard be paid to the wishes of any person for whom the provider provides that care and any reasonably foreseeable risks to any person to whom the provider provides that care.

Approved providers currently have a non-delegable common law duty to exercise reasonable care for the health and safety of residents. The duty we are proposing is in addition to this common law duty and is inspired by, in part, an employer's duty under occupational health and safety law—a duty that the vast majority of approved providers already owe to their employees and contractors.

We believe the imposition of this duty will encourage an approved provider to do more than the minimum. It will focus them on providing the highest quality care that is reasonable, while also requiring them to respect the dignity and choices of those who are receiving care. The duty will provide clarity to providers and to older people. It will also provide a focus for the compliance and enforcement work of the aged care regulator based in broad concepts familiar to all in Australia, rather than in technical rules.

The nature of work within the Australian economy is changing with the development of the 'gig economy'. We have heard about the risks that these arrangements can pose for care; but we have also heard of ways in which older people have been reportedly empowered to better control their own care. To protect against these risks, without disempowering those who wish to manage their own care, we have recommended that any entity that facilitates the provision of aged care services should have a duty to ensure that any worker whom it makes available to perform personal care or nursing work has the experience, qualifications, skills and training to perform the particular personal care or nursing care work the person is being asked to perform. A failure to comply with these duties will expose a provider, and its key personnel, to a civil penalty. The duty we have in mind is similar to the duty such entities already owe to third parties under work health and safety legislation as the conductors of businesses or undertakings.

Independence from Government

The problems in the aged care system are neither new nor unknown. There have been more than twenty substantial official inquiries into aspects of the aged care system over the past twenty years. Many of these inquiries have made similar findings and offered similar recommendations for improvement to those that we make in this report. The responses by successive governments have failed to tackle the underlying problems. There is, in my view, little point in repeating the same process again by asking the same Department that has overseen the current failings to build and run the new aged care system.

This is why I recommend that the Australian Government implement governance arrangements for the aged care system that are independent of Ministerial direction, and that involve an independent statutory body—the Australian Aged Care Commission—as system governor, administrator and regulator. The independence of the Commission will mean that it can give undivided attention and focus to its task of being an effective system governor of aged care. The same cannot be said of a department of state subject to Ministerial direction. Such a body will always face conflicting or competing demands that it will seek to balance through compromise. The evidence to date is that when these compromises are made, older people tend to lose out. A pious requirement that the Minister make aged care a priority is unlikely to undo this system failure.

Central to the Australian Aged Care Commission will be a number of independent, statutory officers (commissioners) each with defined areas of responsibility. While these commissioners will often act together to manage the aged care system, their independence from each other will provide a set of checks and balances to the system that is currently lacking.

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 ought to define its objectives in the new Act and hold the Australian Aged Care Commission accountable for its performance in meeting those objectives.

A recommendation for a dedicated, separate and independent agency to manage aged care was made by the Productivity Commission in its 2011 report *Caring for Older Australians*. It was rejected then by the Australian Government and the problems of aged care have deepened. The rationale for the rejection of the proposal—that similar outcomes could be achieved at lower cost by modifying the current arrangements—has not been vindicated. The recommendation ought to have been accepted in 2011 and I make it again now.

To ensure that the Australian Aged Care Commission does not fall foul of the same conflicts as the system governor (the Australian Department of Health) in the current arrangements I have also proposed several other independent bodies (many of which already exist) to provide checks and balances within the regulatory system.

An independent Inspector-General of Aged Care should be established to provide independent oversight of the aged care system. 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, the Quality Regulator and the Prudential Regulator, and systemic issues relating to the performance of providers and treatment of people who need care.

An independent Aged Care Pricing Authority should be established to determine the schedule of prices that the Australian Aged Care Commission should pay for care based on analysis of the efficient costs of providing safe and high quality care. I consider that it is prudent for a body other than the one regulating approved providers, administering funding to them, and managing the performance of the system to be responsible for determining how much money should be available to them. This is a part of the checks and balances that I have sought to build into the new arrangements. The introduction of independent pricing is critical to restore or to instil confidence and trust between the sector and Government, and to instil confidence in the sustainability of the system in the wider community.

It has been suggested that the Independent Hospitals Pricing Authority could undertake this role. I do not agree because there are very significant differences between hospital admissions and aged care. The Aged Care Pricing Authority should 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. Moreover, I am also proposing that the Aged Care Pricing Authority should have broader economic regulatory functions specific to the aged care sector. The Independent Hospitals Pricing Authority has no expertise or experience in this role.

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 should have responsibility for the review and setting of quality and safety standards and quality indicators.

A national registration scheme should be established for the personal care workforce. The Australian Health Practitioner Regulation Agency should continue to have responsibility for the registration of health professionals working in aged care and consideration should be given to regulating the occupation of ‘personal care worker (health)’ or ‘assistant in nursing’ under the National Registration and Accreditation Scheme, established and governed under the Health Practitioner Regulation National Law.

An Aged Care Advisory Council should be established to provide advice on aged care policy, service arrangements and any aspect of the performance of the aged care system, to the Australian Aged Care Commission. The Council should be appointed by the Minister (not the Australian Aged Care Commission) and should be constituted by people of eminence, expertise and knowledge of aged care services 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.

The Australian Institute of Health and Welfare should be given expanded powers and resources to manage, analyse and report on aged care data and to undertake studies designed to assess the provision, use, cost and effectiveness of aged care services and aged care technologies and to conduct and promote research into aged care services in Australia.

An Aged Care Research and Innovation Council should be established to provide leadership to the sector and to advise the Australian Aged Care Commission on support for research into, and innovation in, the delivery of aged care, including through co-funding arrangements with industry and aged care providers, and through workforce-related research and technology. The Council should also provide such leadership and advice on research into the socioeconomics of ageing, and research into, and innovation in, the prevention and treatment of ageing-related health conditions.

High-level policy development and law reform, including continuing reform of the way aged care interacts with other human services, will remain the responsibility of the Australian Department of Health. There should be a committee of the National Cabinet on ageing and older Australians to harness the resources of all levels of government to develop an integrated system for the long-term support and care of older people.

A secure source of funding

Under current policy settings, Australian Government expenditure on aged care is projected to increase from 0.97% of gross domestic product in 2018–19 to 1.34% in 2049–50.

Modelling undertaken for the Royal Commission implies that Australian Government expenditure on aged care in 2050 is likely to be 2.75% of gross domestic product in total—or 1.41% of gross domestic product higher than it would be if the current policy settings were maintained.

This is a significant additional outlay. Research we commissioned suggests that there is a reasonable level of support to devote public funds to achieving high quality aged care. In particular, a study conducted by the Caring Futures Institute for us asked respondents to the survey whether they thought that the Government should spend a greater proportion of taxpayers' dollars on aged care than the current 4% of tax collected and less on other public services. In total, 59% of respondents agreed with this statement and only 9% disagreed. Of those who agreed with this statement, the mean percentage of tax collected that respondents indicated should be spent on aged care (as opposed to other public services) was around 8% on average. This equates to a doubling of the current proportion of taxpayers' dollars allocated to support the funding of Australia's aged care system.

Of those respondents to the survey who indicated that they currently pay income tax, some 61% indicated that they would be willing to pay an additional amount in income tax to ensure that all Australians have access to a satisfactory level of quality aged care. The mean additional tax rate per year that respondents indicated they were willing to pay to ensure a satisfactory level of quality aged care was 1.4% of their taxable income. More than half of respondents (55%) indicated that they would be willing to pay a higher additional amount in income tax (beyond that previously indicated to achieve satisfactory quality aged care) to ensure that all Australians have access to what they would consider to be a high level of quality aged care. The mean additional income tax rate per year to move from a satisfactory level to high level of quality in aged care was a further 1.7%, providing a combined total of 3.1%. This would be a very significant amount of additional funding, which shows the community sees quality aged care as very important to achieve.

Australia's current spending on aged care, expressed as a percentage of gross domestic product, is relatively low compared with many other Organisation for Economic Co-operation and Development countries. The additional funding implied by our recommendations, even though it is significant, would still leave Australia well behind the levels of expenditure in the Netherlands, Japan, Denmark and Sweden.

It should, moreover, be recalled, as discussed above, that at least half of the increase that we are recommending in expenditure is to undo the actions of successive governments over the last few decades to restrain expenditure on aged care by rationing access to care and by underfunding the sector. This must stop if older Australians are to receive the care that they deserve.

In my view, the aged care system needs a financing source that is as predictable, reliable, objective, and economically sound as possible, without compromising on the quality and safety of aged care, or the equity of financing arrangements. It also needs to be accountable and transparent. The funding arrangements should ensure that people's expectations for high quality aged care are met as assessed and when they are needed. People should not have to worry that they may face high personal costs in the future if they need aged care. The arrangements should also ensure that the funds necessary for timely and equitable access to high quality aged care are available as assessed and, when they are needed, based on an independent objective actuarial assessment of future costs. Funding for aged care should not be subject to the fiscal priorities of the government of the day. The arrangements should ensure that there will be sufficient funds raised to meet expected expenditure. They should also be publicly visible and accountable so that the Australian community can see the connection between their contributions and the effective operation of the aged care system. Finally, the financing arrangements should maintain the general progressivity in the current taxation system.

Under the arrangements that I propose, each person will contribute toward the financing of the aged care system through their working life, and having so contributed their right to assistance when they need it, should not, just as it is not in health care, be subject to a means test. Instead, people should contribute to financing the aged care system in accordance with their income over their entire lives. Moreover, as they do now for aged care and government services in general, the more financially fortunate should continue to pay a greater share.

I also propose, for the reasons that I have discussed above, that the future financing of aged care should also, as far as possible, be independent of Ministerial direction. This too is an area where older people need greater certainty. The financing of aged care must no longer be subject to decisions on indexation and funding levels that are tied to the annual budget cycle; fiscal priorities of the day must not be allowed to take precedence. It is appropriate for government to set priorities, but quality aged care is not a priority that can be traded off on an annual basis.

I am satisfied that there is a persuasive case for the adoption of a levy-based financing scheme. However, there remain many complicated issues concerning the amount of the levy and how it should be administered. I set out in Chapter 20 of this report some details of the manner in which a new 'Aged Care Levy' could work and illustrative calculations of some different options for the design of the proposed levy.

To address these technical design questions, I therefore recommend that, by 1 July 2021 the Australian Government should refer to the Productivity Commission for inquiry and report under section 11 of the *Productivity Commission Act 1998* (Cth) the potential benefits and risks of adoption of an appropriately designed financing scheme based upon the imposition of a hypothecated levy through the taxation system.

Conclusion

The current aged care system and its weak and ineffective regulatory arrangements did not arise by accident. The move to ritualistic regulation was a natural consequence of the Government's desire to restrain expenditure in aged care. In essence, having not provided enough funding for good quality care, the regulatory arrangements could only pay lip service to the requirement that the care that was provided be of high quality. We have proposed a new regulatory system that will be more rigorous and more vigilant. Providers will need to demonstrate their suitability and capacity to deliver high quality care before they are allowed to deliver care and the regulator will be more assiduous in assessing the performance of providers. This new regulatory system will only be possible if it is built on the bedrock of the other structural and institutional reforms we are proposing.

It has been argued that the creation of the new institutions that I have proposed will slow the pace of change and possibly create destructive instability, confusion and uncertainty. I disagree. The alternative, that the institutional arrangements that have by design created the issues that we have identified should be expected to be able to fix the issue, is surely fraught with danger. We cannot keep doing the same thing over and over again and expecting different results.

The benefits of the Independent Commission model can in part be seen in the National Disability Insurance Scheme, which has ushered world-leading improvements in the governance of the system for the provision of benefits for people with disability. The model proposed for aged care goes further by providing a secure source of funding for the reforms while the budget of the National Disability Insurance Scheme is subject to funding decisions by Government. The proposed Commission must be free to act in the interests of older people but, of course, as an entity of the Australian Government it will ultimately be responsible to the taxpayers of Australia: independent of government but responsible to government.

Change is needed but the change must be real. We hear often the laconic lament that the more things change, the more things remain the same. The Sicilian author Lampedusa in the book *Il Gattopardo* put the idea more cynically when a character in the novel says that 'Everything must change for everything to remain the same'. We must ensure that neither occurs in the outcome of this Royal Commission: the change must be real, it must not be more of the same or a change calculated to keep things as they are.

Piecemeal adjustments and improvements are unlikely to achieve what is required. It is an important task because the challenges are very great. The challenges are great because they arise in all sorts of ways that are sometimes difficult to deal with. We have seen many failures and many shortfalls. But the ones that are most difficult to overcome are the failures that occur when the things are working as you would expect them to be working. Good people, well intentioned, doing the best they can, may unwittingly cause the biggest problems. Such people cannot fix the system without a complete overhaul of its structure.

A philosophical shift is required that places the people receiving care at the centre of quality and safety regulation. This means a new system empowering them and respecting their rights. An independent Aged Care Commission with guaranteed funding through a hypothecated Aged Care Levy will, in my view, create the substrate upon which this change in philosophy can flourish.

Endnotes

- 1 Commonwealth of Australia, *Letters Patent*, 6 December 2018, paragraph (a).
- 2 See Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 134, RCD.9999.0530.0002 (excluding expenditure on carer support for older people by the Australian Department of Social Services).

Care, Dignity and Respect— an Overview | Commissioner Lynelle Briggs AO

Few words sum up the potential of the Australian aged care system as well as ‘care, dignity and respect’. Few words articulate what needs to happen in aged care as well as ‘put older people first’.

Older Australians like mum have given of their bodies, minds and spirits to grow a future for their families and communities and have laid the foundations of a society we enjoy today. Growing old should be a dignified experience where self-respect can be maintained. The next generation must have confidence that their basic physical, psychological and human needs will be met and hopefully exceeded when they are at their most vulnerable.¹

We are all growing older and, excepting misadventure, we can expect to live into our 80s. Many of us will then experience chronic illness, physical frailty, and cognitive decline, and we will need to be supported and cared for by others. We all need to be confident that the aged care system will provide for our care needs and our wellbeing, so that we can see out our lives in peace.

As Australians, we live in one of the wealthiest countries in the world, with a long history of social action to address the needs of less fortunate members of society. We were one of the first countries in the world to introduce the old age pension. The Australian Government began its involvement in aged care almost 70 years ago, and it now spends on behalf of every Australian about \$800 per year on aged care.

While many people receive good care, many do not. Even people who receive adequate physical care can find that they are not treated as an individual with thoughts and feelings—they feel that they are treated as objects to be managed. This is not good enough. We should expect better for our parents and grandparents, our friends and partners. And we should expect better for ourselves when we reach an age when we need care.

This Final Report is about the fundamental reform to the aged care system to make sure it delivers the quality of aged care we expect as a nation. In developing these reforms, I have drawn on the evidence, information and research findings available to me since the Royal Commission started in October 2018 as well as the extensive experience that I have had working in policy, program delivery, regulation, service delivery, governance and human services in the Australian Public Service and since that time on boards, reviews and committees ranging from planning, through early learning, construction, superannuation and insurance. The comprehensive reform plan outlined here recognises that the aged care system is large, complex and multi-faceted, with many challenges that need addressing and many opportunities that must be taken up.

Background to reform

The challenges facing the aged care system are well known—an ageing population, increased demand for services, confusing and fragmented service delivery, waiting lists, widespread abuse and substandard care, a lack of transparency about the quality of services, a seemingly ineffective regulatory system that fails to hold under-performing providers to account, an under-resourced and under-skilled workforce. Too often, the aged care system seems deaf to older peoples' needs and preferences. Each of these and other problems need to be addressed.

The demographic changes leading to increasing demand for aged care over the coming decades are widely understood. The generation of children born following World War II are now beginning to enter aged care. At the same time, life expectancy for people aged 65 years is increasing.² As a result, the number of people aged 85 years and over is projected to increase from around 500,000 or 2.0% of the total population in 2018 to 1.5 million or 3.7% of the population in 2058.³ Combined with other demographic changes, this increase in the number of people potentially requiring care will be accompanied by a decline in the number of people available to provide care to them.

The average complexity of the care needs of older Australians is also increasing. Advances in medical treatment are extending the life expectancy of older Australians, but they are also supporting them in living with more chronic conditions and disabilities. As our Background Paper 2 observed, older people in the future are likely to spend more years living with disability than is the case today.⁴ It is clear that older people in need of care prefer to receive that care in their homes in the community, not in an institution, and there is no reason to expect that preference to change in the future. It is important, therefore, that quality services that support their health and wellbeing are available as well as other supports to help them live independently. Delayed entry to residential care will mean that people will be frailer and sicker when they do enter residential care, and will need more skilled workers to look after them. The challenge for the aged care system of the future will, thus, be to deliver care to more people with greater needs, and attract and retain a skilled workforce from a relatively smaller working population.

Many older people find it hard to access aged care services that meet their needs. Their difficulties begin when they try to obtain information about how to access care and what care is available through My Aged Care. While the Australian Government continues to make improvements to My Aged Care, there is still no physical presence. Older people cannot sit down with a staff member and have a face-to-face discussion about their circumstances and options. People with language or literacy problems, and those with limited access to technology, struggle with My Aged Care. Many people without family or friends to assist them may be unable to manage. Even if people are able to use My Aged Care, it does not provide useful information about the quality and characteristics of different providers and services.

Once people are assessed as requiring a Home Care Package, they are required to wait for one to become available. Despite a series of announcements in recent years, over 102,000 people were waiting for a package at their approved level on 30 June 2020.⁵ Many people assessed as requiring a Level 4 package worth around \$52,000 a year are offered an interim Level 2 package of a little under \$16,000. Those people who do receive a package find between one-quarter and one-third of the funding is used up by administration and care management fees. Indeed, according to the StewartBrown provider survey, people on a Level 4 package receive over three times as much care management per week as nursing and allied health care combined.⁶

The lack of access to home care leads people to enter residential care when that is not their preference. So can a lack of access to respite care. There are numerous barriers to respite care—services are in short supply, they need to be booked months in advance, or they are only available for periods of several weeks when people and their carers need a shorter time. Respite care offered by residential care providers is often ‘a try before you buy’ introduction to residential care, rather than a service intended to assist people to remain in the community.

People receiving aged care do not get access to services they need to maintain their function and health. There is a wealth of evidence on the importance of various allied health interventions in maintaining or enhancing people’s mobility, dexterity, and cognitive function. However, only limited allied health is provided under the Commonwealth Home Support Programme or through Home Care Packages. While some residential care services offer a range of allied health services, many provide only the limited range of physiotherapy services that lead to increased Government funding.

People living in residential aged care services do not receive the medical services they need. Medicare is designed for people going to the doctor, and does a poor job of encouraging doctors to go to people living in aged care. Despite their poor health status, less than one-third of aged care residents see a specialist during a year, compared with more than two-thirds of older people living in the community.⁷

As well as these general access problems, particular groups have additional problems. People living in outer regional and remote areas have less access to aged care services than their counterparts in metropolitan and inner regional areas. In remote areas, access to services has declined over the last five years. Some Aboriginal and Torres Strait Islander people find it particularly difficult to access My Aged Care, while there is a shortage of services and workers who are culturally competent. Older people who migrated to Australia from non-English speaking countries find it hard to access care that meets their cultural and language needs. Older people with disability receiving aged care do not have access to services and supports at the same level as those provided to people through the National Disability Insurance Scheme. Other groups that have experienced trauma, such as veterans, people from LGBTI communities, and care leavers, find it difficult to find care that meets their needs.

The reasons for these problems are covered in great detail in Volume 2. The Australian Government provides about three-quarters of the funding for aged care. Yet in order to keep its costs down in the wake of demographic change, the Government has failed to fund the aged care system at a level sufficient to provide uniformly consistent high quality and safe aged care. It has done this through savings measures, limitations on indexation, and the rationing of services, and it has shifted the capital investment costs of aged care onto older people. It has failed to do the work necessary to determine the right level of funding based on the actual cost of providing high quality services. The Government's failure to require information from providers on what is happening in aged care services and its 'light touch' approach to regulation has hidden these problems for many years. The upshot of this is that even the officials said to be in charge of overseeing the aged care system know surprisingly little about how it is working on the ground.

The absence of Government leadership and stewardship of the aged care system has meant that obvious and longstanding problems with aged care have not been dealt with, and necessary adjustments to the system have not been introduced. In many ways, this largely Government-funded system has grown topsy-turvy without enough Government attention—leading to increasing commercialisation of the sector, growth in the market share of large-scale for-profit providers and a loss of focus on the sector's social 'mission' to provide high quality and safe care for older people. The aged care system has suffered from sequential attempts by governments to define it as a market in its own right, which can and should behave like any other market in our economy. Unfortunately, these market-based reforms that redefine the people who use aged care as 'consumers' who 'direct' their own care by purchasing services from businesses in a 'competitive market' have resulted in more confusion than before and certainly have not improved quality or transparency.

At various times during our inquiry, I found myself asking 'why are we as a community prepared to accept this?' and 'have we lost our moral compass?'—and I expect some of the answer lies in the fact that most aged care is largely hidden and out of sight of the rest of the community, so the community is unaware of what has been going on. That points clearly to the need for more openness and transparency about the aged care system, and for strong regulation that safeguards the quality and safety of the system. Beyond this, I fear that society as a whole undervalues older people and their contribution. The acceptance of poorer service provision in aged care reflects an undervaluing of the worth of older people, assumptions and stereotypes about older people and their capabilities, and ageism towards them. This must change.

It is necessary to start with aged care providers and their workforce and with health professionals, because they are responsible for care delivery. Aged care providers hold an important position of trust that they will provide timely, high quality and safe aged care—and yet large numbers of them do not do so. Providers need to shoulder some of the responsibility for the systemic problems of the aged care system. Specifically, providers have not focused sufficiently on the provision of high quality and safe care, on older people's wellbeing, on service innovation and excellence, on listening to older people and hearing their complaints, on effective clinical governance of their services, and on workforce leadership, development, skills and culture. Like older people, the

aged care workforce has been undervalued. It is underpaid and under-skilled, and has been undermined by the replacement of qualified staff by less qualified and unregistered workers. There are not enough qualified and well trained people working in aged care.

After years of critical reviews, it took the Oakden catastrophe in South Australia to expose again the cracks in the aged care system. Over the two years of our inquiry, we have catalogued the failures of the system, shining a light on the egregious abuse, mistreatment and neglect that we discovered. The COVID-19 pandemic reminded us all again of the crisis in aged care in this country and of the failure of our leaders to take responsibility for what happens in this system.

Substandard care in the aged care system takes myriad forms. We have heard compelling and distressing evidence of physical and sexual abuse occurring in the aged care system. We heard about excessive use in the aged care system of physical or chemical restraints, which rob our elders of their dignity and autonomy, and which can result in serious physical and psychological harm, increased health complications and in some cases death.

We heard many examples of inept dementia care that caused unnecessary distress and left pain untreated. Too few people receive evidence-based end-of-life and palliative care, and instead experience unnecessary pain or indignity in their final days. Older people with mental health issues are often heavily medicated, but do not receive access to preventative care and other treatments.

We heard terrible examples of substandard incontinence care, inadequate wound care leading to horrific pressure injuries and infections, and inattention to oral health leading to rotting teeth and difficulties eating. We heard about malnutrition and dehydration of people in aged care who were given poor quality and unappetising food. We also heard about incorrect administration of medicines, and of poor prescribing and dispensing practices. These included overuse of medication in lieu of more suitable treatments, and the prescription of medications that have negative interactions with each other.

And there have been many examples of aged care that did not support, or actively harmed, older people's quality of life. This has included where aged care providers did not prioritise supporting people to maintain or regain their mobility, continence or independence. It has included care that did not meet older people's social and emotional needs, that was dehumanising, failed to recognise individual needs and failed to support older people to make meaningful choices. We heard about a loss of dignity and privacy, carelessness and unkindness. And we heard devastating evidence about older people feeling isolated, lonely and bored, without engaging or meaningful activities.

As Brian Harvey, a resident of Southern Cross Care Tasmania said:

In my whole precious life, I cherished my individuality and independence, so I find these current restrictions devastating. Everything is passed to others. My so-called 'quality of life' is controlled by the priority timelines of others...⁸

He also said:

I can confirm that we, the ancient ones, cry out to be treated as adults who have lived useful lives, had wide ranging experiences, and contributed to our communities and society. Non-mobile residents need a flexible array of choices of ways to spend time left to us in these declining years. Otherwise, the truly boring void of passing time finally makes death a preferred option.⁹

In many ways, the magnitude of substandard care unfolded throughout our inquiry like the peeling of an onion—layer by layer, example after example, statistic by statistic. From the initial suggestion from the Australian Department of Health that 'serious incidents of substandard care do not appear to be widespread or frequent',¹⁰ the actual extent of substandard care revealed itself over the course of our inquiry to be much more than this.

Surprisingly, there is no simple, reliable measure of substandard care available. Quality data is not routinely collected in a way that makes it easy to determine whether people are receiving substandard or high quality care. However, we have received substantial evidence and undertaken and commissioned research to inform our understanding of the extent of substandard care.

In our Interim Report, Commissioner Tracey and I outlined expert evidence on the extent of substandard care.¹¹ This included evidence that 22–50% of people in residential aged care were malnourished;¹² that 75–81% were incontinent;¹³ that pressure injuries occur in a third of the most frail residents towards the end of their lives;¹⁴ and that 61% were regularly taking psychotropic agents—with 41% prescribed antidepressants, 22% antipsychotics and 22% benzodiazepines.¹⁵

In October 2020, we published the results of surveys of people receiving aged care, commissioned by us from the National Ageing Research Institute. These surveys, which reached a representative sample of respondents, capture the experiences and impressions of people accessing the aged care system. The surveys showed that 1 in 3 people using residential care, well over 2 in 5 people using home care and residential respite care, and over 1 in 2 people using community respite care believed that one or more of their care needs, across a number of areas of care, were only sometimes, rarely or never met.¹⁶ These areas of care covered dignity and choice, being involved in making one's own decisions about care and services, having appropriately skilled staff providing care, receiving appropriate personal and clinical care for their health and wellbeing, and being supported in their social relationships and connections. These areas of care align with the elements of our definition of high quality care.

The surveys also asked people about their particular areas of concern. Across all care types, at least 3 in every 5 respondents had one or more main concerns.¹⁷ While not all concerns were indicative of substandard care, the vast majority were either directly indicative of substandard care (for example, medication management and loneliness and boredom) or were about matters that often cause substandard care (for example, understaffing and communication issues).

Accreditation data is an incomplete measure of substandard care, but is still instructive. About 1 in 5 residential aged care service audits in 2018–19 concluded that the service failed to meet at least one expected outcome under the former aged care Accreditation Standards.¹⁸ Similarly, about 1 in 5 quality reviews of home care providers in 2018–19 concluded that the provider failed to meet at least one home care outcome.¹⁹ Accreditation data for the 2019–20 financial year was affected by a pause in some activities due to the COVID-19 pandemic. However, about 2 in 5 residential care audits and 2 in 5 quality reviews or quality audits of home care services found that at least one requirement was not met.²⁰

In 2019, we commissioned research on residential aged care staffing levels by the University of Wollongong. This research found that when Australian staffing levels were compared with benchmarks set by comparable countries such as the United States, more than half of Australian aged care residents were living in facilities with what the authors considered to be unacceptable levels of staffing.²¹

Other data relevant to measuring substandard care includes:

- An estimated incidence of physical and sexual assault of 13–18 per 100 residents, when assaults that are exempt from reporting are included.²²
- In the last quarter of 2019–20, residential aged care services across Australia made 24,681 reports of intent to restrain and 62,800 reports of physical restraint devices.²³
- In the last quarter of 2019–20, the national quality indicator data showed there was an average of 6.79 observations of pressure injuries per 100 residents assessed (or 11,988 observations out of 176,657 residents).²⁴
- In the last quarter of 2019–20, a total of 8% of people in residential care assessed experienced significant unplanned weight loss (13,239 out of 165,560 people). In the same period, 8% of those assessed experienced consecutive unplanned weight loss (12,820 out of 161,496 people).²⁵

The combined impact of the available data leads me to the devastating conclusion that substandard care is widespread in Australia's aged care system. I conclude that substandard care has affected over 30% of older people accessing aged care. It is shocking to think that at least 1 in every 3 older people using aged care has experienced substandard care. It is dispiriting to understand the range and extent of that failure. Behind the statistics are countless older people who did not receive the care they needed. As Ms Helen Valier said:

A model of care that depends on the constant vigilance of family and representatives is unsustainable. Such a model is exhausting for family members...and unsafe for those not fortunate enough to have someone to advocate on their behalf.²⁶

Aged care should be a service, a fundamental element of the closely woven social support system of which Australia is justly proud. However, Australia's aged care system is not worthy of our nation. Far too many people experience it as unkind, uncaring in its response to them and indifferent to their needs. The Australian aged care system is unacceptable and unsustainable in its current form.

Perhaps the most shocking part of this is that the problems in our aged care system are not new. There have been more than twenty substantial official inquiries into aspects of the aged care system over the past twenty years. Many of these inquiries have made similar findings and offered similar recommendations for improvement. The responses by successive governments have failed to tackle the underlying problems.

The condition of the Australian aged care system is the responsibility of us all. Governments, providers, taxpayers and the community at large must all take some responsibility for dodging the issue and leaving aged care to decline into the parlous state that it is in today. Equally, we must all take responsibility for fixing it. It is only by taking collective responsibility that we can all move forward together and do what needs to be done. This will require sacrifices on all our parts.

Our approach

The Royal Commission into Aged Care Quality and Safety is a policy commission, and differs from other Royal Commissions that are intended to seek out and correct wrongdoing. Policy Royal Commissions have to weigh up evidence and opinion and make judgements about the best way forward; often these judgements are fine points of difference, and sometimes they involve important philosophical questions.

Aged care issues are complicated and sometimes there is no single cause of the problems and no single best solution. In a system as complex and as interwoven as aged care, reasonable people can come to different conclusions around the best course of action. In our case, we have elected to provide the Government with two options for the governance of the aged care system, and the impact of those options necessarily flows through into other recommendations.

However, this is a secondary issue to the quality and safety task at hand, which dominates our recommendations and, importantly, on which we agree. We are confident that we have found the best solution to achieving high quality and safe aged care.

I have also made some extra recommendations. Wherever I possibly could, I have tried to provide clear direction in recommendations as to what needs to be done to address specific issues. My knowledge of technology has led me to recommend explicit improvements in the use of technology and an industry strategy. Areas such as workforce, leadership at provider level, improved governance by providers, transparency, and better stewardship by government must be practically reformed and I have recommended accordingly. I have gone to a greater level of detail in my recommendations because without clear direction from the Royal Commission, I am not confident that the necessary level of reform will actually be implemented. All too often, the Government and the aged care sector have avoided change and hidden their poor performance, and we cannot allow that to continue.

In the discussion that follows, I have presented my perspective about what needs to be done to transform the Australian aged care system.

Care, dignity and respect

At its heart, our inquiry has revealed that people receiving aged care want to be treated with care, dignity and respect. Individual needs and preferences vary, but compassionate care, dignity and respect are the building blocks of an aged care system worthy of our nation. At their simplest, care, dignity and respect are about how we would want ourselves and our loved ones to be supported as we age.

There are inevitably going to be challenges that come with growing older. The aged care system should not be contributing to these. People should not be asked to trade dignity and respect for safety and assistance. Instead, aged care should be a service that preserves and enhances a person's sense of identity and worth. It should show older people that they do matter and that they have not been forgotten.

It has been too easy for older people and their families to become disempowered in what can be a depersonalised, confusing and overly bureaucratic aged care system. In this, our Final Report, we set out extensive and ambitious reforms to change this situation. It is critical that these changes are underscored by an approach to care that is grounded in dignity and respect.

Care should begin with an understanding of the experience through the eyes of each older person. Every person's story is different. Some people will arrive at the aged care system following a difficult life transition, such as ailing health or the loss of a partner, while others arrive with different histories, jobs, beliefs and traditions, and some will carry the burden of life's trauma. Understanding and respecting the unique life experiences of people accessing care is affirming. The message it sends is—you are seen, heard, and you matter. Everyone has their own needs, preferences, values, feelings and expectations. These should be put at the centre of a person's experience of care.

Failing to appreciate the vast diversity within older people in care can make people feel like one of many in a homogenous group of 'care recipients' or 'consumers'. It is dehumanising. But making a person feel valued for who they are can protect them from feeling like a passive recipient of care, and support them to feel recognised as a person with a past, a present and a future.

The experience of aged care is inevitably shaped by interactions between people. The small things matter—for instance, referring to a person by their preferred name, looking at each older person when talking rather than automatically deferring to a son or daughter, or taking the time to help them eat and drink. Care delivered through trusting, respectful relationships can help mitigate the feelings of helplessness a person may feel as living independently becomes more difficult. It can help ensure that the balance of power within the aged care system falls in favour of the older person.

People need high quality clinical and personal care and they need to be safe. That is vital. But we need much more than that. Aged care should support people to live a satisfying and fulfilling life. Like all of us, older people deserve opportunities to do things that make life worth living and provide meaning. Rather than shutting older people away, we should be grabbing the opportunity with both hands to benefit from the sharing of a lifetime of experience, wisdom and stories. This is what helps give a rich tapestry to our community.

Old age is a part of the lifespan that can hold as much promise and meaning as all other stages of life. Later life should be appreciated as a time for living, not biding time. This will help move the concept of aged care towards something more fulfilling and empowering for older people.

Transformational reform

The aged care system requires transformational reform. Our comprehensive reform program is summarised in this volume and set out in depth in Volume 3. Here, I attempt to draw out the main elements of the reforms, as I see them. The reform plan is the creation of an aged care system that is based firmly on the following fundamental elements.

Clarity of purpose

A new Aged Care Act is needed, which is based around the support and care needs of older people and their right to high quality and safe aged care.

For too long, legislation has focused on the funding requirements of aged care providers rather than the genuine care needs of older people. The purpose of aged care needs to be clear:

To deliver an entitlement to high quality care and support for older people, and to ensure that they receive it. The 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.

The needs and aspirations of each older person using the aged care system are unique. The aged care system needs to be sufficiently accommodating and flexible to meet the diverse needs and respect the particular life experiences of all older people. The new Act will enshrine a set of rights for older people, which are designed to enunciate the fundamental rights that an older person of any background, situation or income should expect will be respected by the aged care system.

Aged care is all about people, and relationships are the foundation of all human engagement. High quality care requires social connection as well as professional health and personal care. Strong relationships built on dignity, trust and respect are central to physical and emotional wellbeing. Such relationships make a huge difference to older people's happiness, quality of life and care outcomes. We have, therefore, defined high quality aged care in terms not only of clinically safe care, but also of care that is designed to meet the social and psychological needs and aspirations of each person receiving care,

so that their physical, cognitive and mental health is maintained and their lives are enriched by engagement with others.

Two foundational principles in the Act will guide the transformation of the aged care system to deliver high quality and safe aged care:

1. to ensure the safety, health and wellbeing of people receiving aged care, and
2. to put older people first so that their preferences and needs drive the delivery of services.

These principles should provide the basis for high quality and safe aged care, and should be used by all aged care providers, governments, and health and aged care professionals. We have also provided a suite of additional principles for the new Act, which provide further clarity as to what needs to be done to respect, support, protect, and care safely for older people.

On a day-to-day basis, those who work within the system need clear and simple ‘memory joggers’ to help guide their activities as well as provide the necessary ethical constraints on their actions. I delineate these as six core values:

1. to put older people first
2. equitable: to provide fair and equal access to high quality aged care
3. effective: to provide effective care that delivers the best quality care and outcomes for older people
4. to be ambitious so that the aged care system is the best it can be and keeps on improving
5. accountable: an aged care system that is open, honest and answerable to the community for the care it delivers
6. sustainable: the aged care system is adequately funded, resilient and enduring.

The more these values are practiced, and are seen to be practiced, the more likely it will be that the aged care system will deliver high quality care that respects older people, and enhances their health, safety and wellbeing. The values seek to culturally enshrine what is acceptable, and also unacceptable, care and support practice in aged care.

A say and a voice

if a lesson is to be learnt, it is that resident-centred care means everyone’s voice must be heard and respected regardless of being verbal, nonverbal, advocated, evidenced or witnessed...they must be given an opportunity to be heard and they must be listened to.²⁷

One of the great joys of our inquiry has been providing the opportunity for older people to have a voice and to be heard. It was, at times, quite confronting to hear how powerless, disregarded and overlooked many older people and their families felt and how vulnerable older people were to the actions of others, many of whom they depended on for support, care and their quality of life.

While representative organisations do a very important job in advancing the policy interests of older people, it is evident to me that using legislation to put older people's needs and wishes first and at the centre of their support and care is a practical and important way for each older person to have a say in how they are cared for. The rights framework will provide a clear statement of expectation that older people are listened to.

These arrangements will be further strengthened through: the consultation process we recommend for the development and implementation of the strategy for integrated care for older people; the much more engaged care finder network and aged care program and regulatory arrangements we propose; and the stronger advocacy arrangements we recommend.

The new Council of Elders will hear regularly from older people and keep older people's views and needs under the spotlight, as will the Inspector-General of Aged Care in their reports to Ministers and Parliament. A strengthened and empowered advocacy network will help give a voice to those older people confronted by a complex and sometimes intimidating system:

After my first experience of having my service cut off by the provider after complaining, I've been a bit fearful that I could lose my package if I complain. The providers have a lot of power. I had to really fight hard to get my package reinstated. I felt hopeless and disempowered after that experience and it felt like there was no point raising issues or complaining.²⁸

It is a sad fact that many older people, their families and care workers are reluctant to speak up about the quality and safety of care because of the fear of reprisal from providers or their staff members. This is a longstanding problem. Our recommendations to strengthen and make more transparent the complaints process and to strengthen whistleblower protections will go some way to address this issue. I would also expect the regulator to be closely examining the complaints-handling arrangements maintained by providers and to be talking to more older people about their experiences of care when assessing the performance of providers.

There are some things that you cannot make recommendations for, and that includes getting older people to actively engage in community, social, group and family occasions. What I can do, though, is to encourage each and every person aged over 60 years to plan for their future, to consider how they wish to be cared for, to think about what inspires or interests them, and to do it. If we are inspired, we will do things or take action and that, in turn, will serve to keep us engaged, to have a say and be listened to. Everyone needs to feel confident that their voice and presence will make a difference.

Entitlement to care

In any usual system of social welfare, the concepts of access and adequacy sit alongside equity as important tenets of policy. Aged care is unusual in that the design of the system has been driven structurally over the last 25 years by fiscal parameters rather than by these important policy foundations. There is no universal entitlement to aged care. Aged care services are strictly rationed and access depends on the luck or good fortune of where you live, your aged care needs, how many places are available and whether providers are available to meet your needs. This is unacceptable.

Australians expect that older people will receive the level of aged care they need, and are deeply concerned when they don't. We have heard that people have been forced to go into residential care because suitable home care services were not available and that others have died before services were available for them. People are right to be outraged about this.

The system fails to provide home care and respite to people who need it; it is so starved of funds that unacceptably poor standards of care and living have become commonplace; and it neglects, or simply does not have the resources to engage with, older people. Hence, there is a pressing need to reset the parameters of the aged care system and establish new foundational principles and core values based on a clear purpose—the provision of high quality and safe aged care. It is difficult to overstate the importance of this foundation.

We recommend a universal entitlement to aged care, which guarantees access to the level of care and supports each older person is assessed as needing. The reconfiguring of the system as one of an entitlement to care deliberately mirrors Medicare entitlements. It is a major reform, designed to drive access, adequacy, equity and funding improvements by establishing the level of care that is to be supported.

In the first instance, we expect that the universal entitlement will provide the basis for the removal of the home care waiting list, the expansion of access to social supports, respite and home modifications and technical supports, and the reform of aged care funding arrangements based on the actual cost of delivering high quality care. Over time, it will facilitate increases in the maximum level of funding for care at home.

A new aged care program

The aged care program is the vehicle for delivering the principles and values of the new Act as well as people's entitlement to care. A new aged care program is required to support people to function independently for as long as possible, and work with people's physical as well as social, psychological, cultural and spiritual needs. The new program should provide care and supports to older people to preserve and restore their independence and their capacity for dignified living.

The way aged care has been organised and run in Australia is fragmented and far too complex. The existing range of programs overlap in some ways and leave gaps in others.

Programs are not easy to use or even understand. The new arrangements for aged care service delivery—the new program design—should be simpler and fairer. Program design should feature a single set of arrangements for getting into aged care, using aged care and changing between different aged care options when there is a need to do so. The new program should provide the support and care people are assessed as needing, and take into account their location and identity.

Access to services should be based on assessed need and not rationed. The use of the Aged Care Target Provision Ratio as a tool for limiting and apportioning subsidies should be ceased, and a new planning regime should be developed—one that ensures adequate coverage of services and a diverse mix of capable providers across the breadth of our nation. This is a necessity to underpin a universal entitlement to aged care.

There should be a single, scalable assessment process so that older people are clear about what services they are entitled to receive. The process of understanding aged care and how to find the most suitable services should be supported by the introduction of care finders—people who are carefully trained to work with older people and their families to navigate the aged care system and work out with assessors what services the person needs, and where and when these are needed.

We know that everybody's need for aged care is different and changes over time. The aged care program has to be built around the needs of older people. Aged care is an intensely personal experience. Building genuine relationships will help those providing support to understand a person's history, goals, values and preferences. This approach is no less important when an older person has a cognitive impairment. At all times, care and support should be respectful, engaging and kind.

In the new aged care program, older people should not have to make choices and trade-offs between the types of care and supports that they have been assessed as needing. They should be able to access the social supports, assistive technology and home modifications and respite that they require. For those that also have personal and clinical care needs, these support services should be provided in addition to that care. Aged care should address people's needs comprehensively to support their quality of life. Having quality of life is broader than physical health. It is also about social and psychological fulfilment, and a life enjoyed to the fullest extent possible.

Older people and their carers should be supported to balance their care needs. If older people wish to undertake social and community-based activities, or access equipment and technology to make life easier, they should be able to do so. They should have access to a wide range of allied health services to maintain or improve their capacities and prevent deterioration as far as practicable.

For too long the residential side of care has dominated the public conversation about aged care and determined the calls on the public purse. Our inquiry has confirmed over and over again that people do not want to live or die in institutions.

Older people should be supported to remain in their own homes for as long as possible, because this is where they want to be. The new program design will put much greater emphasis on care at home. A comprehensive suite of care at home services will be available to help older people manage independently for as long as possible. The services will include personal, clinical, enabling and therapeutic care, living supports such as cleaning, laundry, shopping for groceries, light gardening and home maintenance, and care management. Subsidy levels will be raised progressively to enable more home-based support to be provided and remove incentives to institutionalisation.

When it is no longer possible to remain at home due to more complex, severe and subacute needs, residential care should be in buildings that resemble people's homes. New residential care funding arrangements will encourage small-scale congregate living and dementia-friendly design, which enhance older people's wellbeing and care quality. My vision is that, over time, large aged care 'facilities' will give way to smaller, more personal residential care accommodation, located within communities, towns and suburbs. Residential care will involve supports and care appropriate to chronic and complex conditions and, where possible, maintain capacity for meaningful and dignified living in a safe and caring environment. Funding will be sufficient to enable approved providers to deliver that high level of quality care.

Getting the program design right should inspire public confidence and ensure the credibility of our aged care system. But this will require some fresh thinking and active management of the aged care program, both locally on the ground and from Canberra. The concept that system management, the use of technologies or workforce reforms are outside the remit of the responsible Department has been shown to be deficient, and I would expect them to be an important part of program management.

Those working in the aged care system should be thinking ahead, planning and working together to address gaps or limits in care, to foster innovation and to bring about positive change that delivers on the outcomes we have outlined in our recommendations.

The circumstances of people with diverse and different life experiences should be a particular concern. For too long, people have been expected to 'make do' with access to aged care services that do not suit their needs. The new entitlement to care should force much more active forward planning of different kinds of service provision. People's life histories, their experiences of trauma, the language they speak or their cultural needs should be recognised and responded to appropriately. Diversity should become core business in aged care. Data should be collected and training provided in cultural safety and trauma-informed care. New arrangements should be put in place to ensure that people with different life experiences and those living in rural and remote areas get their fair share of aged care services. The Multi-Purpose Services Program will be expanded. A dementia support pathway will be introduced.

A Commissioner of Aboriginal and Torres Strait Islander Aged Care will oversee the transformation of aged care services for Aboriginal and Torres Strait Islander people and create a new flexibly-funded Aboriginal and Torres Strait Islander run service pathway within the aged care program to deliver culturally safe care.

Younger people will not enter residential aged care and will be supported to move to more suitable accommodation over the next couple of years as the National Disability Insurance Scheme and the Australian and State and Territory Governments provide more appropriate, alternative accommodation and support services for them.

For those older people with disability, our recommendations will ensure that they have access to the same level of supports in aged care as would be available under the National Disability Insurance Scheme to a person under the age of 65 years, regardless of when the disabilities were acquired. This remedies a grossly unfair gap in access to supports for older people with disabilities.

Love, commitment and service

Throughout this inquiry, I have been touched by the love and commitment to older people from families, friends, volunteers, and others who take on an informal caring role. It was through their efforts that this Royal Commission was established, and it is to their efforts that I return in our recommendations.

The aged care system depends on the contributions of informal carers. It should not take for granted their willingness to contribute. The importance of informal carers to the people they care for and to the aged care system more broadly needs to be better recognised. The caring role can have a profound impact on the lives of informal carers. While I have heard that caring for an older person can be a privilege, I have also heard that it comes with real sacrifice. Carers have described feelings of exhaustion, grief and sometimes frustration. Informal carers have reduced opportunities to participate in paid work and manage their financial and other responsibilities. Their own health and social needs are often compromised as the needs of those they care for increase.

There needs to be proper support for informal carers. The future aged care program should ensure that informal carers are helped to look after their own health and wellbeing. Informal carers need access to support services early in their caring role. My Aged Care and the Carer Gateway should be linked so that informal carers need only use one system to secure respite and the full range of information, training and support services available to them. This should be complemented by the creation of a community-based carers hub network which will provide access to information, advice and practical support in local communities.

The needs of informal carers should be recognised in their own right as part of the assessment of the care needs of the older person. This will add significantly to the holistic nature of the assessment and planning process.

Respite care must be seen as a core part of the aged care system. A new respite support category should be created in the aged care program to ensure respite is properly resourced and delivered. Greater availability of respite will mean that carers can have regular breaks that allow them to attend to other responsibilities or to sustain their personal wellbeing through leisure, interests and self-care without worrying about who will care for the older person. This in turn will sustain and support the caring relationship.

There are currently no provisions in the National Employment Standards for an employee to take extended unpaid leave for the purpose of caring for an older family member or close friend. Flexibility of this nature could relieve some of the burden on informal carers. As the population ages, the availability of informal carers for periods of one or two years will be even more important as workers will be reluctant to leave the workforce if they cannot be guaranteed their job later. That is why I recommend that the Australian Government should examine the potential impact of amending the National Employment Standards of the *Fair Work Act 2009* (Cth) to provide an additional entitlement to unpaid carer's leave.

We also recommend that aged care volunteers be supported and trained to work with older people so that they might reduce older people's social isolation and help them to live a dignified and meaningful life.

Care standards, the duty of care and integrated care

The standard of care generally available to older people needs to be improved. In research work commissioned by us, the University of Queensland found that 11% of residential care services delivered poor quality care, 78% delivered average quality care, and only 11% delivered high quality care.²⁹ In research also commissioned by us, the University of Wollongong found that almost 58% of residential care services had 'unacceptable' staffing levels.³⁰ According to the Australian Department of Health, Home Care Packages deliver only half the hourly value in care services that they did ten years ago.³¹ Our 2019 hearings highlighted the paucity of care in a number of areas, the level of substandard care, the 'time-clock'-driven nature of much care delivery to the exclusion of engagement with older people, and the failure of providers to prioritise care levels above financial motivations and profits. This is unacceptable in a wealthy country like Australia.

The new Act will include a duty to be imposed on approved providers to ensure that the nursing and personal care they provide is safe and of high quality so far as is reasonable, and that their workers providing nursing and personal care services have the experience, qualifications, skills, knowledge and training required to perform the work that they are doing. A failure to comply with this duty will expose a provider, and its key personnel, to a civil penalty. This powerful new duty will, for the first time, make clear to approved providers and the regulator that their primary responsibility is to protect the health, safety and wellbeing of the older people entrusted to their care and oversight. The duty will provide a level playing field, in which good providers are incentivised to prosper.

It is apparent that there is not the same level of effort being put into setting aged care standards as there is in the health system, and that the current system is subject to a great deal of provider influence under the guise of 'red tape removal'. We consider that the setting of aged care quality and safety standards should be the responsibility of the independent health standard setting body, to be renamed the Australian Commission on Safety and Quality in Health and Aged Care.

The expanded Commission should be tasked with the immediate review of the Aged Care Quality Standards to raise the bar in terms of best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention and mobility, infection control, palliative care, dementia care, provider governance, and nutrition. The standards should be regularly reviewed and expanded with a view to raising the bar even further over time. They should incorporate staffing levels, staff development and training requirements, advance care plans, diversity and quality of life requirements. Severe limitations should be imposed on the use of physical and chemical restraints.

The Commission should also take carriage of the setting of quality indicators for all aged care services. Access to reliable and consistent quality indicator data will assist older people and their families to decide which providers deliver the best care services in the most dignified and respectful way. It will enable policymakers and regulators to benchmark performance against the quality indicators, inform their decisions about pricing services and regulating them, and provide the basis for a system of star ratings that will further assist older people and their families to make decisions about their care. Over time, poorer-performing services will be exposed and either be rejuvenated or closed down.

We further recommend that the Australian and State and Territory Governments establish a new National Cabinet Reform Committee on Ageing and Older Australians. This Committee will have a key role in the implementation of those critical elements of our reforms that will require the cooperation of the States and Territories. While aged care is an Australian Government responsibility, essential elements of the care for older Australians, such as housing, allied health and hospital care and palliative care, are delivered by State and Territory Governments. All levels of government need to be working together if we are to rise to this national challenge.

The Committee should oversee cross-jurisdictional implementation of our recommendations and be tasked with the development of a strategy to deliver an integrated system for the long-term care and support of older people, providing for their needs for welfare support, community services directed at enhancing their social participation, housing, health and aged care, in an integrated way. Key objectives would be: to encourage people as they age to take active steps to preserve and maintain their health and wellbeing in later life; to enhance ways within local communities to foster inclusion and encourage older people to engage with their friends, neighbours and community; and to put in place arrangements to facilitate the provision of a complete suite of supportive services that will enable older people to have the best life possible.

Care workers are properly valued

Most of the money spent in aged care is spent on the workforce. More needs to be spent to deliver better quality and safe aged care. Aged care is a worthy profession, and it needs to be appreciated as the key means to keep the aged care system safe and of high quality.

A sufficient, committed and high quality workforce is one of the main factors affecting the quality and safety of aged care. If an aged care worker is well educated and trained, has the right attitude of respect towards older people and their supportive caring work, and is increasingly experienced, older people will receive better care. As a society, we cannot continue to undervalue the work performed in aged care.

One of the great tragedies of the aged care system is that, due to the weakening of qualified staff requirements, providers have been able to reduce the number and proportion of nurses working in the system and increase the proportion of lowly paid care workers. This extraordinary state of affairs has been identified in a series of inquiries but has largely gone unnoticed publicly, except by the families and friends of older people receiving care, who constantly pointed us to deficiencies in nurse coverage, training, staff shortages, and low wage levels throughout our inquiry.

The conjunction of COVID-19 with our inquiry created impetus to rethink and consider restructuring the aged care workforce. The community as a whole needs to reflect upon the value of aged care workers and the essential nature of the work they do, and to pay them accordingly. The pay gap between nurses and personal care workers in aged care and in the health system should be addressed through the Pricing Authority initially, then through structured work value cases led by the Government and employers. Staff ratios should be introduced to ensure that there are sufficient nursing and other care workers present at all times in residential aged care.

The aged care workforce must be ‘professionalised’ if its true value is to be appreciated fully and if there are to be sufficient numbers of these essential workers in the future. By this, I mean that the aged care workforce should develop as a profession, with properly structured career paths and consistent occupational groups, job design, job pathways, training and development programs, and leadership training which support the various occupational groupings. Award wages could then be linked directly to occupational classes. While the Aged Care Workforce Industry Council Limited is best placed to lead this work, the development of a professionalised aged care workforce should be sponsored and supported by the Australian Government providing associated training and development, clinical placements and other requirements through a new Aged Care Workforce Fund.

We found to our surprise that most health and aged care education pays insufficient attention to age-related conditions and the complexities of associated health and personal care requirements. This is despite the fact that a high proportion of older people receive both health and aged care services. We make recommendations to improve education courses and training arrangements, including through mandatory units in areas such as dementia and palliative care.

To protect older people, all aged care workers should be registered, as they would be in other health professions. Registration will deliver national standardisation of entry-level and ongoing qualifications and development requirements for personal care workers, as it does for health care workers such as doctors, nurses and allied health care workers. I consider that the Australian Health Practitioners Regulation Authority is the body best equipped to perform this important function for personal care workers.

Older people get the best care from regular workers they know, who respect them and offer continuity of care as well as insights into their changing care needs and health requirements. That is why I have recommended that aged care providers preference the direct employment of workers, rather than use casuals who may be unable to provide continuity of care and form ongoing relationships with older people.

All of these measures are essential in order to lay the basis for resetting society's view of aged care as an attractive place to work, and which delivers high quality care. They are particularly important at this time when the aged care sector will be in great need of a significantly expanded local workforce due to the ageing of the population and the recommendations we make which will increase staffing levels across the board.

I am, however, very concerned that there are already shortages of nurses, allied health workers and personal care workers in many parts of the country. Workforce supply issues must be dealt with now. New workforce planning arrangements need to be set in place to provide for the projected additional 80,000 workers we will need by 2030 and 180,000 by 2050. The aged care system of the future will offer lots of new jobs for nurse practitioners, registered and enrolled nurses, allied health workers and personal care workers. Steps need to be taken now to ensure that there is a supply of well-trained people ready to enter this important profession.

Many of these new workers will be locally engaged and will need to be educated and trained. There may well be work opportunities for school leavers and people who have lost jobs due to COVID-19, so the Government and the aged care sector need to move quickly to expand aged care education and training opportunities. Special visa arrangements will also need to be considered because there is likely to be a need to bring in people from overseas to help meet the challenge.

Smarter ways of working

If the aged care sector is to provide high quality care, continuous improvement and innovation should be a part of everyday practice. This must be informed by the best available evidence from research and the means to apply it to the everyday practice of aged care. Ideally, there would be a virtuous cycle where the ambition and curiosity of those working in aged care alerts providers, researchers and government to problems and potential solutions and, together, they pursue better practice care. To make continuous improvement a reality in aged care, robust research and its translation into innovative ways of doing things are sorely needed and should be funded.

There are many areas where the aged care sector needs to innovate, and that requires a flexible and adaptive mindset within both government and the aged care sector to design and provide appropriate new services and solutions.³²

Research will have a positive impact on the lives of older people if the right projects are funded. Research funding should be allocated to projects that have strong potential to impact on aged care policy, care practices and the quality of life of older people. For research and innovation to be truly beneficial for people who provide and receive aged

care, it should not be conducted distantly from the direct delivery of care. Our vision is for universities, independent research institutes, training authorities and approved providers to work together to create places where research, evaluation, training and real-world practice can intersect. As well as being places of care, education and training, there should be places where researchers and technology developers can access real care environments and work directly with people receiving care, employees, training and education specialists and students to co-design and evaluate new and innovative care models and technological support and solutions. We have recommended a new Aged Care Research and Innovation Fund to lead and coordinate this important work.

The immense power of data to produce a comprehensive picture of changes in a person's health, service use and wellbeing needs to be harnessed by the aged care sector. Data collection and analysis can support comparisons of providers across the sector, through benchmarking and star ratings. It can improve the safety of medicine use, promote accountability, and improve decision-making within the aged care system. Without adequate data, longer-term improvements in the quality and safety of care cannot be properly measured or evaluated.

The existing data sources and repositories about the aged care system are varied in terms of scope, purpose, accessibility and usefulness in assessing the performance of the aged care sector. Despite the number and sophistication of these existing data sources and integration projects, no single, reliable data source exists that is accessible to all who have a need or a right to know about the quality and safety of aged care services in Australia.

Aged care researchers should be able to draw on a national data system. We recommend a purpose-built national aged care data asset to be run by the Australian Institute of Health and Welfare, which would be required to collect, store and maintain the data, create minimum data sets, analyse the data and make it available publicly in a timely manner. It is only in this way that the Australian public will be able to understand the needs of older people and monitor the quality and safety of aged care services. A reliable base of data is essential to support proper accountability measures for the system.

The new aged care system will need to be supported by an information and communications system that is vastly evolved from the systems that exist now. New information and communications technology architecture is needed to define and connect nodes within the aged care system and enable data and information to efficiently flow between all users. Given the fragmented nature of the aged care system, the role of developing a modern information and communications strategy for the sector should be driven by the Australian Government. It is most important in light of the rapid pace of technological change and the advances in data analytics over recent years that the Government draws on a wide range of resources and experience in developing the new information technology and communications architecture for the sector.

There are many digital technologies that can support aged care providers and their employees to deliver high quality and safe care. These include tools that assist in human resource management, staff communication and training and education. These technologies are particularly valuable when they enhance the relationship-centred nature of care by reducing the time workers spend on non-direct care tasks. It is evident, however,

that the aged care system does not adopt new technologies quickly enough or widely enough. In fact, we encountered a reluctance from some providers to see such investment as part of their core business. Being a ‘people business’ does not mean that aged care can avoid being a ‘technically enabled business’.

Aged care providers should be actively supported to adopt new technology and to support older people to engage with technology that improves their quality of life, wellbeing and care. The workforce will also need to be supported and encouraged to embrace the shift toward new technology and electronic information and data collection.

Technology can help older people to remain living at home for longer and enhance their quality of life. Through supporting older people and their carers to engage with technology, it may be possible to delay, or in some cases avoid altogether, entry into residential care. Technology should also be front and centre when an older person is being assessed for their eligibility for aged care. When an Aged Care Assessment Team assessor is assessing a person for care—irrespective of whether it is home care or residential care—consideration should be given to how assistive technology can improve their care and support their quality of life, and if the older person is open to using it or being trained to do so, because many are very willing.

A fair share of health care

Under Medicare, all Australians are entitled to receive the health care that they need. Older people have higher than average health care needs, yet many struggle to receive health care proportionate to their needs because they cannot get to see a doctor or their needs are given less priority than younger, fitter people.

At community forums and public hearings, we heard many stories about older people not receiving the medical care they needed as and when they needed it, with a number experiencing horrific pain, being hospitalised or dying as a result. Medical specialists, such as specialist physicians, virtually never visit residential care, and older people struggle to get out to see them. The Australian Medical Association told us that 1 in 3 general practitioners are intending to stop taking on new patients in residential aged care, reduce their visits or stop visiting nursing homes. There is insufficient funding to entice doctors to visit older people where they live. The fee-for-service payment system is not delivering the coordinated and team-based care that is needed to optimally manage chronic and complex conditions. In the words of the then President of the Australian Medicare Association, Dr Antony Bartone:

What we’re seeing now is an increased...understanding that fee for service alone will not support the increase in chronicity of care, the increased complexity of care and the increase in non-face-to-face care...

So, not only in aged care, but right across the whole primary care spectrum, we’re now looking at a blended payment of funding. More so than any of those other spectrums... aged care would really be a screaming example, in my opinion, of where that blended approach needs to be considered even more so.³³

Something has to be done urgently to make the Medicare system work for frail and vulnerable older people. The only way to do this is to adopt different ways of supporting and delivering health care for older people receiving aged care.

We have developed a new, generously funded and voluntary primary health care arrangement that extends the reach of Medicare to accredited general practices to meet the primary health needs of older people receiving residential care or personal care at home. In the model we recommend, doctors will agree with each older person choosing to participate and their aged care provider how their health care will be provided, and put in place an ‘Aged Care Plan’ with a focus on active prevention and management of ill health and complex conditions. Other health professionals, such as physiotherapists, may also be included in an interdisciplinary team as required to deliver health care. The holistic, team-based care will be funded through a capitation model, based on each older person’s assessed need, which will be developed with the medical profession. The new Medicare strand of primary health care should not be trialled, but implemented in full. We know that fee-for-service medicine is failing older people receiving care; we know how to address complex health care needs; we know what needs to be done; and we should do it—implement in full the new primary health care model that we recommend.

Proactive local health networks in the States and Territories have developed multidisciplinary hospital outreach teams of medical specialists and other health practitioners who visit residential care services to deliver more complex health care, including palliative care. They are successful, but there are nowhere near enough of them. We recommend that the National Health Care Reform Agreement be amended so that all people receiving residential care or personal care at home have access to these invaluable services, and that the range of specialist services is extended to enable the full range of conditions to be covered.

Older people are more likely than others to have poor oral health. Many of them cannot afford private dental care and must wait years for public dental health care; others have reduced capacity to undertake oral hygiene routines. The neglect of oral health in residential aged care was among the many terrible stories we heard over months of hearings in 2019. Poor oral health is very serious medically because it can contribute to chronic medical conditions, such as diabetes, respiratory diseases and cerebrovascular diseases, as well as to severe pain, discomfort, functional impairment and restrict an older person’s ability to eat, speak and socialise. Older people can be freed from much of this pain through the new Senior Dental Benefits Scheme that we recommend. The scheme will fund dental services for people who live in residential care and older people who live in the community and receive the age pension or have a Commonwealth Seniors Health Card. It will be limited to treatment required to maintain functional dentition and will be an important health prevention intervention.

We also recommend a number of changes: to improve older people’s access to mental health services and rehabilitation; to improve transitions between aged care and hospital care; to provide comprehensive medication management reviews by pharmacists to prevent harmful medicine interactions, overuse of medication or chemical restraint via inappropriate use of antipsychotics; to have more rural health outreach services; and to improve data sharing to facilitate better health care for older people.

A step up for Government

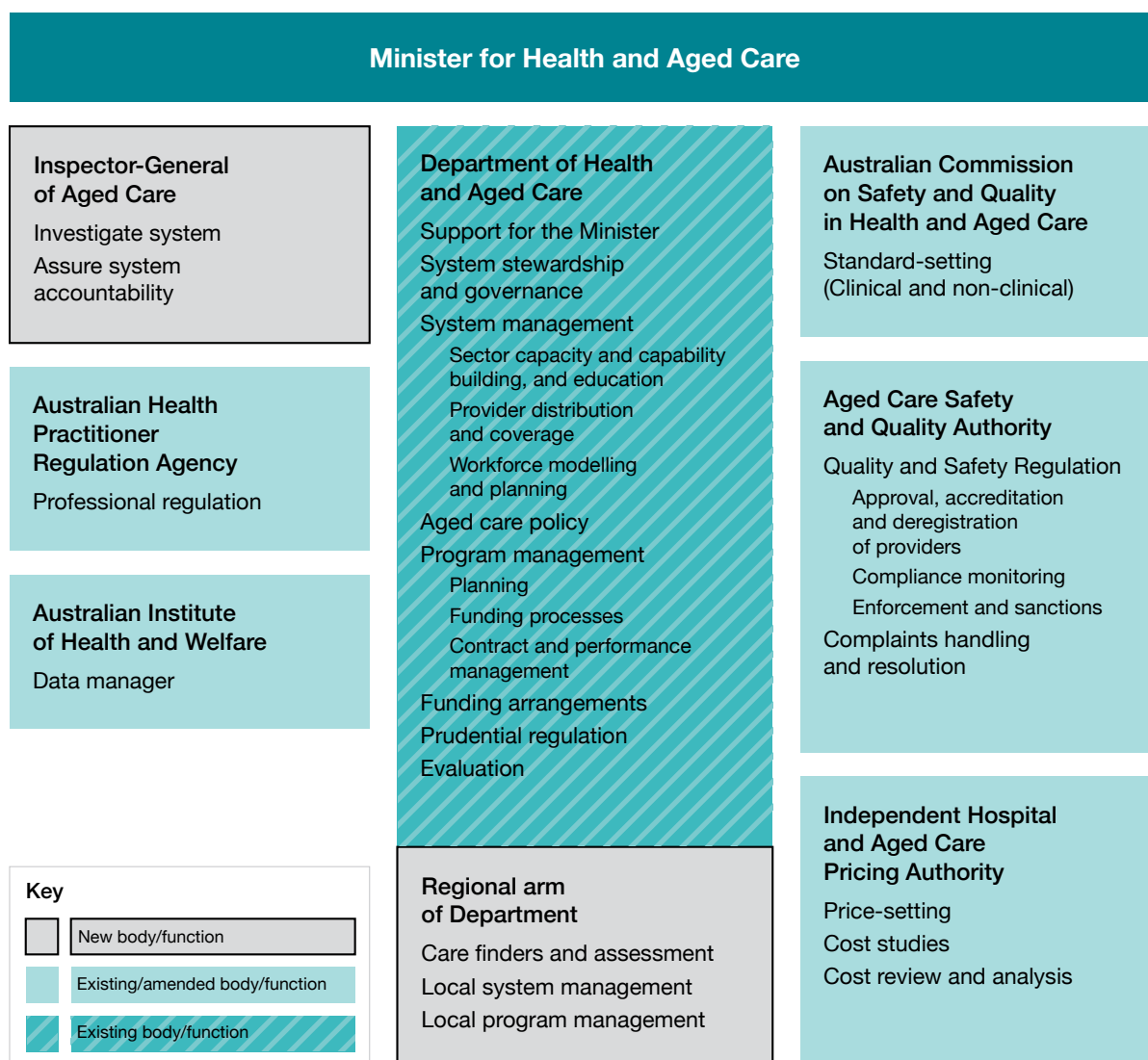
There are two main problems with the governance of the aged care system—that successive governments have misunderstood and not fulfilled their responsibilities, and that the institutional structure is inadequate to ensure the delivery of high quality aged care. At times in this inquiry, it has felt like the Government's main consideration was what was the minimum commitment it could get away with, rather than what should be done to sustain the aged care system so that it is enabled to deliver high quality and safe care. This must change.

The Government must step up and embrace its responsibilities for aged care. Aged care is a social service, not a commodity that can be outsourced so that it can be bought or sold at the lowest price. The Australian Government has a responsibility to lead and manage the delivery of this important service, and it must fund the system at a level sufficient to provide high quality and safe aged care. After all, the Government performs these roles on the behalf of the entire community.

It is clear that successive governments have not understood that responsibility for a distributed system like aged care requires hands-on management on the ground, including meaningful engagement with providers and centralised system stewardship, as well as effective governance institutions. Importantly, it requires the Government to accept its responsibility to lead the aged care sector and to drive continuing reform of the sector so that reforms to improve the aged care system are rolled out progressively and driven in such a way that they are successful in delivering, and sustaining, high quality and safe aged care.

In my view, only Government can do this in a system as large, complex and fragmented as the aged care system. Only Government can wield the resources and system oversight to make it happen. Only Government has the cut-through capability to motivate and direct transformational change of the magnitude we recommend. Not the private sector, not the insurance sector, and not a progressively privatised administration, distant and unaccountable to the community. Only the Government; just as only the Government delivers Medicare and the social security system.

The success of our reforms will require purposeful and strategic governance from the Australian Government to steer the aged care system in the desired direction, and constant monitoring and refinement of arrangements for the continued effectiveness of high quality care into the future. I propose a Government Leadership model for governance of the aged care system. The institutions within this system are set out in Figure 1.

Figure 1: Main features of the Government Leadership model

The new, enriched role for Government in the aged care system should be focused on ensuring the safety, health and wellbeing of people receiving aged care and that older people come first, so that their preferences and needs drive the delivery of supports and care services. They should do so in ways that reflect the core values of putting older people first, in a system of care that is equitable, effective, ambitious, accountable and sustainable. The Minister responsible for aged care must be in Cabinet as the Minister for Health and Aged Care, maintaining the critical and close links between health and aged care.

The next step is for a renamed Department of Health and Aged Care to also step up and embrace the role of steward of the aged care system. It can no longer be a distant and seemingly disengaged player, providing commentary to Ministers but not driving the aged care system forward. It should partner with older people and service providers to discover and embed best practice or to develop and foster the energy and curiosity that looks for new and better ways to do things that improve the lives of older people.

Befitting the precious and highly valued nature of aged care services to older people and Australians generally, the Department's system stewardship and leadership role needs to be purposeful, active and engaged in the quality and effectiveness of the system. It will need to not only oversee, but also to nurture the system. It can do this by: listening first to older people; facilitating research and innovation; ensuring the development of workforce capabilities; carefully educating and assisting providers to deliver better services; leading other government agencies and coordinating reforms with stakeholders; establishing a local network of people to assess and assist older people and work with providers; and reviewing the system for necessary improvements and then implementing them. This will require a change in mindset, in culture and direction for the Department. It will necessarily greatly involve increased resources, capability enhancements and a dual policy development and localised program delivery focus, as well as high level networking and coordination.

I am confident that the transformation of the Department is achievable. It is also necessary, to ensure that the transformation of the aged care sector that we recommend occurs quickly and effectively.

The alternative of establishing a new Australian Aged Care Commission will only delay the important reforms that are required for the delivery of aged care services. I have observed and participated in many machinery of government changes over the years, with agencies moved in and out of 'core government' and combined and separated. They create destructive instability, confusion and uncertainty which distracts leadership and workers alike and diverts attention from reform. This cannot be allowed to occur in aged care where the level of substandard care is so high as to be completely unacceptable; where the extent, depth and spread of reform and change necessary to fix the system is enormous; and where sensible and timely action on many fronts is required. The Department of Health and Aged Care is the only agency with the expertise and experience to lead the implementation of our recommendations, but it needs to be better funded to be able to do so.

In addition to the cost and inevitable delays in setting up a new body, I am concerned that the creation of a new, arms-length Commission to oversee the delivery of aged care services would weaken the direct accountability of Ministers for the quality of aged care. While the Independent Commission model acknowledges that there would continue to be a Minister responsible for aged care, it also requires that the Commission should be independent of the Minister. One of the problems with the aged care system as we found it was the reluctance of successive Australian Government Ministers to take responsibility for the quality and safety outcomes of the aged care system or to lead and manage the delivery of better services. In a democracy, the ultimate accountability for the performance of government has to rest with Ministers through the Parliament. Ministers should be responsible for deciding on the balance between competing social values and objectives, not non-elected technocrats operating behind a corporate veil. The last thing the aged care system needs is an arms-length body that can be blamed for service delivery while the Minister retains the funding and policy powers that largely determine the outcomes that the agency can achieve. Ministerial accountability for aged care needs to be strengthened, not weakened.

I am also concerned that the structure of the new body will lead to dysfunctional governance. It is proposed that the Commission would subsume many of the functions currently performed by the Department and the Aged Care Quality and Safety Commission and take on some new or enhanced roles. These functions would be divided between Assistant Commissioners who would be appointed as statutory office holders. I am not aware of any other Australian service delivery agency organised along these lines. In my view, the organisation of aged care functions in this way would further fragment the delivery of aged care services and stymie necessary reforms.

It also seems to me unacceptable that decisions about the regulation of the quality and safety of aged care, including the sanctioning of providers, or the management of complaints, should be made by a Presiding Commissioner or its executive board, which would also have system management and program delivery functions that could conflict with those regulatory responsibilities. The Australian Government deserves some credit for establishing an aged care regulator separate from the program delivery agency, and combining these functions again would be a retrograde step.

In our inquiry, we found that a number of other important system governance functions are either not being done or are done suboptimally. My focus has been on improving the quality and safety of aged care quickly and effectively, rather than on creating new institutional structures with associated problems of overlapping functions, inconsistency of approach, and fragmentation of expertise. Wherever desirable and feasible, I have prioritised enhancing well-performing, independent and expert Government organisations by giving them new aged care functions. I recommend that:

- aged care standards setting be allocated to the renamed Australian Commission on Safety and Quality in Health and Aged Care
- the costing of, and associated pricing and funding arrangements for, aged care services be allocated to the renamed Independent Hospital and Aged Care Pricing Authority
- aged care data management functions be allocated to the Australian Institute of Health and Welfare
- professional registration of personal care workers be allocated to the Australian Health Practitioner Regulation Agency.

Quality and safety regulation deserves particular attention. World best practice involves the structural separation of policy and funding from regulation. The Government recognised this when it established the current quality regulator, the Aged Care Quality and Safety Commission, in January 2019. The Aged Care Quality and Safety Commission has been under-resourced and lacks the capacity and capability to perform its functions. It also lacks the independence that this important function requires. I propose that it be replaced by a stronger, independent regulator, whose role would be to safeguard the quality and safety of the aged care system. There should be a strong focus on gatekeeping, complaints investigation, compliance monitoring and enforcement. The regulator would exercise tight controls on the suitability and capacity of providers entering the system and would exercise vigorous sanctions against those providers failing to meet high quality care standards and their duty of care, including withdrawal of their accreditation and approved

provider status so that they can no longer endanger the safety and wellbeing of the older people entrusted to their care. Its independence from Government would be increased by establishing it as the Aged Care Safety and Quality Authority, answerable to a governing board (with clinical and regulatory expertise and community representation), by fully funding it from Government appropriations, and by requiring it to report publicly on its performance, operations and effectiveness.

We also recommend that an independent Inspector-General of Aged Care be established to conduct systemic reviews and provide independent oversight of the aged care system. It will hold other institutions operating in the system to account, and report annually to the Parliament on systemic issues and the extent to which the aged care system meets the objectives of the new Act.

Provider governance

We were unable to consider market dynamics to any great extent in our inquiry, but several issues did emerge. First, the market share of profit-making providers has increased substantially in the last ten years to 40% of residential care places and 21% of Home Care Packages. This means that mission-based, social purpose and government aged care services have lost out to the expansion of the private sector. Second, market consolidation has quickened, with extremely large providers now holding 39% of all residential care places and providing 47% of all paid Home Care Packages. This has reduced competition, especially in rural areas. These trends are important when matched against quality indicators because private providers have much worse quality outcomes than government and not-for-profit providers. In effect, the increasingly private composition of the market has placed further pressure on quality and safety in aged care.

I was told repeatedly in community forums that aged care should not be seen simply as an opportunity to make money and that quality and safety should never be traded off for profit. I agree. The Australian Government has a critical stewardship role in determining who should be allowed to deliver aged care on its behalf. The Government needs to take a more active role in guiding and shaping the aged care system to ensure an appropriate mix of suppliers and to avoid undue consolidation. It should be actively supporting social impact investment and increased social purpose and mission-based aged care.

The current system provides few incentives to motivate good providers to continue to provide high quality care when they are undercut by poor providers, who get away with providing lower standards of care. The Government therefore also needs to do more to ensure that there is alignment between its objectives in maintaining high quality and safe aged care and the operational incentives that drive the day-to-day decisions that determine the quality of care actually experienced by older people and their families and carers. It should be vigilant as a gatekeeper and in keeping providers up to the mark. It should reward good providers.

The investors and managers who provide aged care services also need to take responsibility for the choices that are made in how aged care services are delivered. If aged care service providers are not prepared to operate as social enterprises, I am not sure

that they should be in the business. 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. This should be the case irrespective of the size of a provider's ownership and business models. Organisational culture and governance arrangements must be designed around this core purpose.

Our recommendations to establish a statutorily based duty of care send a clear message to providers, the community and the regulator about the primary duty of an approved provider—to protect the health, wellbeing and safety of its residents. In the future, the leaders of aged care providers will have an obligation to deliver high quality and safe care, and they will be expected to demonstrate to the regulator that they have the necessary systems, structures and skills to meet this obligation. They will need to establish appropriate care and clinical governance arrangements and ensure access to skilled and well-trained staff.

Every single provider should be thinking about, and talking with the older people in their care and their workforce about, what they need to do to improve their care and to make a genuine difference to the lives of older people. The rewards will be immeasurable.

Providers will need to lift their game to meet these new requirements. They will also need to embrace the concept of accountability and its benefits including by promoting open disclosure and good complaint handling within their organisations. Poor complaint handling and a lack of open disclosure can be a reflection of the poor culture of an approved provider, or a particular service.

Increasingly, aged care providers are represented and supported by several industry bodies, which are very effective lobby groups for industry interests. There are also a few aged care organisations that have the size, leadership and capacity to participate actively in aged care policy discussions and who drive reform. Too often the voices of powerful lobby groups have stymied reform that would improve the quality and safety of aged care. As Professor Ron Paterson ONZM observed, the voices of providers are prominent in the Australian aged care system but the voices of older people, families and consumer advocates are relatively weak.³⁴

Australia needs more approved providers who strive for excellence, who are driven by social purpose and who share their insights into how to achieve aged care quality and safety on the ground. The aged care system needs highly committed and active leaders from within the system—Chairs, CEOs and Directors of Nursing who are prepared to accept that the aged care system is in crisis and who want to commit to implementing not only the reforms advocated by us in this report, but to driving further reforms. The recommendations from our Royal Commission give providers a once in a generation opportunity to make a fundamental difference to the quality and safety of aged care.

We considered provider governance extensively, and we have made a series of recommendations for improvements which reinforce the need for boards and executives to act responsibly and appropriately; to lead their services with the interests of older people at heart; and to be more open and transparent about the quality performance of their services.

We recommend a new governance standard and governance support for providers. And I recommend that the quality regulator considers in its approval and accreditation processes the leadership, cultural and workforce development actions of providers.

Open, accountable and honest

A lack of transparency and accountability is a pervasive feature of the current aged care system. The consequences for the quality and safety of care have been profound. The aged care system needs to be far more open to feedback on its own performance and more accountable to older people receiving care and the community more generally. Aged care providers must acknowledge their shortfalls openly before they can begin to change.

Dr Ben Gauntlett, Disability Discrimination Commissioner, told us that transparency can allow light to be shone on practices that may otherwise remain hidden.³⁵ It is disturbing that the numbers of young people in residential aged care, the prevalence of the use of physical and chemical restraints, the frequency of assaults in aged care and other instances of abuse and substandard care that we have uncovered in the course of our inquiry have remained hidden for so long in this opaque system. Professor Debora Picone AO, Chair of the Australian Commission on Safety and Quality in Healthcare, said:

There's strong evidence that promoting transparency will also inform the choice of the consumer by providing them with direct information. It certainly stimulates improvements in quality and safety and it also holds the provider accountable for the delivery of health services.³⁶

It is critical that the public has access to information that provides a meaningful overview of the performance of individual services and providers, in an accessible and easy-to-understand form. Without this information, older people are unable to exercise the choice that would drive improved performance over time. If this information is not routinely available, it is difficult to see how the Government can effectively manage the system and how older people and the wider community can hold government agencies and service providers to account for the quality of the care for which they have been responsible.

We recommend a series of reforms that should make the aged care system more open, transparent and accountable. This will require an investment in transparency and culture change that favours open access to information over secrecy, and continuous improvement over denial.

In the first instance, the Australian Government should facilitate the development of an authoritative data collection on the needs and preferences of older people and on their experiences of aged care. That database should be routinely available to researchers and commentators so that they can understand what is happening inside the aged care system and to assess alternative policy and service delivery options.

Existing secrecy provisions that are 'hardwired' into the aged care system that unnecessarily limit access to the performance of service providers should be removed. This should be accompanied by the mandatory publication of information about the governance and capabilities of service providers, and about the performance of individual providers and of the aged care system as a whole.

The star ratings system—with one to five stars and five being the highest—will provide the public with graded assessments of services' performance against standards, as well as information on services' performance against relevant clinical and quality indicators, their staffing levels and robust information from people receiving aged care services, their families and advocates, when available.

The star rating system should, in my view, be supported by more transparent information on regulatory strategies and outcomes. The quality regulator needs to be more accountable for its performance and be ready to adjust its strategies on the basis of experience. This should provide service providers with a more predictable regulatory environment while informing older people about the quality of the service they should expect to receive.

Better information needs to be provided for older people on opportunities within the system for complaints and redress against poor care, including access to advocates. The quality regulator also needs to provide much more detailed information on the number and nature of complaints against specific providers or services and on the outcome of those complaints.

The Inspector-General of Aged Care will report annually on administration and governance of the aged care system, and the Department of Health and Aged Care will provide a triennial report to Parliament on aged care system performance, including directions for future reform, both of which will increase accountability and transparency and, in turn, honesty.

Regulation that works

Aged care regulation is about protecting and safeguarding older people receiving supports and care. It needs to be both effective and fit for its purpose. Older people need to have confidence that the aged care system will be effectively regulated against high standards, and that the regulator will act promptly and will deal severely with substandard care.

The current regulatory arrangements lack the effectiveness that should be expected of a contemporary regulatory regime. The oversight of residential providers relies too much on a cycle of accreditation audits that is inefficient and ineffective in preventing, detecting or responding adequately to instances of substandard care, and sanctioning arrangements are ineffective. Compliance monitoring of home care providers is virtually non-existent, despite the obvious risks to people receiving care in the home. The experience of older people receiving care has been pushed to the edge of this system, with their concerns too often dismissed or ignored in the complaints process.

Overall, the system has failed to provide the assurance of quality and safety of care that older people and the community at large would reasonably expect—it is not fit-for-purpose. The regulatory regime and the approach of the quality regulator to its responsibilities need to be fundamentally redesigned so that regulation guides and shapes the performance of the aged care system.

Aged care service providers have a duty to ensure high quality and safe care delivered in a respectful and compassionate way that maintains the dignity and wellbeing of the older person. It is clear that people receiving aged care and their families want to see a regulator that is a 'tough cop on the beat' to ensure that service providers meet their obligation to provide appropriate standards of quality and safety of care.

The regulator needs to put much more emphasis on its gatekeeper functions so that older people can have greater assurance that new providers are equipped to deliver high quality and safe care before they are approved to provide services. This should include stronger tests of the suitability of key personnel to provide aged care services.

Once providers are approved, the oversight arrangements should shift from a standard accreditation cycle to ongoing accreditation with regular monitoring. The regulator needs to be out and about, observing and visiting approved providers to make sure that they understand their obligations and are meeting them. The monitoring and assessments of providers should be based on a much broader range of intelligence, such as the experience of people receiving care, complaints, reports of serious abuse or assaults, coronial reports and signs of provider financial distress, and not just on template, tick and flick inspections.

The regulator needs to be in direct and continuous contact with people receiving care, and to engage with them in assessing the quality of care they receive. It is not good enough to deal only with providers or to engage only with people receiving care through providers. The regulator should build networks with complainants, advocacy organisations and community visitors, and should supplement the views of these stakeholders with information derived from quality indicators and other sources, such as direct observation, to build a sense of the quality of care and the risks in the system that may threaten the quality of care in particular providers, regions or areas of care.³⁷ As Professor John Braithwaite said, the regulator needs to take a 'detective-oriented' approach, by using available intelligence in a strategic way to build a picture of possible concerns with an approved provider and the risks they pose to the future delivery of high quality and safe aged care.³⁸

A wider range of enforcement powers should be available to the regulator. The regulator needs to be supported and encouraged when it uses these powers to sanction under-performing providers who are placing the health, safety and wellbeing of older people at risk. More providers should be expelled from the provision of aged care.

Under the current system, providers have not been effectively held to account for their performance. The approach to regulation of the sector has failed to encourage good providers or apply effective sanctions to providers who have failed in their obligations to older people. This must change. Genuine accountability for those responsible for poor care is vital to the health of the system. There needs to be much more transparency around the performance of providers and the regulator needs to act much more decisively against poor providers.

There is a place for working with a well-intentioned provider with a good track record that is experiencing difficulties for a time, but the regulator also needs to be prepared to exercise tough sanctions when providers are placing the health and safety of older people at risk. The focus of the quality regulator should not be to educate approved providers and ‘manage them back to compliance’. It must be to make sure that older people get the care that they deserve.

In summary, the new regulatory system needs to be:

- much more rigorous in only letting into the system those providers that can demonstrate their suitability and capacity to deliver high quality care
- more vigilant and energetic in assessing the performance of providers, and
- more determined to remove from the system providers that are either unable or unwilling to deliver consistently high quality and safe care.

Fit-for-purpose funding and financing

Much of the evidence we have received during our inquiry has pointed to the inadequate funding available to provide high quality care. There are not enough staff, and many of those that are available are inadequately trained. Care has been reduced to a mechanistic process. Older people with challenging behaviours are tied up or drugged because there are not enough staff to provide proper care. Continence pads are rationed, or re-used. Unplanned weight loss is rife, because there is not enough money to buy and prepare nutritious food and not enough staff to help people who need assistance with eating. Tens of thousands of people are waiting to receive the care they need to stay at home because the number of packages has been rationed. And when they do receive a package, the most expensive package only funds eight hours of care a week—down from 18 hours when this form of care was introduced in 2001.³⁹

We were told that there has never been an assessment of how much money is required to deliver high quality care. The indexation arrangements applied to aged care payments over the last twenty years have systematically reduced the real value of the funding that is available. To make matters worse, the Australian Government has intervened from time to time to reduce indexation further to reduce growth in outlays. These limitations on funding have been a major contributor to the substandard care so many older Australians experience.

We recommend that an independent body should establish the costs of providing safe and high quality care, and determine the schedule of prices the Australian Government should pay care providers. It should base its assessment on the costs of providing care. It should also work in line with policy guidance from the Government on the improvements required to deliver high quality care. Such an independent body should also determine the funding models to be used for different kinds of care, using a mix of block and activity based funding to ensure service availability and to enhance equity.

While it is important for funding decisions to be made at arm's length from the Government, I consider that the Government should be able to override this independent determination if Parliament approves. This will ensure public scrutiny of, and accountability for, any attempt to reduce the level of funding required to deliver high quality care.

The current arrangements for determining the contribution people are required to make to the costs of the aged care services they receive have evolved in a piecemeal fashion over many years, and now produce results that are grossly unfair. Pensioners with private income of between \$23,000 and \$45,000 face an effective marginal tax rate of 99.5%. People with incomes over \$130,000 pay marginal tax rates that are lower than 50%. It is hard to imagine how these arrangements were developed. The aged care means test used to determine user contributions to these costs should be reformed to remove the double counting of income and assets that currently applies, reduce the inequitable impacts on part pensioners, and smooth transitions.

Consistent with the Medicare principle of universal access to health care without compulsory co-payments, people receiving aged care should not be required to contribute to the costs of care. I draw a distinction between care and the ordinary costs of living or the costs of accommodation, where I think older people should contribute to these services. Everybody in the community meets these costs from their income, and there is no reason why people living in residential aged care should be treated any differently.

Residential aged care providers are empowered by law to require interest free loans in the form of Refundable Accommodation Deposits of up to \$550,000 from people who do not meet the aged care means test. Even though there is an option to make Daily Accommodation Payments instead of a lump sum, we were told of providers pressuring people and their families into paying a Refundable Accommodation Deposit.⁴⁰

While access to free capital has allowed the upgrading and refurbishing of many services, we heard that 'the residential aged care sector has effectively become a property industry rather than a care industry'.⁴¹ We also heard that free capital may be encouraging overinvestment in residential care, which flies in the face of truly rational planning, especially given older people's clear preference to receive care in their own homes. We were advised that the current financial reporting arrangements do not provide a reliable basis for determining how these funds have been used by many providers. I consider that Refundable Accommodation Deposits should be phased out, and that the Australian Government should establish an aged care accommodation capital facility to replace this source of capital as well as return to making capital grants available to incentivise small-scale and congregate living.

The nature and extent of the transformational reforms that we recommend to ensure the aged care system delivers the high quality of care that reflects the values of modern Australia and the love and respect Australians have for their parents, grandparents, friends and partners will have a significant financial cost.

Many of our recommendations will have financial implications in the order of hundreds of millions of dollars per year. These include more and better paid staff, better access to more comprehensive home care, removal of co-contributions to the costs of care, equality of access for people with disability receiving aged care, an immediate increase in the Government subsidy for basic living costs, and a senior dental benefits scheme. Given the interactions between a number of these measures, we have not attempted a comprehensive costing of the full suite of recommendations. However, the extent of the reforms and size of their financial impact is so significant that they will stand beside Medicare and the National Disability Insurance Scheme as landmark Australian social policy reforms.

In my view, the additional revenue to fund the aged care reforms we are recommending should be sourced from an ongoing earmarked levy on personal taxable income of 1% to be known as the ‘aged care improvement levy’. The visibility of this levy will help taxpayers hold the Government to account as it implements reforms to improve the quality and safety of aged care in this country.

Much of the additional expenditure required is essentially catching up on the delayed indexation and inadequate level of service provision that has applied for the last twenty years. The Australian Government has enjoyed the fiscal benefit of underfunding during this time, and there is an argument that it should now make up the shortfall from general revenue. The Government must commit to improving the quality and safety of aged care as part of the Australian social contract.

The Government should, therefore, commit to cover the increasing costs of aged care above and beyond that funded by the aged care improvement levy. It should also fund the health care and disability reforms we recommend, the aged care costs of demographic changes, and further enhancements to aged care in the future in line with recommendations from Ministers for Health and Aged Care and independent agencies on standards, prices, regulation and data requirements and movements in aged care sector wages and salaries.

Thank you

It has been an enormous privilege to be a Royal Commissioner. It has provided me with a very great opportunity to make a difference to the lives of all Australians, and I am hopeful that we have delivered on your expectations.

I am grateful to many people for the opportunity. I would like to thank the people of Australia and the Australian Government for supporting and contributing to the work of this Royal Commission. I especially want to thank all of the people and organisations who appeared before us in hearings, workshops, community forums and roundtables, and who provided submissions and ideas about the aged care system. Your contributions have been invaluable to our work.

Thank you to my three Commission Chairs, especially Commissioners Tracey and Pagone, for their fellowship and engagement. Our staff—our official secretary James Popple, the barristers and solicitors, the senior advisers and consultants, and the policy and research and corporate staff—have worked around the clock to make the Royal Commission effective and to deliver all of our reports. People like Patrick Allington, Zoë Gill, Peter Gray, Meredith Hagger, Sue Jarrad, Richard Knowles, Rachel McDonald, Peter Meere, Beth Midgley, Mary Ann O’Loughlin, Tara Philip, Rodger Prince, Nikki Prouse, Peter Rozen, Cabrini Shepherd, Carolyn Smith, Chloe Stoddart, Sam Thorpe and Grant Whitesman deserve special mention. Their passion for older people and their circumstances has been exemplary. I thank you all sincerely.

Finally, and at a very personal level, there have been some people who have gone above and beyond the call of duty to support me and who have moved mountains to deliver our very best work—Louise Amundsen, Barbara Carney, Roger Fisher, Rod Halstead, Charles Maskell-Knight and Sara Samios. I am indebted to you for your considerable contributions, your intellect, your knowledge, and to your good spirits and perseverance. Thank you.

Conclusion

In our Interim Report, Commissioner Tracey and I said:

This cruel and harmful system must be changed. We owe it to our parents, our grandparents, our partners, our friends. We owe it to strangers. We owe it to future generations. Older people deserve so much more.

We have found that the aged care system fails to meet the needs of our older, often very vulnerable citizens. It does not deliver uniformly safe and quality care for older people. It is unkind and uncaring towards them. In too many instances, it simply neglects them.⁴²

Life is to be lived. No matter how old we are, how frail or incapacitated we might be, how rich or poor, we all have the fundamental right to wellbeing, enjoyment and fulfilment as we age. In order for this aspiration to become reality, our aged care system must be founded on the principles of unfailing compassion—care, dignity and respect. In the words of our oldest witness, Ms Eileen Kramer:

I don’t feel old. I don’t want to behave old. But I realise that the spirit has a house to live in and that house is our body, so we have to look after that. And that’s what aged care is about, in a way. We have to look after that house so that our spirit can enjoy life. Mine does.⁴³

In this, our Final Report, Commissioner Pagone and I present a comprehensive plan for reform of the aged care system designed to deliver high quality and safe aged care with dignity and respect. We encourage the community to maintain their interest in this important area of public policy and to continue to press for improvements in the care of our elders in their most vulnerable years.

It is really important to remember that this Final Report is just the beginning. It is now time for the Australian people, governments, providers, workers, carers and volunteers to take our recommendations forward in the spirit with which they are intended, and truly transform Australia’s aged care system. And keep on doing so!

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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 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 reablement. 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 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

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2. Approach to the Inquiry

2.1 Introduction

The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018 by Letters Patent issued by the then Governor-General of the Commonwealth of Australia, His Excellency General the Honourable Sir Peter Cosgrove AK MC (Retd). The Letters Patent required the Royal Commission to inquire into the quality and safety of care provided in residential aged care facilities and community and flexible aged care settings. They formally appointed the Royal Commissioners and outlined the Royal Commission's key areas of inquiry, which we refer to throughout this report as our Terms of Reference. These were developed by the Australian Government, following a consultation process announced by the Prime Minister on 16 September 2018.

The Letters Patent of 8 October 2018 appointed the Honourable Justice Joseph McGrath as Chair and Ms Lynelle Briggs AO as Royal Commissioner. Those Letters Patent were revoked and replaced on 6 December 2018, when Justice McGrath stepped down from his position as Chair. The replacement Letters Patent appointed the Honourable Richard Tracey AM RFD QC as Chair and Ms Briggs as Royal Commissioner.

The Letters Patent of 8 October and 6 December 2018 required delivery of the Final Report no later than 30 April 2020. On 29 July 2019, Commissioners Tracey and Briggs wrote to the Prime Minister requesting an extension of time. On 13 September 2019, the Governor-General, His Excellency General the Honourable David Hurley AC DSC (Retd), issued further Letters Patent. These amended Letters Patent extended the date for delivery of the Final Report until 12 November 2020. The amending Letters Patent also appointed a third Commissioner, the Hon Gaetano (Tony) Pagone QC, including to act as the Chair of the Royal Commission during any period, or during all periods, when Commissioner Tracey was absent from duty or from Australia or was, for any reason, unable to perform the duties of the Chair.

Commissioner Tracey died on 11 October 2019. On 14 October 2019, we spoke in honour of Commissioner Tracey at a hearing of the Royal Commission held in Melbourne. Commissioner Pagone said:

He had, by any measure, a distinguished career as a lawyer, as a jurist and, I must say, from my experiences of him, he was a remarkable friend. He had a selfless drive and energy which he blended with good humour and compassion...His work on this Commission has also been solid, selfless and significant.

Commissioner Briggs said:

Few people ever have the privilege to be a Royal Commissioner but Richard was made for it. He was experienced. He was wise. He was admired. He knew the law like the back of his hand. He was prepared to take a punt if it meant getting a better outcome for older Australians.

On 31 October 2019, Commissioner Briggs presented the Interim Report to the Governor-General. The Interim Report was authored by Commissioners Tracey and Briggs. This Final Report is authored by Commissioners Pagone and Briggs.

On 20 March 2020, we had to suspend hearings, workshops and group consultations due to the COVID-19 pandemic. The need to suspend hearings recognised that meaningful engagement with the aged care sector, paramount to our work, could not proceed given that aged care providers, the Australian Government, including the Department of Health, and other key stakeholders were focused on the pandemic. Also because of the COVID-19 pandemic, we extended the deadline for public submissions from 30 April to 31 July 2020. Submissions relating specifically to COVID-19 were open until 4 September 2020.

On 20 April 2020, we wrote to the Prime Minister, requesting a further extension of time. We sought this extension because of delays in public hearings and other public consultations caused by the pandemic. We also needed time to consider the impact of the COVID-19 pandemic on older people and the aged care sector. On 25 June 2020, the Governor-General issued further Letters Patent. These amending Letters Patent extended the date for delivery of the Final Report until 26 February 2021. The Letters Patent also confirmed Commissioner Pagone as Chair of the Royal Commission.

The three extant Letters Patent—those of 6 December 2018, 13 September 2019 and 25 June 2020—are reproduced below.

On 15 July 2020, public hearings recommenced. Due to the ongoing impact of the COVID-19 pandemic, witnesses generally appeared via video link. Although hearings from this time on were closed to the public and the media for public health reasons, they were live-streamed from the Royal Commission's website.

General submissions closed on 31 July 2020, although submissions continued to be accepted on several specific topics after that date.

On 30 September 2020, we presented a special report on COVID-19 to the Governor-General. The special report is republished in Volume 5 of this report.

On 22–23 October 2020, Counsel Assisting presented their final submissions at a hearing. Some 376 public submissions were received in response to Counsel Assisting's final submissions. We have considered both Counsel Assisting's submissions and those responses in finalising our recommendations.

2.2 Staffing and structure

The Office of the Royal Commission was established in October 2018 to support us to complete our inquiry. The Office was led by an Official Secretary, who was supported by a team of Senior Executive Officers. A small group of Senior Advisers was engaged to provide strategic and expert advice to Commissioners. A small group of Clinical Advisors was also engaged.

Counsel Assisting were responsible for preparing for, and leading the evidence at, public hearings, workshops and roundtables, as well as formulating submissions for the Commissioners' consideration and providing general legal advice to Commissioners.

The Office of the Solicitor Assisting was responsible for providing the Royal Commission with legal and investigatory support for Counsel Assisting, including the planning, preparation and delivery of public hearings. Solicitors Assisting worked directly with witnesses and offered strategic advice to Commissioners and other branches of the Royal Commission.

The Policy and Research branch developed policy options, worked across various hearings, coordinated community and stakeholder engagement, and managed data and research projects under the direction of the Commissioners.

The Community Engagement team was responsible for the four major elements in the community engagement plan: engagement with individuals, community forums, roundtables and site visits.

The Operations branch provided corporate services and logistical support, including human resources, records management, media and communications, correspondence, enquires and information line management, witness support, finance, property, security, information and communications technology support, travel and hearings coordination.

Volume 5 contains a list of staff across the life of the Royal Commission. It also contains financial information relating to the Royal Commission.

2.3 Engagement

We employed a number of strategies to engage with the community, media, service providers, government and other interested parties. In addition to holding public hearings and receiving submissions, we held a range of structured community engagement events, had an ongoing media and communication presence, and allowed for direct engagement with the public via telephone, online and hard copy correspondence. The Community Engagement program offered many opportunities for the public to connect with the Royal Commission. In turn, this informed the way we undertook our inquiries.

Media and communication strategies were critical in informing the public and the media of the Royal Commission's work.

2.3.1 Enquiries and counselling

The Counselling, Enquiries and Correspondence team had a daily link to the community. This team partnered with the public to assist them to share their story. There were two arms to the team: Enquires and Correspondence and Counselling and Support.

The Enquiries and Correspondence team provided an avenue for people to tell their stories and to explain their concerns and hopes for aged care. This connection with the public assisted all teams across the Royal Commission because potential witnesses were identified and knowledge received from the public was shared.

The team provided an in-house information line to answer enquiries from members of the public. Skilled listeners showed compassion and empathy while recording people's stories. As appropriate, the team also provided referral and navigation options for the public to connect with services and support when required.

The telephone enquiry service was initially outsourced and then a dedicated team was appointed to manage this work in-house. This enabled a stronger link between the various elements of community engagement and the broader work of the Royal Commission. Callers inquired about a wide range of matters. Some gave submissions over the phone. When a caller was distressed, they could be referred to a counsellor for support, funded by the Royal Commission. A witness support and counselling service was available, especially for members of the public who gave evidence about their direct experience.

Across the life of the Royal Commission, 6821 telephone calls were received by the information line, providing these callers with the opportunity to share their personal stories—often for the first time. General information, phone submissions, support related to hearings, and counselling support were provided.

The Counselling and Support Team supported 345 people on 904 occasions. They provided support to distressed callers, witness support at hearings, support at community forums and internal staff support. The team supported witnesses in the lead up to, during, and after the hearing. This support was vital to those people who were engaging with the Royal Commission in stressful, challenging and upsetting circumstances.

Media and communications

The Media and Communications team conveyed information on Royal Commission activities using the Royal Commission's website, social media, broadcast and print media advertising, newsletters, and email lists for media and members of the public. This included publication of five newsletters and almost 200 social media posts. Strategies were developed for communicating with the public, including culturally and linguistically diverse groups, and the team used a variety of platforms to reach urban, rural and remote communities. Media and Communications engaged with Australian media to provide updates through media alerts and media releases, and by responding to media enquiries via email and telephone. During hearings, staff engaged with media directly usually within a dedicated media room.

Translations, accessibility and cultural outreach

A third-party provider was engaged to translate information about the Royal Commission into 31 languages, which was made available on the website and promoted through social media channels. Select content on the website itself was translated into 18 languages.

Communications material was developed in concert with organisations representing culturally and linguistically diverse groups to increase awareness of the Royal Commission's work and encourage individuals and minority communities to participate and share their experiences and views, regardless of their first language or background.

2.4 Forms of inquiry

Given the complexity of our task, we adopted eight key methods for our inquiry:

- a call for public submissions, including targeted calls for submissions in response to hearings or published reports
- public hearings, where Counsel Assisting asked questions of individuals and panels
- notices under the *Royal Commissions Act 1902* (Cth) requiring the production of documents, information or statements in writing
- community forums
- targeted consultations, including expert roundtable discussions, facilitated by Commissioners and the Office of the Royal Commission
- visits to service providers
- research conducted by the Office of the Royal Commission
- research commissioned from external providers.

Key aspects of each of these methods are described below. Each method informed, and was informed by, the others.

2.5 Submissions

Submissions from individuals and organisations provided information that helped us identify issues that we should consider, including at public hearings.

Public submissions were made in the following formats:

- online via the website (web submission)
- email submissions
- hard copy submissions (letters / mail)
- phone submissions
- community forum submissions.

We received a total of 10,574 public submissions. Of these, 4890 were submitted directly via the internet, 3618 by email, 801 by telephone, 236 from forums, and 1029 by hard copy.

These submissions provided the views of people, including older people, service providers, peak organisations and other experts. They helped form our views and helped Solicitors Assisting identify witnesses for public hearings and Counsel Assisting devise their questions and plan hearings. Making a submission to a Royal Commission, and revisiting traumatic events, can be daunting. We acknowledge and thank everyone who made a submission.

One of the first activities of the Royal Commission was to invite each approved provider under the *Aged Care Act 1997* (Cth) to make an early written submission in relation to each aged care service or outlet they operated. As part of this process, the Office of the Royal Commission asked approved providers to complete a detailed Service Provider Survey.

The request sought information about a number of specific matters and gave providers an opportunity to identify the areas they thought needed to be changed, and how those changes might be implemented. A total of 1029 approved aged care providers responded to the voluntary Royal Commission 'Service Provider Survey', which was 60% of the aged care service providers active as at 30 November 2018.

2.5.1 General submissions

Public submissions of a general nature were received from 24 December 2018 until 31 July 2020. People made submissions online, by phone or email, or through mail. Interpreter services were available for those with a primary language other than English. Funds were also allocated by the Australian Government to the Australian Attorney-General's Department to contract organisations to support older people and people with a disability using aged care services to make submissions. In addition, the Australian Department of Health funded a number of organisations to facilitate submissions for, or on behalf of, people facing barriers that could prevent their participation in the process.

2.5.2 Targeted submissions

From time to time, including after 31 July 2020 when general submissions closed, submissions were sought from the sector and the public on particular topics. This included invitations to respond to consultation papers that had been published on the Royal Commission website.

Counsel Assisting the Royal Commission made submissions on the aged care workforce (26 February) and program design (4 March 2020). Counsel Assisting made their final submissions for our consideration on 22 and 23 October 2020. On each occasion, a call was made for submissions in response to Counsel Assisting's submissions. We are grateful to the many individuals and organisations who provided detailed responses all of which have been considered.

2.5.3 Hearings

Although the Office of the Royal Commission was based in Adelaide, public hearings and workshops were held in every capital city and various regional and remote locations across Australia. In all, well over 600 witnesses gave evidence across 99 hearing days.

The following institutions and organisations acted with generosity and professionalism to make court rooms and other facilities available for our hearings:

- Roma Mitchell Commonwealth Law Courts Building, Adelaide, South Australia
- Family Court of Australia, Lionel Bowen Building, Sydney, New South Wales
- Broome Civic Centre, Western Australia
- Peter Durack Commonwealth Law Courts Building, Perth, Western Australia
- Supreme Court of the Northern Territory, Darwin, Northern Territory
- Cairns Convention Centre, Cairns, Queensland
- Mildura Arts Centre, Mildura, Victoria
- Harry Gibbs Commonwealth Law Courts Building, Brisbane, Queensland
- County Court of Victoria, Melbourne, Victoria
- Owen Dixon Commonwealth Law Courts Building, Melbourne, Victoria
- Parklands Resort and Conference Centre, Mudgee, New South Wales
- Derwent Room, Wrest Point, Sandy Bay, Hobart, Tasmania
- The Vibe Hotel, Canberra, Australian Capital Territory
- Adelaide Convention Centre, Adelaide, South Australia
- InterContinental, Adelaide, South Australia
- Australian Government Solicitor's offices in Melbourne and Canberra
- Fair Work Commission, Sydney, New South Wales

Early in the Royal Commission's operation, the Commissioners decided that each public hearing would focus on a particular theme or themes associated with our Terms of Reference.

The location and themes of each hearing were announced progressively as arrangements were finalised. Hearings were open to the public and the media up until Adelaide Workshop 2, in March 2020, after which time witnesses appeared remotely.

At public hearings, we heard from people receiving aged care, and the families and friends of people receiving care, about their direct experiences of aged care. We also heard from a range of expert witnesses, including academics, clinicians, representatives of peak bodies, advocates, service providers and government agencies. We have drawn upon these experiences and this expertise in this report.

While every person's story is important, not every personal account could be presented at a public hearing. We are especially grateful to all those people who contributed to hearings and appreciative of the courage people showed to tell their stories and provide important information about the way the aged care system works in practice and the way it should work in future.

When considering the approach to hearings, Counsel Assisting and Solicitors Assisting the Royal Commission recommended that, where appropriate, case studies would be used to illustrate the themes to be examined in the hearings.

The investigation of case studies for examination at public hearings involved a number of steps, including:

- detailed review of submissions from the public and other information held by the Royal Commission
- interviewing potential witnesses
- issuing notices to relevant entities and comprehensively reviewing the material returned.

Following this process, Counsel and Solicitors selected the case studies that proceeded to examination at a hearing. Counsel Assisting presented 19 case studies in 2019. Following the conclusion of the Hobart Hearing in November 2019, we decided it was unnecessary to hear further case studies with the focus shifting to the recommendations we might make in this report.

Volume 4 of this report contains hearing overviews and case studies. Table 1 contains a list of the hearings and their themes.

Table 1 – HEARINGS		
Location	Date	Theme
Adelaide (Preliminary)	18 January 2019	Operation of the Royal Commission
Adelaide 1	11–13 February 2019	Perspectives on the aged care system as it exists
Adelaide 2	18–22 March 2019	Aged care in the home
Sydney 1	6–8 May 2019 13–17 May 2019	Dementia care and residential care
Broome	17–19 June 2019	Access and inclusion
Perth	24–28 June 2019	Person-centred care
Darwin	8–12 July 2019	Access to aged care and clinical care
Cairns	15–17 July 2019	Access to aged care and clinical care
Mildura	29–31 July 2019	Carers for older Australians

Table 1 – HEARINGS

Location	Date	Theme
Brisbane	5–9 August 2019	Regulation of aged care
Melbourne 1	9–11 September 2019 13 September 2019	Younger people in residential aged care
Melbourne 2	7–11 October 2019	Diversity in aged care
Melbourne 3	14–18 October 2019	Aged care workforce
Mudgee	4–6 November 2019	Provision of aged care in regional areas
Hobart	11–15 November 2019	Aged care operations of selected approved providers
Canberra	9–13 December 2019	Interfaces between the aged care and the health care systems
Adelaide Workshop 1	10–11 February 2020	Redesign of the aged care system
Adelaide 3	21 February 2020	The future of the aged care workforce
Adelaide 4	4 March 2020	Future aged care program redesign
Adelaide Workshop 2	16–17 March 2020	Research, innovation and technology
Melbourne 4	15–17 July 2020	Mental health, oral health and allied health care
Sydney 2	10–13 August 2020	The response to COVID-19 in aged care
Sydney 3	13–14 August 2020	Accommodation
Sydney 4	31 August–2 September 2020	Home Care
Sydney 5	14–18 September 2020 21–22 September 2020	Funding, financing and prudential regulation
Final Hearing	22–23 October 2020	Counsel Assisting's final submissions

2.5.4 Notices

As Commissioners, we had a number of compulsory powers to gather evidence and information. These powers included the power to require the production of documents and things and the power to require individuals to give information or a statement in writing. This inquiry was the first Royal Commission to exercise the power to require giving of information in writing, following amendment to the *Royal Commissions Act 1902* (Cth).

2.5.5 Community Forums

The community forums provided an opportunity for members of the public to tell their stories or provide their perspective to the Commissioners in town hall-like public forums.



Twelve community forums were held between March and November 2019 in a mix of major cities, regional and remote areas. Forums were held in Bankstown (Sydney, NSW), Bendigo (Vic), Wollongong (NSW), Maidstone (Melbourne, Vic), Broome (WA), Townsville (Qld), Adelaide (SA), Brisbane (Qld), Rockhampton (Qld), Launceston (Tas), Canberra (ACT) and Newcastle (NSW).

Approximately 20 people were offered the opportunity to speak at each forum. In total, 228 people told their stories and around 2416 people attended the 12 forums. The average attendance was about 235 people. Some of those attending had travelled considerable distances from a regional location or interstate, which demonstrates their commitment and passion for reform.

The community forums were very valuable to the inquiry, as Commissioners were able to hear directly from the community. The accounts that people shared gave a direct and immediate picture of the aged care experience. Many of the stories told at community forums were sad and confronting. They made a lasting impression. We are grateful to everyone who attended and appreciate the courage people showed in telling and hearing difficult personal and family stories.

All the speakers at forums helped to shape our understanding of the reality of aged care in Australia. The deep love and dedication of family and friends of older people was abundantly clear in the stories that people told.

Volume 5 of this report includes summaries of the community forums, as well as a summary of the results of a questionnaire provided to attendees of forums.

2.6 Targeted engagement

2.6.1 Consultations by Commissioners

Commissioners attended 13 roundtable discussions with invited experts on a range of themes in Sydney, Melbourne, Adelaide and Canberra. These included two roundtables in Canberra with officers from Australian Government agencies with responsibility for, or an interest in, aged care.

Roundtable discussions were smaller forums, based on selected themes. At the roundtable discussions, experts in different fields shared their knowledge and opinions, and responded to policy issues arising from research and submissions. Attendance at the roundtable discussions was by invitation.

The roundtable discussions formed part of an approach that encouraged frank, spontaneous and detailed conversations about aged care with those who have both expertise and ideas about specific issues within our Terms of Reference. Where referring to outcomes of roundtable discussions in this report, comments are not attributed to specific participants.

Volume 5 of this report includes a list of roundtable topics and participants, together with a list of other key consultations we engaged in.

2.6.2 Consultation by Royal Commission staff

Royal Commission staff members also conducted meetings with members of the public, advocates and service providers in specific locations as part of preparation for hearings. The need for, and scope of these activities, was identified on a case-by-case basis, depending on the themes of a hearing and particular information gaps requiring attention.

Examples of this engagement included:

- a series of consultations, in Canberra in February 2020, about the Royal Commission's consultation paper on aged care program redesign. Participants were chosen for their expertise and previous engagement with the Royal Commission
- meetings with Aboriginal health services, community organisations, public servants, local researchers and members of the Broome and Bidjardanga communities in Western Australia
- a site visit and meetings with advocacy groups and government and non-government service providers in Darwin
- community meetings focused on local issues and informal carers in Mildura
- site visits and meetings with community members in Mudgee and Dubbo.

2.6.3 Service provider visits

Visits to aged care service providers enabled the Commissioners and Royal Commission staff members to see a range of different care settings and services provided to older people. The sites visited were diverse in size, specialty and innovation in residential, home care and respite service settings. Each site visit was pre-arranged with the provider. The selection of a service for a visit did not reflect any judgement, positive or negative, about the safety and quality of a service.

Commissioners conducted 34 service visits in seven States and Territories. A list of these is included in Volume 5 of this report.

2.6.4 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Throughout the course of our inquiry, we noted a number of issues that had relevance to Terms of Reference for both this Royal Commission and those of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. We agreed that each inquiry would identify issues that were likely to be of interest to the other and, as appropriate, share relevant information or identify a lead on particular issues. Commissioners from both inquiries met a number of times in 2019 and 2020 to discuss issues in common, such as the impact of COVID-19 and the treatment of older people with disability. Staff members from the respective offices of the Royal Commissions also consulted from time to time, to discuss practical issues such as hearing schedules, the calling of common witnesses and the findings of research reports or background papers.

2.7 Research and publications

2.7.1 International research

In January 2020, we undertook focused international research to examine approaches to aged care design and funding in different countries and to consider their relevance to Australia. We met with experts on ageing, aged care design and delivery, quality and measurement of quality, governance, system design, funding models, and the implementation of transformational change. We were able to view examples of innovative aged care services, and to consider their relevance for our recommendations about the future aged care system in Australia. The research included meetings and site visits in Canada, Denmark, France, Germany, Japan, the Netherlands, Sweden, the United Kingdom, and the United States.

Details of our international research are included in Volume 5 of this report.

2.7.2 Internal and commissioned research

The Royal Commission completed and commissioned a wide range of innovative research that answered important policy questions and informed the recommendations in this report. This internal and commissioned research included economic modelling, surveys, focus groups, analysis of industry finances, calculation of quality indicators, and research into international practice and benchmarks. As part of the research, a huge volume of data was acquired from different parts of the aged care system that had previously been inaccessible to researchers. Key commissioned research projects were documented in papers on the Royal Commission website and will continue to inform policy for years to come. Published commissioned research is listed in Appendix 6 in Volume 5 of this report. We are grateful to the many dedicated people who gave their expertise to this challenging work.

The Royal Commission produced eight background papers, two consultation papers, and other research relevant to our Terms of Reference. These papers provided critical background information on key issues within aged care in Australia. A list of background papers is included in Volume 5 of this report and are published on the website. The background papers do not represent the Royal Commission's direction or position, and any views expressed in these papers are not necessarily our views as Commissioners.

2.8 Costing of recommendations

To assist our consideration of the issues and policy responses, we prepared indicative estimates of the possible cost of a range of propositions and scenarios.* We used these indicative costings to inform our deliberations and have taken them into account when finalising our recommendations.

However, we do not consider that it would be useful to publish the cost estimates of individual recommendations. We are mindful that:

- Costings are highly dependent on their underlying assumptions and can vary considerably, even with minor changes to those assumptions. Where multiple assumptions have to be made, uncertainties around each assumption can aggregate to create broad cost ranges.
- The costings were developed on a standalone basis that does not take into account the interactions between the reforms we recommend. Recommendations interact, so implementing some may either increase or decrease the costs of others. The indicative cost estimates of individual recommendations cannot simply be added together to reach an aggregated total.

* We were fortunate to be assisted in this by Mr Stephen Bartos, a former NSW Parliamentary Budget Officer and Deputy Secretary in the Australian Department of Finance. The methodology we used was based on the approach taken by the fiscal agencies and Parliamentary Budget Offices of the Australian Government and some State Governments in assessing the costs of proposed policies.

- Cost estimates, as with the Australian Government's own forward estimates, become more uncertain the further out in time they extend. Over the implementation timeframe, costs are likely to vary considerably due to external factors such as changes in technology, the economy and social preferences.
- Final costings will require information on how the Australian Government proposes to implement the measure we recommend. That information is not available to us.

We recognise that the costs of our recommendations will rise progressively over five years as they are implemented, and that this is likely to require a very substantial increase in expenditure on aged care over coming years.

We consider that the Australian Government should itself establish the costings of the measures we have recommended. The Government is in a better position than us to complete that work, on the advice of the agencies responsible for their implementation.

2.9 Out-of-scope themes

We received over 10,000 submissions. Many were within our Terms of Reference and highlighted the multiple themes and topics we discuss in this report.

We also received submissions that highlighted a mix of issues. These submissions were partly within and partly outside our Terms of Reference. A smaller proportion of submissions, approximately 10%, fell outside the scope of our Terms of Reference.

Some submissions raised out-of-scope concerns about hospital care—care or services within hospitals rather than the interactions between the aged care sector and health care sector (which is the subject of Chapter 9 in Volume 3 of this report). This included complaints about the care older people receive in hospitals as well as the absence of follow-up after a person has left hospital.

Guardianship was another out-of-scope issue prominent in submissions. There were concerns raised in relation to urgent guardianship and administrative (public trustee) orders being implemented in hospitals and aged care settings, without the involvement of family members. Some noted the lack of a complaints process once a person is the subject of such orders. Other guardianship-related matters included financial mismanagement by appointed guardians and powers of attorney, primary decision-making queries and compliance with protocols, palliative care issues and decisions about medication.

Family disputes featured prominently in out-of-scope submissions and covered a wide range of issues, including:

- financial mismanagement, misappropriation and disputes about estates
- identifying who was the primary decision-maker
- lack of consultation
- provision of palliative care for loved ones
- medication management, types and doses of medicines
- whether treatment should be provided and if it is in the best interests of the person
- human rights in a family context.

Some submissions also raised issues related to retirement villages. This included concerns about contracts—understanding them, their long-term implications, and being ‘locked in’ to agreements—and financial arrangements, fees and charges.

Mental health and older people was another matter raised in submissions. This included issues relating to older people living at home and the challenges of social isolation. Some older people and their families expressed uncertainty about what mental health services are available.

We received submissions relating to the situation of older people in prisons. This included concerns about the lack of services within the prison system given its separation from mainstream health and aged care services. Other submissions focused on the future needs of older people who leave correctional services, including the need to connect to aged care services.

Other submissions raised concerns about disadvantage faced by older people when dealing with some services. These submissions raised such problems as a lack of access to information, difficulty in navigating services, and a lack of assistance to do so. The submissions made mention of both the public and private sectors, including telecommunications companies, financial institutions, Australian, State and Territory and local Government agencies.

While not directly related to the aged care sector, some members of the community felt that they had experienced elder abuse—that they were disrespected and not heard.

We cannot deal with issues or themes raised in submissions that fall outside our Terms of Reference. However, we wish to acknowledge people who made these submissions, even though it was not possible for us to investigate or make recommendations about their submissions.



ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth

TO

The Honourable Richard Ross Sinclair Tracey AM RFD QC, and

Ms Lynelle Jann Briggs AO

GREETING

RECOGNISING the contribution of older Australians to society, and that older Australians deserve high quality care in a safe environment that protects their wellbeing and dignity.

AND the importance of building a national culture of respect for ageing and older persons.

AND that Australia's population is ageing and the proportion and number of people accessing and needing care is increasing.

AND the many positive examples of high quality care within the Australian aged care sector which engages thousands of dedicated people providing aged care services every day, complemented by the important contribution of families and volunteers.

AND that as a community all Australians expect high standards of quality and safety from our aged care services, and it is important that the Australian Government has the best regulatory and policy framework to provide a sustainable aged care system that meets the needs of older Australians in the future.

AND that it is important that frail, older people needing care should receive services that reflect and address their care needs.

AND that the Commonwealth provides funding to, and regulates, providers of aged care services.

AND that some people residing in aged care facilities, including younger people, or otherwise receiving aged care services, have disabilities and Australia has undertaken relevant international obligations, including to take

ENTERED ON RECORD by me in Register of Patents No. 53, page 48, on 6 December 2018

Secretary to the Federal Executive Council

John Carr

all appropriate legislative, administrative and other measures for the implementation of the rights of people with disabilities.

NOW THEREFORE We do, by Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia on the advice of the Federal Executive Council and under the Constitution of the Commonwealth of Australia, the *Royal Commissions Act 1902* and every other enabling power, appoint you to be a Commission of inquiry, and require and authorise you, to inquire into the following matters:

- (a) the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response;
- (b) how best to deliver aged care services to:
 - (i) people with disabilities residing in aged care facilities, including younger people; and
 - (ii) the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged care services;
- (c) the future challenges and opportunities for delivering accessible, affordable and high quality aged care services in Australia, including:
 - (i) in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age; and
 - (ii) in remote, rural and regional Australia;
- (d) what the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe;
- (e) how to ensure that aged care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care-related matters;
- (f) how best to deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure;
- (g) any matter reasonably incidental to a matter referred to in paragraphs (a) to (f) or that you believe is reasonably relevant to the inquiry.

AND We direct you to make any recommendations arising out of your inquiry that you consider appropriate, including recommendations about any policy, legislative, administrative or structural reforms.

AND, without limiting the scope of your inquiry or the scope of any recommendations arising out of your inquiry that you may consider appropriate, We direct you, for the purposes of your inquiry and recommendations, to have regard to the following matters:

- (h) all forms of Commonwealth-funded aged care services, whatever the setting or environment in which those services are delivered;
- (i) all aspects of the quality and safety of aged care services, including but not limited to the following:
 - (i) dignity;
 - (ii) choice and control;
 - (iii) clinical care;
 - (iv) medication management;
 - (v) mental health;
 - (vi) personal care;
 - (vii) nutrition;
 - (viii) positive behaviour supports to reduce or eliminate the use of restrictive practices;
 - (ix) end of life care;
 - (x) systems to ensure that high quality care is delivered, such as governance arrangements and management support systems;
- (j) the critical role of the aged care workforce in delivering high quality, safe, person-centred care, and the need for close partnerships with families, carers and others providing care and support;
- (k) the wide diversity of older Australians and the barriers they face in accessing and receiving high quality aged care services. This should take into account the increasing incidence of chronic and complex conditions;
- (l) the interface with other services accessed by people receiving aged care services, including primary health care services, acute care and disability services, and relevant regulatory systems. This should take

into account how people transition from other care environments or between aged care settings;

- (m) examples of good practice and innovative models in delivering aged care services;
- (n) the findings and recommendations of previous relevant reports and inquiries.

AND We further declare that you are not required by these Our Letters Patent to inquire, or to continue to inquire, into a particular matter to the extent that you are satisfied that the matter has been, is being, or will be, sufficiently and appropriately dealt with by another inquiry or investigation or a criminal or civil proceeding.

AND, without limiting the scope of your inquiry or the scope of any recommendations arising out of your inquiry that you may consider appropriate, We direct you, for the purposes of your inquiry and recommendations, to consider the following matters, and We authorise you, as you consider appropriate, to take (or refrain from taking) any action arising out of your consideration:

- (o) the need to establish mechanisms to facilitate the timely communication of information, or the furnishing of evidence, documents or things, in accordance with section 6P of the *Royal Commissions Act 1902* or any other relevant law, including, for example, for the purpose of enabling the timely investigation and prosecution of offences;
- (p) the need to ensure that evidence that may be received by you that identifies particular individuals as having been subject to inappropriate treatment is dealt with in a way that does not prejudice current or future criminal or civil proceedings or other contemporaneous inquiries;
- (q) the need to establish appropriate arrangements in relation to current and previous inquiries, in Australia and elsewhere, for evidence and information to be shared with you in ways consistent with relevant obligations so that the work of those inquiries, including, with any necessary consents, the testimony of witnesses, can be taken into account by you in a way that avoids unnecessary duplication, improves efficiency and avoids unnecessary trauma to witnesses;
- (r) the need to establish, as you see fit and having regard to the date by which you are required to submit your final report, appropriate arrangements for evidence and information to be shared with you by people about their experiences, including people receiving aged care services, their families, carers and others who provide care and support, recognising that some people will need special support to share their experiences.

AND We appoint you, the Honourable Richard Ross Sinclair Tracey AM RFD QC, to be the Chair of the Commission.

AND We declare that you are a relevant Commission for the purposes of sections 4 and 5 of the *Royal Commissions Act 1902*.

AND We declare that, in exercising your powers under Part 2 of the *Royal Commissions Act 1902*, you are to inquire into the matters falling within the scope of paragraphs (a) to (g) only to the extent that Commonwealth constitutional power extends to those subjects of inquiry.

AND We declare that you are a Royal Commission to which item 5 of the table in subsection 355-70(1) in Schedule 1 to the *Taxation Administration Act 1953* applies.

AND We declare that in these Our Letters Patent:

aged care services means services provided by any of the following:

- (a) approved providers within the meaning of the *Aged Care Act 1997*;
- (b) entities to which a grant is payable under Chapter 5 of the *Aged Care Act 1997*;
- (c) entities to which funding is payable under a program relating to aged care specified in Schedule 1AA or 1AB to the *Financial Framework (Supplementary Powers) Regulations 1997*;
- (d) entities that receive funding for the purposes of the Veterans' Home Care Program established under the *Veterans' Entitlements Act 1986*.

AND We:

- (s) require you to begin your inquiry as soon as practicable; and
- (t) require you to make your inquiry as expeditiously as possible; and
- (u) require you to submit to Our Governor-General an interim report that you consider appropriate not later than 31 October 2019; and
- (v) require you to submit to Our Governor-General a final report of the results of your inquiry, and your recommendations, not later than 30 April 2020.

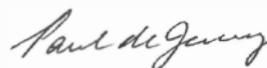
IN WITNESS, We have caused these Our Letters to be made Patent.

Paul de Jersey AC

WITNESS ~~General the Honourable Sir Peter Cosgrove AK MC~~
(Ret'd), ~~Governor-General~~ of the Commonwealth of Australia,

Administrator of the Government

Dated *6th December* 2018



~~Governor-General~~

**Administrator of the Government
of the Commonwealth of Australia**

By His Excellency's Command



Attorney-General



ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth

TO

The Honourable Richard Ross Sinclair Tracey AM RFD QC,

Ms Lynelle Jann Briggs AO, and

The Honourable Gaetano Tony Pagone QC

GREETING

WHEREAS, by Letters Patent issued in Our name and entered in the Register of Patents on 6 December 2018, We appointed you:

- (a) The Honourable Richard Ross Sinclair Tracey AM RFD QC; and
- (b) Ms Lynelle Jann Briggs AO;

to be a Commission of inquiry, required and authorised you to inquire into certain matters, and required you to submit to Our Governor-General a final report of the results of your inquiry, and your recommendations, not later than 30 April 2020;

AND WHEREAS it is desired to amend Our Letters Patent;

NOW THEREFORE We do, by these Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia on the advice of the Federal Executive Council and under the Constitution of the Commonwealth of Australia, the *Royal Commissions Act 1902* and every other enabling power, amend those Letters Patent:

- (c) by appointing you, the Honourable Gaetano Tony Pagone QC, to be an additional member of this Commission of inquiry; and
- (d) so that those Letters Patent apply to you in a corresponding way to the way those Letters Patent apply to Ms Lynelle Jann Briggs AO, subject to paragraph (e); and

ENTERED ON RECORD by me in Register of Patents No. 54, page 64, on 13 September 2019

Joanne M. Cooper
Secretary to the Federal Executive Council

- (e) by inserting the following paragraphs after the paragraph “AND We appoint you, the Honourable Richard Ross Sinclair Tracey AM RFD QC, to be the Chair of the Commission.” in those Letters Patent:

“AND We appoint you, the Honourable Gaetano Tony Pagone QC to act as the Chair of the Commission during any period, or during all periods, when the Honourable Richard Ross Sinclair Tracey AM RFD QC is absent from duty or from Australia or is, for any reason, unable to perform the duties of the Chair.

AND We declare that while you, the Honourable Gaetano Tony Pagone QC, are acting as the Chair of the Commission:

(ra) you have and may exercise all the powers, and must perform all the functions and duties, of the Chair of the Commission; and

(rb) the *Royal Commissions Act 1902*, or any other Act, applies in relation to you as if you were the Chair of the Commission.”; and

- (f) by omitting from paragraph (v) of the Letters Patent “30 April 2020” and substituting “12 November 2020”.

IN WITNESS, We have caused these Our Letters to be made Patent.

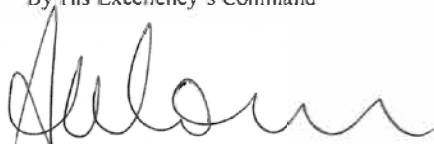
WITNESS General the Honourable David Hurley AC DSC
(Retd), Governor-General of the Commonwealth of Australia.

Dated 13 September 2019



Governor-General

By His Excellency's Command



Prime Minister

ENTERED ON RECORD by me in Register of Patents No.

8, page 1, on

25 JUNE 2020

Secretary to the Federal Executive Council



ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth

TO

The Honourable Gaetano Tony Pagone QC, and

Ms Lynelle Jann Briggs AO

GREETING

WHEREAS, by Letters Patent issued in Our name and entered in the Register of Patents on 6 December 2018 and amended by Our Letters Patent and entered in the Register of Patents on 13 September 2019 We appointed you, and the Honourable Richard Ross Sinclair Tracey AM RFD QC who is now deceased, to be a Commission of inquiry, required and authorised you to inquire into certain matters, and required you to submit to Our Governor-General a report of the results of your inquiry, and your recommendations, not later than 12 November 2020;

AND WHEREAS it is desired to further amend Our Letters Patent;

NOW THEREFORE We do, by these Our Letters Patent issued in Our name by Our Governor-General of the Commonwealth of Australia on the advice of the Federal Executive Council and under the Constitution of the Commonwealth of Australia, the *Royal Commissions Act 1902* and every other enabling power, further amend those Letters Patent:

(a) by omitting the following paragraphs:

"AND We appoint you, the Honourable Richard Ross Sinclair Tracey AM RFD QC, to be the Chair of the Commission.

AND We appoint you, the Honourable Gaetano Tony Pagone QC to act as the Chair of the Commission during any period, or during all periods, when the Honourable Richard Ross Sinclair Tracey AM RFD QC is absent from duty or from Australia or is, for any reason, unable to perform the duties of the Chair.

AND We declare that while you, the Honourable Gaetano Tony Pagone QC, are acting as the Chair of the Commission:

(ra) you have and may exercise all the powers, and must perform all the functions and duties, of the Chair of the Commission; and

(rb) the *Royal Commissions Act 1902*, or any other Act, applies in relation to you as if you were the Chair of the Commission.”; and”

and substituting the following paragraph:

“AND We appoint you, the Honourable Gaetano Tony Pagone QC, to be the Chair of the Commission.”

(b) by omitting from paragraph (v) of the Letters Patent “12 November 2020” and substituting “26 February 2021”.

IN WITNESS, We have caused these Our Letters to be made Patent.

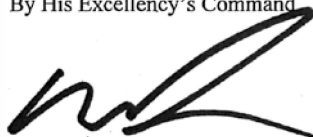
WITNESS General the Honourable David Hurley AC DSC
(Retd), Governor-General of the Commonwealth of Australia.

Dated 25 June 2020



Governor-General

By His Excellency's Command



Attorney-General

3. Recommendations

Chapter 1: Foundations of the New Aged Care System

Recommendation 1: A new Act

1. The *Aged Care Act 1997* (Cth) should be replaced with a new Act to come into force by no later than 1 July 2023.
2. The new Act should define aged care as:
 - a. 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
 - b. supports, including respite for informal carers of people receiving aged care.
3. The objects of the new Act should be to:
 - a. provide a system of aged care based on a universal right to high quality, safe and timely support and care to:
 - i. assist older people to live an active, self-determined and meaningful life, and
 - ii. ensure older people receive high quality care in a safe and caring environment for dignified living in old age
 - b. protect and advance the rights of older people receiving aged care to be free from mistreatment and neglect, and harm from poor quality or unsafe care, and to continue to enjoy rights of social participation accessible to members of society generally
 - c. enable people entitled to aged care to exercise choice and control in the planning and delivery of their care
 - d. ensure equity of access to aged care
 - e. provide advocacy and complaint mechanisms for people receiving aged care
 - f. provide for regular and independent review of the aged care system
 - g. promote innovation in aged care based on research
 - h. promote positive community attitudes to enhance social and economic participation by people receiving aged care.
4. Unless indicated otherwise, the new Act should incorporate provisions giving effect to amendments to the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth) (as well as to delegated legislation made under those Acts) the subject of other recommendations.

Recommendation 2: Rights of older people receiving aged care

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

- a. for people seeking aged care:
 - i. the right to equitable access to care services
 - ii. the right to exercise choice between available services
- b. for people receiving aged care
 - i. the right to freedom from degrading or inhumane treatment, or any form of abuse
 - ii. the right to liberty, freedom of movement, and freedom from restraint
 - iii. the right of autonomy, the right to the presumption of legal capacity, and in particular the right to make decisions about their care and the quality of their lives and the right to social participation
 - iv. the right to fair, equitable and non-discriminatory treatment in receiving care
 - v. the right to voice opinions and make complaints
- c. for people receiving end-of-life care, the right to fair, equitable and non-discriminatory access to palliative and end-of-life care
- d. for people providing informal care, the right to reasonable access to supports in accordance with needs and to enable reasonable enjoyment of the right to social participation.

Recommendation 3: Key principles

The new Act should:

- a. provide that the paramount considerations in the administration of the Act should be:
 - i. ensuring the safety, health and wellbeing of people receiving aged care
 - ii. putting older people first so that their preferences and needs drive the delivery of care
- b. specify the following principles that should also guide the administration of the Act:

- i. older people should have certainty that they will receive timely high quality support and care in accordance with assessed need
- ii. informal carers of older people should have certainty that they will receive timely and high quality supports in accordance with assessed need
- iii. older people should be supported to exercise choice about their own lives and make decisions to the fullest extent possible, including being able to take risks and be involved in the planning and delivery of their care
- iv. older people should be treated as individuals and be provided with support and care in a way that promotes their dignity and respects them as equal citizens
- v. older people are entitled to pursue (and to be supported in pursuing) physical, social, emotional and intellectual development and to be active and engaged members of the community, regardless of their age or level of physical or cognitive capability
- vi. the relationships that older people have with significant people in their lives should be acknowledged, respected and fostered
- vii. to the fullest extent possible, older people should receive support and care in the location they choose or, where that is not possible, in the setting most appropriate to their circumstances and preferences
- viii. older people are entitled to receive support and care that acknowledges the aged care setting is their home and enables them to live in security, safety and comfort with their privacy respected
- ix. older people should have equal access to support and care irrespective of their location or personal circumstances or preferences
- x. care should be provided in an environment which protects older people from risks to their health
- xi. care and supports should, as far as possible, emphasise restoration and rehabilitation, with the aim of maintaining or improving older people's physical and cognitive capabilities and supporting their self-determination
- xii. Aboriginal and Torres Strait Islander people are entitled to receive support and care that is culturally safe and recognises the importance of their personal connection to community and Country
- xiii. the system should support the availability and accessibility of aged care for all older people, including people of diverse backgrounds and needs and vulnerable people
- xiv. the aged care system should be transparent and provide public access to meaningful and readily understandable information about aged care

- xv. government entities, providers, health care professionals and aged care workers operating in the aged care system should be open, honest and answerable to older people and the wider community for their decisions and actions
- xvi. innovation, continuous improvement and contemporary best practice in aged care are to be promoted
- xvii. older people should be supported to give feedback and make complaints free from reprisal or adverse impacts
- xviii. people receiving aged care should respect the rights and needs of other people living and working within their environment, and respect the general interests of the community in which they live; the rights and freedoms of people receiving aged care should be only limited by the need to respect the rights of other members of their community
- xix. the Australian Government will fund the aged care system at the level necessary to deliver high quality and safe aged care and ensure the aged care system's sustainability, resilience and endurance.

Recommendation 4: Integrated long-term support and care for older people

1. The Australian Government should coordinate the development of an integrated system for the long-term support and care of older people providing for their needs for welfare support, community services directed at enhancing social participation, affordable and appropriate housing, high quality health care, and aged care. This should be achieved through a new National Cabinet Reform Committee on Ageing and Older Australians, to be established between the Australian and State and Territory Governments, and composed of the highest-ranking ministers whose primary responsibility is the care, health and wellbeing of older people.
2. Work on a strategy to develop the integrated system for the long-term support and care of older people should begin immediately. That work should:
 - a. involve consultation with older people; and
 - b. include measures to support the wellbeing of people receiving aged care by connecting and integrating aged care services with the broader community.
3. The strategy should provide for implementation of an integrated system for the long-term support and care of older people within a 10-year period.

Chapter 2: Governance of the New Aged Care System

Recommendation 5: Australian Aged Care Commission

Commissioner
Pagone

1. By 1 July 2023, the Australian Aged Care Commission should be established under the new Act as a corporate Commonwealth entity within the meaning of the *Public Governance, Performance and Accountability Act 2013* (Cth) and:
 - a. be a body corporate, with perpetual succession;
 - b. have a common seal;
 - c. be able to acquire, hold and dispose of real and personal property; and
 - d. be able to sue and be sued in its corporate name.
2. The Australian Aged Care Commission:
 - a. should be constituted by a board appointed to their respective roles by the Governor-General as full-time or part-time members, namely:
 - i. a Presiding Commissioner, who must be appointed as a full-time member
 - ii. a System Commissioner, who must be appointed as a full-time member
 - iii. a Quality Commissioner, who must be appointed as a full-time member, and who acts as Presiding Commissioner in the absence of the Presiding Commissioner
 - iv. a Complaints Commissioner
 - v. a Workforce Development and Planning Commissioner
 - vi. an Aboriginal and Torres Strait Islander Commissioner
 - vii. the Secretary of the Department administered by the responsible Minister, who shall be an ex officio member of the board
 - viii. two additional part-time members who are to be chosen for their integrity, eminence and public standing, each of whom must be independent of any current involvement in the aged care sector, and who should have experience and proven capacity in: aged care, clinical services, human services, legal services, or corporate governance; or in finance, accounting or general business
 - b. shall appoint a Chief Executive Officer and staff, all of whom are to be employed or engaged by the Commission (whether under the provisions of the *Public Service Act 1999* (Cth) or otherwise).

3. The functions of the Australian Aged Care Commission should be:
 - a. to maintain and operate a distributed network of offices, including regional offices, to deliver or manage the delivery of assessment and care finding services, administer the aged care program, and provide general assistance to the public
 - b. to manage the system, including support and funding of local assessment and care finding teams and personnel, provision of information on services and providers, system data management, ensuring service availability for all aged care services to which people are assessed as eligible, commissioning and funding of providers to provide aged care services in all locations, analysis of information relating to financial risk presented by approved providers, providing assistance to providers to build capacity where appropriate, and managing the orderly exit of consistently poor-performing providers
 - c. the following particular functions:
 - i. approval of service providers as providers eligible to receive subsidies for providing aged care
 - ii. financial risk monitoring of providers, and prudential regulation of providers
 - iii. approval of the scope of subsidised services approved providers may provide, and accreditation of the services provided
 - iv. payment of subsidies to approved providers of aged care
 - v. quality and safety regulation of approved providers and their services
 - vi. ensuring that appropriate aged care services are widely available for Aboriginal and Torres Strait Islander people
 - vii. workforce planning and development, including setting and refining requirements for minimum staffing levels and minimum qualifications for staff providing care, and (through a workforce planning division within or operated by the Australian Aged Care Commission) ongoing development of workforce capacity through requirements for training and professional development
 - viii. consulting with the Australian Commission on Safety and Quality in Health and Aged Care (which is to be responsible under the new Act for review and setting of quality and safety standards and quality indicators) on reviews and revisions of the standards and indicators for the provision of safe and high quality aged care
 - ix. management of complaints about providers, staff, assessors and care finders

- d. system governance, including the responsibility of continuously monitoring the performance of the system, informing the responsible Minister and Department about new policy and reform proposals for improvement of the performance of the system, limited authority to make subordinate instruments about the details of arrangements for the administration of funding and service delivery, and the ability to raise and recommend amendments of legislation and delegated legislation to the responsible Minister and Department.
4. The responsibilities and functions of the Commissioners should be as follows:
- a. the Presiding Commissioner should:
 - i. be the senior member of the Commission and chair of the board
 - ii. be responsible for managing the performance of all of the Commission's functions, subject to the joint responsibility of other Commissioners for management of the performance of certain functions specified in subparagraphs b–e below
 - iii. be responsible for governance and direction of the Chief Executive Officer as to the management of the administration of the Commission
 - iv. be, for the purposes of the *Public Governance, Performance and Accountability Act 2013* (Cth), the accountable authority of the Commission
 - b. the System Commissioner should be responsible for managing the performance of the Commission's functions of, and relating to, general management of the system, as described in paragraph 3.b
 - c. the Quality Commissioner should be responsible for managing the performance of the Commission's functions of and relating to:
 - i. the approval of the scope of subsidised services approved providers may provide, and accreditation of the services provided
 - ii. the quality and safety regulation, prudential regulation and financial risk monitoring of approved providers and their services
 - d. the Complaints Commissioner should be responsible for managing the performance of the Commission's functions of, and relating to, the management of complaints about providers, staff, assessors and care finders
 - e. the Workforce Development and Planning Commissioner should be responsible for managing the performance of the Commission's functions of, and relating to, workforce planning and development
 - f. the Aboriginal and Torres Strait Islander Commissioner should be responsible for managing the performance of the Commission's functions and relating to ensuring that appropriate aged care services are widely available for Aboriginal and Torres Strait Islander people

and the Commissioners should have the powers to do all things necessary or convenient to be done for or in connection with the performance of their functions.

5. The Remuneration and allowances of the Commissioners should be determined by the Remuneration Tribunal.
6. The Chief Executive Officer should:
 - a. be appointed by the Presiding Commissioner on the advice of the board of the Commission
 - b. have their remuneration and entitlements determined by the Remuneration Tribunal
 - c. in relation to matters not covered by the Act, hold office on the terms and conditions (if any) that are determined by the Presiding Commissioner on the advice of the board of the Commission
 - d. be required to comply with any written direction by the Presiding Commissioner about the duties of the Chief Executive Officer
 - e. for the purposes of the *Public Service Act 1999* (Cth), and together with the staff of the Australian Aged Care Commission, constitute a Statutory Agency of which the Chief Executive Officer is the 'Agency Head'.
7. The Commission should be independent of Ministerial direction, and there should be a requirement that any expectations or advice provided by the responsible Minister to the Australian Aged Care Commission should be made public.
8. The Commission should be required to:
 - a. report quarterly to the Inspector-General of Aged Care and to the responsible Minister on the performance of its functions, and to publish these reports within one month of being provided to the responsible Minister subject to redaction of contents that are subject to public interest immunity
 - b. lay before the Parliament and to publish an annual report on such aspects of the operation of the Act as the Australian Aged Care Commission considers relevant to ensure an accurate understanding of the operation of the Act, including:
 - i. the extent to which providers are complying with their responsibilities under the Act
 - ii. the amounts paid by people receiving residential care in connection with their care, including amounts paid for accommodation and daily living needs and amounts provided by way of accommodation deposits.

Recommendation 6: Australian Aged Care Pricing Authority

Commissioner Pagone

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

Recommendation 7: Aged Care Advisory Council

Commissioner Pagone

1. The Minister should appoint an Aged Care Advisory Council, to be constituted by such people of eminence, expertise and knowledge of aged care services as the Minister sees fit, drawn from all relevant aspects of the aged care system, including people receiving aged care, representatives of the aged care workforce, approved providers, health and allied health professionals, specialists in training and education, and independent experts.
2. The Advisory Council should be established with its own secretariat, funded by the Australian Government.
3. The Advisory Council's function should be to provide advice on aged care policy, service arrangements and any aspect of the performance of the aged care system, to the System Governor
4. The Advisory Council should convene itself regularly, and should have authority to provide advice to the System Governor on its own initiative.
5. The System Governor should have authority to convene the Advisory Council on reasonable notice, and may refer particular issues to it for advice.

Recommendation 8: Cabinet Minister and Department of Health and Aged Care

Commissioner Briggs

1. The Australian Government should ensure in all future Ministerial arrangements that there is a senior Cabinet Minister, preferably the Minister for Health and Aged Care, responsible for aged care.
2. The Department of Health should immediately be renamed the Department of Health and Aged Care.

3. The Department should have an Associate Secretary tasked with day-to-day responsibility for aged care, acting as the principal policy adviser to the Minister and the Secretary, leader of aged care administration, and member of the Aged Care Workforce Industry Council.¹
4. The Administrative Arrangements Orders should be amended to provide for the Department to also be responsible for the education, training, development and supply of the aged care workforce.
5. The Department of Health and Aged Care should have a focus on:
 - a. aged care system renewal consistent with the recommendations of the Royal Commission
 - b. personal engagement with older people
 - c. promoting positive attitudes towards ageing and encouraging social and community engagement
 - d. stewardship of the aged care system and all of its component parts, including:
 - i. guiding the aged care sector in the delivery of safe and high quality care
 - ii. building providers' capacity and where necessary managing the exit of poor performers
 - iii. fostering innovation and continuous improvement
 - iv. leadership in support of all Government agencies and aged care and other service providers to ensure that the aged care system as a whole delivers safe and high quality aged care
 - v. proactive management of the interface between aged care services, health services, accommodation services, homelessness and disability services and services for those with diverse needs to ensure that barriers to older people receiving fair and equal access to services are removed, and
 - vi. performance of the aged care system, including whether it is meeting the objects and principles of the Act
 - e. a proactive and ambitious ongoing aged care policy reform agenda
 - f. the planning and delivery of safe and high quality aged care
 - g. program design, development and delivery
 - h. research, evaluation and statistical analysis
 - i. funding for the aged care system
 - j. determining user contributions to the cost of aged care services

- k. prudential oversight and approval of providers, and
 - l. public information and disclosure, including the star rating system.
- 6. The Department of Health and Aged Care should have a network of up to 50 small and dedicated regional offices responsible for local planning, engagement with older people, information provision, care finding, assessment, engagement with, and education and support for, providers.
- 7. The fundamental restructuring of the Department of Health and Aged Care should be supported by an immediate capacity and capability review carried out by an eminent person with experience in public sector administration to determine the nature and level of the resources required to fulfil these functions.
- 8. The Department will report annually to Parliament on all important aspects of the operation of the new Act, including:
 - a. the extent of unmet demand for aged care, including unmet demand for particular services or in particular places
 - b. the adequacy of the Australian Government subsidies provided to meet the care needs of people needing or receiving aged care
 - c. the extent to which providers are complying with their responsibilities under the Act
 - d. the amounts paid by people receiving residential care in connection with their care, including amounts paid for accommodation and daily living needs
 - e. the amounts paid for accommodation in the form of lump sum deposits and in the form of daily payments
 - f. the duration of waiting periods for assessment, and between assessment and commencement of provision of particular services, including respite and residential care
 - g. the extent of building, upgrading and refurbishment of aged care facilities, and
 - h. such other aspects of the operation of the Act as the Department considers relevant to ensure an accurate understanding of the operation of the Act.
- 9. Commencing in 2024, the Department should provide a triennial 'state of the aged care sector' report to the Australian Parliament on aged care system performance, which would also identify directions for further aged care reform.

Recommendation 9: The Council of Elders**Commissioner
Briggs**

The Australian Government should, by 1 July 2021, establish a high-level older people's advisory body—The Council of Elders—with a wide remit to consult older people and advise the Minister and Department on any aspect of aged care from the perspective of the quality and safety of care and the rights and dignity of older people.

Recommendation 10: Aged Care Safety and Quality Authority**Commissioner
Briggs**

1. The Aged Care Quality and Safety Commission should be abolished by 1 July 2022 and replaced by an independent Aged Care Safety and Quality Authority, overseen by a board made up of up to five members, with a Chief Executive Officer responsible to the Authority.
2. The Authority should have the overarching purpose of safeguarding the quality and safety of aged care through enforcing compliance with the Act and Standards. In carrying out this purpose, the Authority should actively engage with older people and their families and carers to ensure that their views are incorporated in the Authority's compliance and decision-making, and are kept informed of the outcome of regulatory activities.
3. The functions of the Authority are to:
 - a. approve and accredit providers
 - b. monitor and assess compliance with the quality and safety obligations required of providers under the new Aged Care Act
 - c. address non-compliance with quality and safety obligations by taking enforcement action including:
 - i. enforceable undertakings
 - ii. directions
 - iii. civil penalties on directors
 - iv. amending approval or accreditation conditions
 - v. appointing an administrator to assume responsibility for the conduct of a service
 - vi. revocation of approval as an approved provider or withdrawal of accreditation of a service
 - d. investigate and respond to complaints about the aged care system

- e. provide timely and accurate data as specified by the Department for inclusion in the national information service, including information on compliance and accreditation activities, serious incident reporting and complaints by provider and service
 - f. publish information on the outcomes of regulatory actions, including information on system-wide regulatory activity and outcomes, and publication of enforcement action taken against individual providers
 - g. do anything incidental or conducive to the performance of any of the above functions.
4. The Authority should be fully funded from Budget appropriations.
 5. The Authority's staff will be employed under the *Public Service Act 1999* (Cth). The Authority should ensure that it maintains an appropriate regulatory capability, including regulatory and investigatory skills, clinical skills, assessment skills, and enforcement skills.

Recommendation 11: Independent Hospital and Aged Care Pricing Authority

**Commissioner
Briggs**

The legislation establishing the Independent Hospital Pricing Authority should be amended by 1 July 2021 to rename the Authority as the Independent Hospital and Aged Care Pricing Authority and confer upon it the functions relating to aged care set out in Recommendation 115.

Recommendation 12: Inspector-General of Aged Care

1. The Australian Government should establish an independent office of the Inspector-General of Aged Care to investigate, monitor and report on the administration and governance of the aged care system. This should be done by:
 - a. conducting reviews on its own motion and/or at the request of the System Governor or the Minister or Parliament to ensure the quality and safety of aged care
 - b. reviewing regulator decisions on a systematic basis to ensure regulator integrity and performance
 - c. reviewing the performance of functions by the System Governor, the Quality Regulator, the Prudential Regulator and the Pricing Authority
 - d. monitoring the adequacy of aged care data collection and analysis

- e. monitoring the implementation of the reforms recommended by the Royal Commission, and
 - f. reporting annually to the Australian Parliament on systemic issues in the aged care system and the extent to which the aged care system attains the objects of the new Act.
2. The Inspector-General should have a statutory right of access to all documents and data related to aged care held by the System Governor, the Quality Regulator, the Prudential Regulator and the Pricing Authority.
 3. The Inspector-General of Aged Care should have responsibility for dealing with complaints about the System Governor, the Quality Regulator, the Prudential Regulator and the Pricing Authority.
 4. An Inspector-General should be appointed under interim administrative arrangements, and should in due course be established formally under the new Act.
 5. The Inspector-General should have a separate appropriation and its own staffing, and be housed separately from the System Governor.

Chapter 3: Quality and Safety

Recommendation 13: Embedding high quality aged care

1. The *Aged Care Act 1997* (Cth) should be amended to provide that the Australian Commission on Safety and Quality in Health and Aged Care, in setting and amending safety and quality Standards for aged care (under the functions referred to in Recommendation 18), give effect to the following characteristics of high quality aged care:
 - a. diligent and skilful care
 - b. safe and insightful care
 - c. caring and compassionate relationships
 - d. empowering care
 - e. timely care.

2. 'High quality' care puts older people first. It means a standard of care designed to meet the particular needs and aspirations of the people receiving aged care. High quality care shall:
 - a. be delivered with compassion and respect for the individuality and dignity of the person receiving care
 - b. be personal and designed to respond to the person's expressed personal needs, aspirations, and their preferences regarding the manner by which their care is delivered
 - c. be provided on the basis of a clinical assessment, and regular clinical review, of the person's health and wellbeing, and that the clinical assessment will specify care designed to meet the individual needs of the person receiving care, such as risk of falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care
 - d. enhance to the highest degree reasonably possible the physical and cognitive capacities and the mental health of the person
 - e. support the person to participate in recreational activity and social activities and engagement.

Recommendation 14: A general duty to provide high quality and safe care

1. The new Act should include a general, positive and non-delegable statutory duty on any approved provider to ensure that the personal care or nursing care they provide is of high quality and safe so far as is reasonable, having regard to:
 - a. the wishes of any person for whom the provider provides, or is engaged to provide, that care
 - b. any reasonably foreseeable risks to any person to whom the provider provides, or is engaged to provide, that care, and
 - c. any other relevant circumstances.
2. Any entity that facilitates the provision of aged care services funded in whole or in part under the new Act should have a duty to ensure that any worker whom it makes available to perform personal care work has the experience, qualifications, skills and training to perform the particular personal care or nursing care work the person is being asked to perform.

Recommendation 15: Establishment of a dementia support pathway

1. By 1 January 2023, the Australian Government should establish a comprehensive, clear and accessible post-diagnosis support pathway for people living with dementia, their carers and families. This should involve:
 - a. providing information and advice on dementia and support services, including the aged care system
 - b. facilitating access to peer support networks
 - c. providing education courses, counselling and support services
 - d. providing assistance with planning for continued independent living and access to care, including regular and planned respite for carers.
2. The Australian Government should provide information and material to general practitioners and geriatricians about the pathway and encourage them to refer people to the pathway at the point of diagnosis.

Recommendation 16: Specialist dementia care services

1. By 1 July 2023, the Australian Government should review and publicly report on:
 - a. whether the number of Specialist Dementia Care Units established or planned to be established is sufficient to address need within the areas and populations they are designed to cover
 - b. the capacity of those Units to address the needs of people exhibiting extreme changed behaviour and whether any further resources are required, and
 - c. the suitability of the Units for shorter-stay respite for people living with moderate to extreme changed behaviour
2. The outcome of the review should be implemented by the Australian Government as a matter of urgency.
3. The Australian Government should immediately ensure that the specialist dementia service it funds provides treatment to people with a mental health condition if they meet other eligibility criteria (including, for instance, a diagnosis of dementia).

Recommendation 17: Regulation of restraints

1. The *Quality of Care Principles 2014* (Cth) should be amended by 1 January 2022 to provide that the use of restrictive practices in aged care must be based on an independent expert assessment and subject to ongoing reporting and monitoring. The amendments should reflect the overall principle that people receiving aged care should be equally protected from restrictive practices as other members of the community. In particular, restrictive practices should:
 - a. be prohibited unless:
 - i. recommended by an independent expert, accredited for the purpose by the Quality Regulator, as part of a behaviour support plan lodged with the Quality Regulator and reviewed quarterly by the expert, with reports on implementation of the behaviour support plan being provided to the Quality Regulator on a monthly basis, or
 - ii. when necessary in an emergency to avert the risk of immediate physical harm, with any further use subject to recommendation by an independent expert under Recommendation 17(1)(a)(i), and with a report of the restraint to be provided with reference to the matters in Recommendation 17(1)(b) as soon as practicable after the restraint starts to be used; and
 - b. only be used:
 - i. as a last resort to prevent serious harm after the approved service provider has explored, applied and documented alternative, evidence-based strategies to mitigate the risk of harm
 - ii. to the extent necessary and proportionate to the risk of harm
 - iii. for the shortest time possible to ensure the safety of the person or others
 - iv. subject to monitoring and regular review (to be stipulated in the behaviour support plan) by an approved health practitioner
 - v. in accordance with relevant State or Territory laws and with the documented informed consent of the person receiving care or someone authorised by law to give consent on that person's behalf
 - vi. in the case of chemical restraint, if prescribed by a doctor who has documented the purpose of the prescription.
2. In making these amendments, the Australian Government should consider whether any adjustments or additions are warranted as a result of the statutory review of Part 4A of the *Quality of Care Principles 2014* (Cth).

3. The amendments should also provide that:
 - a. any use of restrictive practices that is not in accordance with the statutory scheme should be reportable under the updated serious incident reporting scheme, and
 - b. any breach of the statutory requirements should expose the approved provider to a civil penalty at the suit of the regulator. If a person directly affected by the breach wants to be compensated, the regulator or the person should have the power to seek an order for compensation.
4. In the interim, the repeal of Part 4A of the *Quality of Care Principles 2014* (Cth) should be delayed until 31 December 2021.
5. Following the conclusion of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, the Australian Government should consider the applicability to aged care of any findings from that Royal Commission about restrictive practices and make further legislative amendments required to ensure that the treatment of people receiving aged care services is consistent with the treatment of other members of the community.

Recommendation 18: Aged care standard-setting by the renamed Australian Commission on Safety and Quality in Health and Aged Care

1. Section 9 of the *National Health Reform Act 2011* (Cth) should be amended to:
 - a. rename the Australian Commission on Safety and Quality in Health Care as the 'Australian Commission on Safety and Quality in Health and Aged Care', and
 - b. confer upon that body the functions of formulating standards, guidelines and indicators relating to aged care safety and quality.
2. Amendments to section 10 of the *National Health Reform Act 2011* (Cth) should also be made to provide for a consultation process for the Commission's aged care functions.

Recommendation 19: Urgent review of the Aged Care Quality Standards

1. By 15 July 2021, the responsible Minister should refer to the Australian Commission on Safety and Quality in Health and Aged Care the following matters for urgent review and, if the Commission considers appropriate, amendment of the Aged Care Quality Standards:
 - a. requiring best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention and mobility, and infection control, and providing sufficient detail on what these requirements involve and how they are to be achieved
 - b. imposing appropriate requirements to meet resident nutritional needs and ensure meals are desirable to eat, having regard to a person's preferences and religious and cultural considerations
 - c. sufficiently reflecting the needs of people living with dementia and providing high quality dementia care
 - d. provider governance, and
 - e. high quality palliative care in residential aged care, including staff capacity (number, skill and type), processes and clinical governance, for recognising deterioration and dying.
2. The Australian Commission on Safety and Quality in Health and Aged Care should complete its review by 31 December 2022.

Recommendation 20: Periodic review of the Aged Care Quality Standards

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

Recommendation 21: Priority issues for periodic review of the Aged Care Quality Standards

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

- a. imposing appropriate requirements relating to the professional development and training for staff
- b. including sufficient reference to and delineation between staff practice roles and responsibilities
- c. requiring providers to assist people receiving care to make and update advance care plans if they wish to, and ensuring that those plans are followed
- d. reflecting the Aged Care Diversity Framework and underlying Action Plans, including considering making them mandatory
- e. incorporating elements of care delivery which reflect a focus on the quality of life of people receiving care.

Recommendation 22: Quality indicators

1. By 15 July 2021, the responsible Minister should refer to the Australian Commission on Safety and Quality in Health and Aged Care responsibility for the introduction, implementation and amendment of aged care quality indicators, including:
 - a. ongoing research into the use and evidence basis for quality indicators
 - b. publication of guidance on use of indicator data to identify risks and to undertake evidence-based risk management.
2. By 1 July 2023, the Australian Commission on Safety and Quality in Health and Aged Care should:
 - a. expand the quality indicators for care in residential aged care
 - b. develop quality indicators for care at home, and
 - c. implement a comprehensive quality of life assessment tool for people receiving aged care in residential care and at home.
3. In the interim, in addition to the existing commitment to implement quality indicators in the new domains of falls and fractures and medication management, the Australian Government should expand the National Mandatory Indicator Program, as set out in the 2019 PwC Consultation Paper 'Development of Residential Aged Care Quality Indicators', to use more comprehensive indicators for the existing domains of pressure injuries, physical restraint and unplanned weight loss.

Recommendation 23: Using quality indicators for continuous improvement

By 1 July 2022, the Australian Government should implement reporting and benchmarking of provider performance against quality indicators. To achieve this:

- a. the Australian Commission for Safety and Quality in Health and Aged Care should develop a methodology to enable providers to be benchmarked against similar providers
- b. the Australian Government should track sector and provider performance and set progressive improvement targets to raise performance against quality indicators over time
- c. the Australian Government should publicly report on sector and provider performance against benchmarks.

Recommendation 24: Star ratings: performance information for people seeking care

1. By 1 July 2022, 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 services and providers. The star ratings and accompanying material should be published on My Aged Care.
2. The star ratings should incorporate a range of measurable data and information, including, at a minimum:
 - a. graded assessment of service performance against Standards
 - b. performance against relevant clinical and quality indicators
 - c. staffing levels
 - d. robust information from people receiving aged care services, their families and advocates, when available.
3. The overall star rating should be accompanied by appropriate additional information on performance and outcomes, in a readily understandable form and capable of comparison across services and providers. This should include all performance information that is relevant to the performance of a service, even if it is not reflected in the overall star rating outcome. For example, it should include:
 - a. details about current and previous assessment by the Quality Regulator, including notices of non-compliance, sanctions, withdrawal of accreditation or approved provider status
 - b. benchmarked performance for all quality indicators that are suitable for publication, including changes in performance over time

- c. information from older people, their families and advocates
- d. serious incident reports data
- e. complaints data.

4. The Australian Aged Care Commission should assume responsibility for the star ratings system from 1 July 2023 onwards.

Commissioner
Pagone

Chapter 4: Program Design

Recommendation 25: A new aged care program

By 1 July 2024, the System Governor should implement a new aged care program that combines the existing Commonwealth Home Support Programme, Home Care Packages Program, and Residential Aged Care Program, including Respite Care and Short-Term Restorative Care. The new program should retain the benefits of each of the component programs, while delivering comprehensive care for older people with the following core features:

- a. a common set of eligibility criteria identifying a need (whether of a social, psychological or physical character) to prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects of such deterioration, and to enhance the person's ability to live independently as well as possible, for as long as possible
- b. an entitlement to all forms of support and care which the individual is assessed as needing
- c. a single assessment process based upon a common assessment framework and arrangements followed by all assessors
- d. certainty of funding and availability based upon assessed need
- e. genuine choice and flexibility accorded to each individual about how their aged care needs are to be met (including choice of provider and level of engagement in managing care, and appropriate and adapted supports to enable people from diverse backgrounds and experiences to exercise choice)
- f. access to one or multiple categories of the aged care program simultaneously, based on need
- g. portability of entitlement between providers throughout Australia.

Recommendation 26: Improved public awareness of aged care

1. By 1 July 2022, the System Governor in cooperation with other levels of government, and working with health professionals, aged care providers and Primary Health Networks, should fund and support education, and the dissemination of information, and strategies to:
 - a. improve public awareness of the resources available to assist people to plan for ageing and potential aged care needs
 - b. improve knowledge about aged care among those responsible professionals with whom older people have frequent contact
 - c. encourage public discussion about and consideration of aged care needs.
2. These strategies should be implemented by 1 July 2022 and should:
 - a. support continual planning for ageing, including consideration of health care preferences, finances, housing and social engagement
 - b. bring older people's general practitioners to the centre of planning for ageing and aged care; and
 - c. be evaluated and revised annually by the System Governor.

Recommendation 27: More accessible and usable information on aged care

**Commissioner
Briggs**

The Australian Government should continue to enhance My Aged Care to ensure it is the Government's official source of consistent, accessible, inclusive, reliable and useful information about the aged care system and aged care providers. This should include developing a comprehensive provider search function on My Aged Care that allows people to review and compare:

- a. information on the kinds of services the provider delivers, including whether providers of home care services offered in regional, rural and remote areas are locally available.
- b. information on service capacity and use
- c. information on star ratings and other performance indicators (as detailed in Recommendation 24 in the quality and safety chapter)
- d. annual reports from approved providers about their operations and performance (as detailed in Recommendation 88 in the provider governance chapter)
- e. all information at (a) to (d) will be standardised and verified by the System Governor.

Recommendation 28: A single comprehensive assessment process

1. By 1 July 2023, the Australian Government should replace the Aged Care Assessment Program and the Regional Assessment Services with one assessment process. That assessment process should:
 - a. be undertaken by an assessor who is independent from approved providers, so that a person's level of funding should be determined independently of the approved provider
 - b. occur, wherever possible, before funded services commence, although funded services may be offered on an interim basis pending assessment where this is necessary in the opinion of a care finder
 - c. be efficient and scalable according to the complexity of needs and vulnerability of the older person
 - d. be forward-looking and promote older people's autonomy and self-determination
 - e. include assessment of the need for care management and the intensity and complexity of that need
 - f. include an assessment of any informal carer's needs
 - g. use multidisciplinary teams for more complex needs.
2. People should be provided with details of their assessed need and funding level at the conclusion of the assessment process.
3. Reasonable requests for reassessment of need can be made by a person receiving care (or their informal carer, close family or other representative), their care finder, or their approved provider.
4. The determination referred to in 1.a may involve consultation with providers or prospective providers, provided final assessment decisions affecting eligibility for funding are made by independent assessors.

**Commissioner
Pagone**

Recommendation 29: Care finders to support navigation of aged care

**Commissioner
Briggs**

1. From 1 July 2023, the Australian Government should fund the engagement of a workforce of personal advisers to older people, their families and carers, called 'care finders'.
2. The function of care finders will be to assist older people seeking aged care services with information about the aged care system and case management services by:

- a. providing face-to-face support to older people to help them identify the best options for care to meet their individual needs and goals, to exercise informed choice, and to understand their entitlements. That support should be scalable and proportionate to need and vulnerability
 - b. assisting older people to understand, gain access to and participate in assessments and reassessments of needs and eligibility for aged care, and work closely with the local assessment team to facilitate the assessment process
 - c. ascertaining the best options for services in the local area and link them to these options. This may also involve linking the older person to services outside the aged care system, such as housing, mental health or health care more generally
 - d. following up to make sure that referrals have been accepted and the support and care identified in the assessment is in place
 - e. conducting regular check-ins with the older person to ensure that the services are meeting their needs
 - f. where changes in needs occur, or services are not meeting needs, taking the necessary steps in consultation with the older person, including reassessment or referrals to services.
3. Care finders will be employees of the System Governor, a State or Territory or a local government body, who are suitably qualified in aged care, health care or social work.

Recommendation 30: Designing for diversity, difference, complexity and individuality

1. From 1 July 2022, the System Governor should:
 - a. require that:
 - i. as a condition of approval or continued approval of providers, training on cultural safety and trauma-informed service delivery be provided for all workers engaged by providers who are involved in direct contact with people seeking or receiving services in the aged care system
 - ii. comparable training be provided for people engaged to provide care finder and assessment services
 - iii. as a condition of approval or continued approval, providers verify to the satisfaction of the System Governor that the provider has proper grounds for making any representation of being able to provide specialised services for groups of people with diverse backgrounds and life experiences

- b. formulate a standard dataset and data collection mechanism for collecting, monitoring, analysing and using data about the diverse backgrounds and life experiences of older people seeking or receiving aged care, including, as considered appropriate, people whose circumstances are not currently included in the 'special needs' provision, such as those living with mental illness, dementia or disability, and
- c. commence collection and analysis of those data for the purpose of identifying variations in and improving equity of access to, and use of, aged care by people of diverse backgrounds and experiences (subject to the operation of the *Privacy Act 1988* (Cth)).

2. The System Governor should:

- a. by 1 July 2024, in consultations with representative and peak organisations, complete a national audit evaluating regional and local variation in levels of services for people from diverse backgrounds and life experiences, including consumer experience information, and, in light of the outcomes of the national audit, thereafter undertake commissioning arrangements to address deficits in meeting the needs of people from diverse backgrounds on a regional and local basis as required
- b. by 31 December 2024, report to the Inspector-General and the public on the extent to which the needs of diverse older people are being met by the aged care system and what further steps need to be taken for the aged care system to meet the needs of diverse older people.

Recommendation 31: Approved provider's responsibility for care management

- 1. From 1 July 2022, a person's approved provider must assign a care manager to the person unless an assessment team has assessed the person as eligible for home care and, in future, 'care at home' without the need for any care management.
- 2. In the case of home care and, in future, 'care at home', if the person has more than one approved provider, the person's lead provider must assign a care manager to the person.
- 3. Care management should be scaled to match the complexity of the older person's needs and should be provided in a manner that respects any wishes of the person to be involved in the management of their care.
- 4. The care manager should:
 - a. have relevant qualifications and experience suitable for the range and complexity of the care needs of the people to whom the care manager provides care management

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

Recommendation 32: Respite supports category

From 1 July 2022, the Australian Government should implement a respite supports category within the aged care program that:

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

Recommendation 33: Social supports category

From 1 July 2022, the Australian Government should implement a social supports category within the aged care program that:

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

Recommendation 34: Assistive technology and home modifications category

From 1 July 2022, the Australian Government should implement an assistive technology and home modifications category within the aged care program that:

- a. provides goods, aids, equipment and services that promote a level of independence in daily living tasks and reduces risks to living safely at home
- b. includes the assistive technology, home modifications and hoarding and squalor service types from the Commonwealth Home Support Programme
- c. is grant funded.

Recommendation 35: Care at home category

The System Governor should be in a position to commence payment of subsidies for service provision within a new care at home category by 1 July 2024. This category should be developed and iteratively refined in consultation with the aged care sector and older people. The starting point for this consultation and refinement process should be that this category:

- a. supports older people living at home to preserve and restore capacity for independent and dignified living to the greatest extent and prevents inappropriate admission to long-term residential care

- b. offers episodic or ongoing care from low needs (for example, one hour of domestic assistance per week) to high needs (for example, multiple hours of personal care and nursing care)
- c. provides a form of entitlement (such as, for example, a budget) based on assessed needs which allows for a coordinated and integrated range of care and supports across the following domains:
 - i. care management
 - ii. living supports, including cleaning, laundry, preparation of meals, shopping for groceries, gardening and home maintenance
 - iii. personal, clinical, enabling and therapeutic care, including nursing care, allied health care and restorative care interventions
 - iv. palliative and end-of-life care
- d. requires a lead provider to be chosen by the older person. The lead provider will:
 - i. be responsible for ensuring that services are delivered to address the assessed needs
 - ii. monitor the status of people receiving care and adjust the nature and intensity of the care to meet the person's needs
 - iii. seek a reassessment if an increased need persists beyond three months.

Recommendation 36: Care at home to include allied health care

1. From 1 July 2023, the System Governor should ensure care at home includes a level of allied health care appropriate to each person's needs.
2. From 1 July 2024, System Governor should:
 - a. ensure that the assessment process for eligibility for care at home identifies any allied health care that an older person needs to restore their physical and mental health to the highest level possible (and maintain it at that level for as long as possible) to maximise their independence and autonomy
 - b. ensure that the funding assigned to the older person following the assessment includes an amount to meet any identified need for allied health care, whether episodic or ongoing. This allocation must be spent on allied health care and be consistent with practice guidelines developed by the System Governor

- c. require the older person's lead home care provider to:
 - i. be responsible for ensuring that these services are delivered
 - ii. monitor the status of people receiving care and adjust the nature and intensity of the care provided to meet their needs
 - iii. seek a new aged care assessment if an increased need persists beyond three months
- d. reimburse the provider for the cost of any additional allied health care needed by the older person through an adjusted Home Care Package, without the need for a new aged care assessment, for a period of up to three months, and undertake a new aged care assessment if the need for additional services persists beyond three months.

Recommendation 37: Residential care category

1. From 1 July 2024, the System Governor should implement a category within the new aged care program for residential care that:
 - a. provides older people with:
 - i. goods, aids, equipment and services to meet daily living needs
 - ii. accommodation
 - iii. care and support to preserve and, where possible, restore capacity for meaningful and dignified living in a safe and caring environment
 - b. ensures care is available for people who can no longer live at home due to their frailty, vulnerability or behavioural and psychological symptoms of dementia, or other reasons
 - c. provides integrated and high quality and safe care based on assessed needs, which allows for personalised care, regular engagement, and a coordinated and integrated range of supports across the following domains:
 - i. care management
 - ii. social supports, including support for psychological, cultural and (if applicable) spiritual wellbeing
 - iii. personal, clinical, enabling, therapeutic care and support, including nursing care and allied health care
 - iv. palliative and end-of-life care.

Recommendation 38: Residential aged care to include allied health care

To ensure residential aged care includes a level of allied health care appropriate to each person's needs, the System Governor should, by no later than 1 July 2024:

- | | |
|---|-----------------------------------|
| <p>a. require providers to have arrangements with allied health professionals to provide services to people receiving care as required by their assessment or care plan</p> | <p>Commissioner Pagone</p> |
| <p>b. require approved providers to:</p> <ul style="list-style-type: none"> i. employ, or otherwise retain, at least one of each of the following allied health professionals: an oral health practitioner, a mental health practitioner, a podiatrist, a physiotherapist, an occupational therapist, a pharmacist, a speech pathologist, a dietitian, an exercise physiologist, and a music or art therapist ii. have arrangements with optometrists and audiologists to provide services as required to people receiving care | <p>Commissioner Briggs</p> |
| <p>c. provide funding to approved providers for the engagement of allied health professionals through a blended funding model, including:</p> <ul style="list-style-type: none"> i. a capped base payment per resident designed to cover about half of the costs of establishing ongoing engagement of allied health professionals ii. an activity based payment for each item of direct care provided <p>with the Pricing Authority determining the quantum of funding for the base payment and the level of activity based payments, including by taking into account the extra costs of providing services in regional, rural and remote areas</p> | |
| <p>d. ensure that providers provide allied health services to residents in accordance with their individual care plans through the strict monitoring of the level of allied health services that are actually delivered, including the collection and review of data on:</p> <ul style="list-style-type: none"> i. the number of full-time equivalent allied health professionals delivering services ii. the number of current allied health assessments iii. the volume of service provision, and iv. expenditure on allied health services. | |

Recommendation 39: Meeting preferences to age in place

The Australian Government should clear the Home Care Package waiting list, otherwise known as the National Prioritisation System, by:

- a. immediately increasing the Home Care Packages available and allocating a package to all people on the waiting list that do not yet have a package or do not yet have a package at the level they have been approved for (as set out in their letter from the Aged Care Assessment Team / Service). The package allocated should be at the level the person was approved for (Level 1, 2, 3 or 4). This must be completed by 31 December 2021
- b. keeping the waiting list clear by allocating a Home Care Package at the approved level to any new entrants to the waiting list within one month of the date of their assessment. This must occur between 1 January 2022 and 1 July 2024
- c. publicly reporting, each quarter, the status of the waiting list, showing progress in clearing the waiting list as set out in paragraphs a. and b. above, at a national, State or Territory, and regional level. This report should include reasons for delay in clearing the waiting list and actions being taken to address the delay. This must occur every quarter from 31 March 2021 to 1 July 2024
- d. pending the establishment of the care finder workforce, the Government should immediately establish a short-term program to link people allocated a Home Care Package with appropriate providers and to encourage the expansion of the home care sector. The 50-day requirement to accept a Home Care Package should be increased to 150 days.

Recommendation 40: Transition to care at home

1. The Australian Government should commence the transition to the care at home category by ensuring:
 - a. from 1 July 2022, any older person that is accessing the Home Care Packages Program can also access supports from the new respite or social support grant categories. These supports should be in addition to the Home Care Package and not be paid for from Home Care Package funds. This should also apply to the assistive technology and home modifications category, but a short assessment should be undertaken to determine the needs of older people for this category
 - b. from 1 December 2023, all older people who are assessed for aged care in their home, should be assessed for a Home Care Package level as well as the equivalent classification in the new care at home category

- c. between 1 July 2024 and 1 July 2025, any older people who are still accessing the Home Care Packages Program (and do not yet have a care at home classification) should be assessed for a care at home classification, so long as the classification does not disadvantage the person (for example, it does not offer lower funding than they had been receiving under the Home Care Packages Program).
- 2. To support this transition, the Australian Government should increase the assessment workforce between 1 July 2023 and 1 July 2025.

Recommendation 41: Planning based on need, not rationed

By 1 July 2024, the System Governor should replace the Aged Care Provision Ratio with a new planning regime which:

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

Chapter 5: Informal Carers and Volunteers

Recommendation 42: Support for informal carers

The Australian Government should improve services and support for informal carers by:

- a. linking My Aged Care and the Carer Gateway by 1 July 2022, 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
- b. on and from 1 July 2022:
 - i. enabling direct referral and information sharing for informal carers between My Aged Care, care finders, assessment services and the Carer Gateway

- ii. providing accurate and up-to-date information on My Aged Care about the range of supports locally available to informal carers, including training, education, counselling, respite, income support, and, access to the Carers Hub network (once established)
- c. on and from 1 July 2023:
 - i. requiring My Aged Care, care finders and assessment services to identify the primary informal carer when assessing a person for aged care
 - ii. enabling care finders to refer the primary informal carer to assessment services for assessment for, and access to, formal respite care and other supports available
 - iii. establishing and funding a community-based Carers Hub network.

Recommendation 43: Examination of Leave for Informal Carers

Commissioner
Briggs

1. By 30 September 2022, the Australian Government should examine the potential impact of amending the National Employment Standards under Part 2-2 of the *Fair Work Act 2009* (Cth) to provide for an additional entitlement to unpaid carer's leave.
2. The results of this investigation should be made public by 31 December 2022.

Recommendation 44: Volunteers and Aged Care Volunteer Visitors Scheme

From 1 July 2021, the Australian Government should promote volunteers and volunteering in aged care to support older people to live a meaningful and dignified life and supplement the support and care provided to them through the aged care system, whether in their own home or in a residential care home, by:

- a. increasing the funding to the Volunteer Grants under the Families and Communities Program – Volunteer Grants Activity in 2021–22 to support organisations and community groups to recruit, train and support volunteers who provide assistance to older people
- b. requiring, as a condition of approval and continuing approval of all approved providers, that all aged care services which use volunteers to deliver in-house coordinated and supervised volunteer programs must:
 - i. assign the role of volunteer coordination to a designated staff member

- ii. provide induction training to volunteers and regular ongoing training to volunteers in caring for and supporting older people, complaints management and the reporting of reasonably suspected abuse or neglect
 - iii. retain evidence of provision of such training
- c. providing additional funding, and expanding the Community Visitors Scheme and changing its name to the Aged Care Volunteer Visitors Scheme, to provide extended support for older people receiving aged care who are at risk of social isolation.

Chapter 6: Aged Care Accommodation

Recommendation 45: Improving the design of aged care accommodation

The Australian Government should guide the design of the best and most appropriate residential aged care accommodation for older people by:

- a. developing and publishing by 1 July 2022 a comprehensive set of National Aged Care Design Principles and Guidelines on accessible and dementia-friendly design for residential aged care, which should be:
 - i. capable of application to ‘small household’ models of accommodation as well as to enablement and respite accommodation settings
 - ii. amended from time to time as necessary to reflect contemporary best practice
- b. implementing by no later than 1 July 2023 a program to promote adoption of these National Aged Care Design Principles and Guidelines in design and construction of residential aged care buildings, which should include:
 - i. industry education, including sharing of best practice models
 - ii. financial incentives, whether by increased accommodation supplements or capital grants or other measures or a combination of such measures, for residential aged care buildings that comply with the Guidelines
- c. advancing to the National Federation Reform Council by 1 July 2025 a proposal for any amendments to Class 9c of the *National Construction Code* 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.

Recommendation 46: Capital grants for ‘small household’ models of accommodation

1. From 1 January 2022, the Australian Government should provide additional capital grants for building or upgrading residential aged care facilities to provide small-scale congregate living.
2. 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.
3. Priority for these capital grants should be given to approved providers whose premises have or will have a majority of aged care residents who are (within the meaning of section 7 of the *Grant Principles 2014* (Cth)) in one or more of the following categories:
 - a. low-means care recipients, supported residents, concessional residents or assisted residents
 - b. people with special needs
 - c. people who live in a location where there is a demonstrated need for additional residential care services
 - d. people who do not live in a major city.
4. The capital grants program for building or upgrading residential aged care facilities to provide small-scale congregate living should continue after the introduction of the new Act.

Commissioner
Briggs

Chapter 7: Aged Care for Aboriginal and Torres Strait Islander People

Recommendation 47: Aboriginal and Torres Strait Islander aged care pathway within the new aged care system

The Australian Government should ensure that the new aged care system makes specific and adequate provision for the diverse and changing needs of Aboriginal and Torres Strait Islander people and that:

- a. Aboriginal and Torres Strait Islander people receive culturally respectful and safe, high quality, trauma-informed, needs-based and flexible aged care services regardless of where they live

- b. priority is given to existing and new Aboriginal and Torres Strait Islander organisations, including health, disability and social service providers, to cooperate and become providers of integrated aged care services
- c. regional service delivery models that promote integrated care are deployed wherever possible
- d. there is a focus on providing services within, or close to, Aboriginal and Torres Strait Islander populations while maximising opportunities for people to remain on, and maintain connection with, their Country and communities
- e. aged care is available and providers are engaged at the local aged care planning region level on the basis of objectively established need that is determined in consultation with Aboriginal and Torres Strait Islander populations and communities, and recognising that aged care needs and service delivery preferences may vary between locations and population centres
- f. older Aboriginal and Torres Strait Islander people are given access to interpreters on at least the same basis as members of culturally and linguistically diverse communities when seeking or obtaining aged care, including health care services.

Recommendation 48: Cultural safety

1. By 1 July 2022, the Australian Government and the System Governor should:
 - a. require all of its employees who are involved in the aged care system, and any care finders who are not its employees, to undertake regular training about cultural safety and trauma-informed service delivery
 - b. require all aged care providers which promote their services to Aboriginal and Torres Strait Islander people to:
 - i. train their staff in culturally safe and trauma-informed care, and
 - ii. demonstrate to the System Governor that they have reached an advanced stage of implementation of the Aboriginal and Torres Strait Islander Action Plan under the Diversity Framework.
2. From 1 July 2023, the System Governor should:
 - a. ensure care finders serving Aboriginal and Torres Strait Islander communities are local Aboriginal and Torres Strait Islander people who are culturally trained and familiar with existing Aboriginal and Torres Strait Islander service providers who are trusted by the local population

- b. 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
 - c. work with State and Territory Governments to establish culturally appropriate advance care directive processes, guidance material and training for aged care providers that account for the diversity of cultural practices and traditions within each State and Territory.
3. From 1 July 2023, the System Governor should require its employees, and any care finders who are not its employees, to undertake regular training about cultural safety and trauma-informed service delivery.

Recommendation 49: An Aboriginal and Torres Strait Islander Aged Care Commissioner

1. By 1 July 2023, there should be within the System Governor a statutory role that involves the ongoing fostering, promotion and development of culturally safe, tailored and flexible aged care services for Aboriginal and Torres Strait Islander people across the country. The person appointed to this role shall be an Aboriginal or Torres Strait Islander person.
2. A person should be appointed by 31 December 2021 under interim administrative arrangements to perform relevant functions and exercise relevant powers.

Recommendation 50: Prioritising Aboriginal and Torres Strait Islander organisations as aged care providers

1. The Australian Government should assist Aboriginal and Torres Strait Islander organisations to expand into aged care service delivery, whether on their own or in partnership with other organisations, including with Aboriginal Community Controlled Organisations and existing Aboriginal and Torres Strait Islander providers.
2. The Australian Government and the System Governor should encourage and support additional Aboriginal and Torres Strait Islander aged care providers by flexible approval and regulation of them to ensure:
 - a. existing Aboriginal and Torres Strait providers are not disadvantaged and should continue to provide high quality and safe aged care while being assisted to meet the new provider requirements

- b. other organisations that wish to move into aged care to enhance services to Aboriginal and Torres Strait Islander people across Australia are given special consideration.
- 3. Flexibility in approval and regulation should extend to such matters as: additional time to meet new requirements; alternative means of demonstrating the necessary capability or requirement; and, in some very limited cases, exemptions. Assistance should include financial assistance for capacity-building.

Recommendation 51: Employment and training for Aboriginal and Torres Strait Islander aged care

- 1. By 1 December 2022, the Australian Government should:
 - a. develop a comprehensive national Aboriginal and Torres Strait Islander Aged Care Workforce Plan in consultation with the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care, including:
 - i. the refinement of existing Aboriginal and Torres Strait Islander training and employment programs
 - ii. targets for the training and employment of Aboriginal and Torres Strait Islander people across the full range of aged care roles
 - b. provide the funds necessary to implement the Plan and meet the training and employment targets
 - c. work with the State and Territory Governments to implement the Plan, which should include making available vocational educational training facilities, teachers and courses available in urban, rural, regional and remote Australia.
- 2. In the interim, the Australian Government should ensure, in consultation with the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care, that the existing employment programs and initiatives for Aboriginal and Torres Strait Islanders are aligned to the needs of the aged care sector.

Recommendation 52: Funding cycle

1. The Australian Government should block fund providers under the Aboriginal and Torres Strait Islander aged care pathway (see Recommendation 47) on a three-to seven-year rolling assessment basis.
2. The Pricing Authority should:
 - a. set the funding of the Aboriginal and Torres Strait Islander aged care pathway following advice from the Aboriginal and Torres Strait Islander Commissioner, and
 - b. annually assess and adjust the block funding on the basis of the actual costs incurred while providing culturally safe and high quality aged care services to Aboriginal and Torres Strait Islander people in the preceding year.

Recommendation 53: Program streams

1. Under the Aboriginal and Torres Strait Islander aged care pathway, the Australian Government and the System Governor should:
 - a. provide flexible grant funding streams that are able to be pooled for:
 - i. home and community care
 - ii. residential and respite care, including transition
 - b. establish funding streams under the Aboriginal and Torres Strait Islander aged care pathway that allow Aboriginal and Torres Strait Islander aged care pathway providers to apply for funding for:
 - i. capital development and expenditure
 - ii. provider development
 - c. make funds available, on application, for any residential aged care provider that has Aboriginal and Torres Strait Islander residents who require assistance to retain connection to their Country, including meeting the costs of:
 - i. travel to and from Country, as well as the costs of any people needed to provide clinical or other assistance to the resident to make the trip
 - ii. a family member travelling to and from the older person at a distant residential facility
 - iii. establishing, maintaining and using infrastructure that facilitates connection between the residential facility and communities on Country, such as videoconferencing technology.

Chapter 8: Aged Care in Regional, Rural and Remote Areas

Recommendation 54: Ensuring the provision of aged care in regional, rural and remote areas

The System Governor should ensure that older people in regional, rural and remote locations are able to access aged care in their community equitably with other Australians by:

- a. identifying areas where service supply is inadequate, and
- b. actively responding by planning for, and supplementing services to meet entitlements and needs.

Recommendation 55: The Multi-Purpose Services Program

From 1 December 2021, the Australian Government, working together with State and Territory Governments, should maintain and extend the Multi-Purpose Services Program by:

- a. establishing new Multi-Purpose Services in accordance with community need as identified by the System Governor, including:
 - i. in areas where there is an existing aged care provider, if the System Governor advises that the demographic and market profile justify increased access to aged care services
 - ii. in areas where there is not an existing acute health service, but governments agree that a combined aged care and health service would address local needs
- b. ensuring that people entering Multi-Purpose Services are subject to the same eligibility and needs assessments as all other people receiving aged care
- c. requiring people accessing Multi-Purpose Services to make contributions to the cost of their care and accommodation on the same basis as all other people receiving aged care (with appropriate protections for people currently accessing Multi-Purpose Services)
- d. permitting Multi-Purpose Service providers to access all aged care funding programs on the same basis as other aged care providers

- e. developing a funding model for Multi-Purpose Services which reflects the changing number and acuity of people receiving care over time while maintaining certainty of funding over the course of a financial year
- f. establishing a cost-shared capital grants program to rebuild or refurbish older Multi-Purpose Services to ensure that the infrastructure meets contemporary aged care design standards, particularly to support the care of people living with dementia.

Chapter 9: Better Access to Health Care

Recommendation 56: A new primary care model to improve access

- | | |
|--|-----------------------------------|
| <p>1. Commencing by no later than 1 January 2024, the Australian Government should trial for six to ten years a new voluntary primary care model for people receiving aged care.</p> | <p>Commissioner Pagone</p> |
| <p>2. Commencing by no later than 1 January 2024, the Australian Government should implement a new voluntary primary care model for people receiving aged care.</p> | <p>Commissioner Briggs</p> |
3. The new primary care model would have the following characteristics:
- a. general practices may, if they choose, apply to the Australian Government to become accredited aged care general practices
 - b. the initial accreditation criteria would be:
 - i. accreditation with the Royal Australian College of General Practitioners
 - ii. participation in after-hours cooperative arrangements, and
 - iii. use of My Health Record
 - c. over time, as aged care general practices mature, the accreditation requirements could be strengthened
 - d. each accredited aged care general practice would enrol people receiving residential care or personal care at home who choose to be enrolled with that practice
 - e. each accredited aged care general practice would receive an annual capitation payment for every enrolled person, based on the person's level of assessed need

- f. an accredited aged care general practice would agree with each enrolled person and the person's aged care provider on how care will be provided, including by any use of telehealth services and nurse practitioners
 - g. the accredited aged care general practice would be required to:
 - i. meet the primary health care needs of each enrolled older person (including through any cooperative arrangements with other general practices to provide after-hours care if required)
 - ii. use My Health Record in conjunction with aged care providers
 - iii. initiate and take part in regular medication management reviews
 - iv. prepare an 'Aged Care Plan' (in collaboration with a geriatrician and the aged care provider and others) for each enrolled person
 - v. accept any person who wishes to enrol with it (subject to geography) to avoid practices accepting only patients with less complex care needs, and
 - vi. report on performance against a range of performance indicators, including immunisation rates and prescribing rates
 - h. the capitation payment would be reduced by the value of benefits paid when an enrolled person sees a general practitioner in another practice.
4. The Australian Government should undertake a thorough evaluation of the new primary care model, including any trial, in 2030 and make appropriate adjustments to the model at that time.

Recommendation 57: Royal Australian College of General Practitioners accreditation requirements

By 31 December 2021, the Royal Australian College of General Practitioners should amend its *Standards for general practices* to allow for accreditation of general practices which practise exclusively in providing primary health care to people receiving aged care in residential aged care facilities and in their own homes.

Recommendation 58: Access to specialists and other health practitioners through Multidisciplinary Outreach Services

1. By 1 January 2022, the Australian and State and Territory Governments should introduce Local Hospital Network-led multidisciplinary outreach services.
2. These services should be funded through amendment of the National Health Reform Agreement, and all people receiving residential care or personal care at home should have access based on clinical need.
3. The amended National Health Reform Agreement should include a recurrent and sustainable funding mechanism to stimulate outreach services. The level of funding should be based on underlying costs as determined by the Independent Hospital Pricing Authority.
4. The key features of the model should include:
 - a. provision of services in a person's place of residence wherever possible
 - b. multidisciplinary teams, including nurse practitioners, allied health practitioners and pharmacists
 - c. access to a core group of relevant specialists, including geriatricians, psychogeriatricians and palliative care specialists
 - d. embedded escalation to other specialists (including endocrinologists, cardiologists, infectious disease specialists and wound specialists), who are already salaried within the hospital and assigned to the model for part of their work
 - e. 24 hour a day on-call services available to:
 - i. people receiving residential care or personal care at home
 - ii. the families of those people receiving aged care, and
 - iii. staff of aged care services
 - f. proactive care and rehabilitation
 - g. a focus, where feasible, on skills transfer to staff working in aged care
 - h. a specific focus on palliative care outreach services
 - i. clinical governance arrangements involving Local Hospital Networks and relevant aged care and primary care providers.

Recommendation 59: Increased access to Older Persons Mental Health Services

By 1 January 2022, the Australian and State and Territory Governments should:

- a. fund separately, under the National Health Reform Agreement, outreach services delivered by State and Territory Government Older Persons Mental Health Services to people receiving residential aged care or personal care at home
- b. introduce performance measures and benchmarks for these outreach services
- c. promulgate standardised service eligibility criteria for hospital, community-based, and aged care Older Persons Mental Health Services that do not exclude people living with dementia from eligibility for such services.

Recommendation 60: Establish a Senior Dental Benefits Scheme

The Australian Government should establish a new Senior Dental Benefits Scheme, commencing no later than 1 January 2023, which will:

- a. fund dental services to people who:
 - i. live in residential aged care, or
 - ii. live in the community and receive the age pension or qualify for the Commonwealth Seniors Health Card
- b. include benefits set at a level that minimises gap payments, and includes additional subsidies for outreach services provided to people who are unable to travel, with weightings for travel in remote areas
- c. provide benefits for services limited to treatment required to maintain a functional dentition (as defined by the World Health Organization) with a minimum of 20 teeth, and to maintain and replace dentures.

Recommendation 61: Short-term changes to the Medicare Benefits Schedule to improve access to medical and allied health services

The Australian Government should:

- a. create specific Medicare Benefits Schedule items by 1 November 2021 to allow for a benefit to be paid for a comprehensive health assessment, whether conducted by a general practitioner or a nurse practitioner, when a person receiving aged care begins to receive residential aged care or personal care at home and at six month intervals thereafter, or more frequently if there is a material change in a person's circumstances or health
- b. immediately amend the Medicare Benefits Schedule to allow benefits to be paid under the GP Mental Health Treatment items 2700 to 2717 to patients receiving these services at a residential aged care facility
- c. create specific Medicare Benefits Schedule items by 1 November 2021 for:
 - i. a mental health assessment, and subsequent development of a treatment plan, by a general practitioner or psychiatrist, within two months of a person's entry into residential aged care
 - ii. three-monthly reassessments or reviews of a mental health assessment by a general practitioner, psychiatrist, or psychologist
- d. create new Medicare Benefits Schedule items by 1 November 2021, with the value of the benefit aligned with recommended professional fees, for allied mental health practitioners (including psychologists, occupational therapists and social workers) providing services to people in residential aged care and:
 - i. the number of services for which a benefit is payable should be based on clinical advice
 - ii. these benefits should cease on 30 June 2024, when the aged care allied health funding arrangement is established
- e. amend the General Practitioner Aged Care Access Incentive payment to:
 - i. increase the minimum annual number of services required by general practitioners to qualify for the payment and the amount of the corresponding payment
 - ii. introduce incremental increases to the amount of the payment for general practitioners who deliver more than the minimum annual number of services

and index these amounts on the same basis as Medicare Benefits Schedule general practitioner attendance items.

Recommendation 62: Enhance the Rural Health Outreach Fund to improve access to medical specialists for people receiving aged care

The Australian Government should:

- a. amend the priorities of the Rural Health Outreach Fund by 1 July 2021 to include delivery of:
 - i. geriatrician services in regional, rural and remote Australia, and
 - ii. medical specialist services to people receiving aged care in regional, rural and remote Australia
- b. increase, for these additional priorities, the annual funds available by \$9.6 million, starting in the 2021–22 financial year, and
- c. ensure that these additional priorities of the Fund are maintained on an ongoing basis.

Recommendation 63: Access to specialist telehealth services

By 1 November 2021, the Australian Government should:

- a. expand access to Medicare Benefits Schedule-funded specialist telehealth services to older people receiving personal care at home
- b. require aged care providers delivering residential care or personal care at home to have the necessary equipment and clinically and culturally capable staff to support telehealth services.

Recommendation 64: Increased access to medication management reviews

The Australian Government should immediately improve access to quality medication management reviews for people receiving aged care by:

- a. allowing and funding pharmacists from 1 January 2022 to conduct reviews on entry to residential care and annually thereafter, or more often if there has been a significant change to the person receiving care's condition or medication regimen
- b. amending the criteria for eligibility for residential medication management reviews to include people in residential respite care and transition care
- c. monitoring quality and consistency of medication management reviews.

Recommendation 65: Restricted prescription of antipsychotics in residential aged care

By 1 November 2021, the Australian Government should amend the Pharmaceutical Benefits Scheme Schedule so that:

- a. only a psychiatrist or a geriatrician can initially prescribe antipsychotics as a pharmaceutical benefit for people receiving residential aged care, and
- b. for those people who have received such an initial prescription from a psychiatrist or a geriatrician, general practitioners can issue repeat prescriptions of antipsychotics as a pharmaceutical benefit for up to a year after the date of the initial prescription.

Recommendation 66: Improving the transition between residential aged care and hospital care

The Australian and State and Territory Governments should:

- a. by 1 July 2022, implement, and commence publicly reporting on compliance with, hospital discharge protocols that ensure that discharge to residential aged care from hospital should only occur once appropriate clinical handover and discharge summary (including medications list) has been provided to and acknowledged by the residential care service, and provided to the person being discharged
- b. by 1 December 2021, require staff of aged care services, when calling an ambulance for a resident, to provide the paramedics on arrival with an up-to-date summary of the resident's health status, including medications and advance care directives.

Recommendation 67: Improving data on the interaction between the health and aged care systems

The Australian Government and State and Territory Governments should improve the data available to monitor the interaction between the health and aged care systems and improve health and aged care planning and funding decisions. In particular:

- a. the Australian Government should implement an aged care identifier by no later than 1 July 2022 in the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme Schedule datasets to allow regular public reporting on the number and type of medical and pharmaceutical services provided to people receiving aged care

- b. by no later than 1 July 2023, all health National Minimum Data Sets reported to the Australian Institute of Health and Welfare (other than those relating to maternity, neonatal and paediatric care) should include an item identifying whether a person is receiving aged care services and the type of aged care the person is receiving
- c. National Minimum Data Sets covering all State and Territory Government-funded health services should be implemented by no later than 1 July 2023
- d. all governments should implement a legislative framework by no later than 1 July 2023 for health and aged care data to be directly linked, shared and analysed to understand the burden of disease of current and prospective people receiving aged care and their current and future health needs
- e. the Australian Government should direct the Australian Institute of Health and Welfare to include data tabulated on the basis of aged care recipient status in any relevant health statistical publications, and make the de-identified data publicly available through the Australian Government's data portal data.gov.au.

Recommendation 68: Universal adoption by the aged care sector of digital technology and My Health Record

The Australian Government should require that, by 1 July 2022:

- a. every approved provider of aged care delivering personal care or clinical care:
 - i. uses a digital care management system (including an electronic medication management system) meeting a standard set by the Australian Digital Health Agency and interoperable with My Health Record
 - ii. invites each person receiving aged care from the provider to consent to their care records being made accessible on My Health Record
 - iii. if the person consents, places that person's care records (including, at a minimum, the categories of information required to be communicated upon a clinical handover) on My Health Record and keeps them up to date
- b. the Australian Digital Health Agency immediately prioritises support for aged care providers to adopt My Health Record.

Recommendation 69: Clarification of roles and responsibilities for delivery of health care to people receiving aged care

1. By 31 December 2021, the Australian and State and Territory Governments should amend the National Health Reform Agreement to include an explicit statement of the respective roles and responsibilities of approved aged care providers and State and Territory health care providers to deliver health care to people receiving aged care, similar to the Applied Principles and ‘tables of supports’ for the National Disability Insurance Scheme, on the basis that, among other things:
 - a. allied health care should generally be provided by aged care providers
 - b. specialist services, including specialist palliative care and subacute rehabilitation, should be provided by State and Territory health care providers, even if these services involve allied health practitioners
 - c. less complex health conditions should be managed by aged care providers’ staff, particularly nurses.
2. By 31 December 2021, the Australian Government should amend the *Quality of Care Principles 2014* (Cth) to clarify the role and responsibilities of approved providers to deliver health care to people receiving aged care, including but not limited to their particular role and responsibilities to deliver allied health care, mental health care, and oral and dental health care.

Recommendation 70: Improved access to State and Territory health services by people receiving aged care

By 1 July 2022, the Australian and State and Territory Governments should amend the National Health Reform Agreement or any future health funding agreement to include explicit commitments by State and Territory Governments to provide:

- a. access by people receiving aged care to State and Territory Government-funded health services, including palliative care services, on the basis of the same eligibility criteria that apply to residents of the relevant State and Territory more generally
- b. clinically appropriate subacute rehabilitation for patients who:
 - i. are receiving residential aged care or personal aged care at home, or
 - ii. may need such aged care services if they do not receive rehabilitation,as well as performance targets and reporting requirements on the provision of subacute rehabilitation care to people receiving aged care.

Recommendation 71: Ongoing consideration by the Health National Cabinet Reform Committee

The Health National Cabinet Reform Committee should require the Australian Health Ministers' Advisory Council to:

- a. consider the full suite of the Royal Commission's recommendations related to the interface of the health care and aged care systems and report to the next meeting of the Committee
- b. include a standing item in all future meetings of the Council on the aged care system and its interface with the health care system.

Chapter 10: Aged Care for Older People with Disability

Recommendation 72: Equity for people with disability receiving aged care

By 1 July 2024, every person receiving aged care who is living with disability, regardless of when acquired, should receive through the aged care program daily living supports and outcomes (including assistive technologies, aids and equipment) equivalent to those that would be available under the National Disability Insurance Scheme to a person under the age of 65 years with the same or substantially similar conditions.

Recommendation 73: Annual reporting to Parliament by the Disability Discrimination Commissioner and the Age Discrimination Commissioner

By 1 July 2024, the Disability Discrimination Commissioner and the Age Discrimination Commissioner should be required, as part of the new National Disability Strategy, to report annually to the Parliament on the number of people receiving aged care with disability who are aged 65 years or older and their ability to access daily living supports and outcomes (including assistive technologies, aids and equipment) equivalent to those available under the National Disability Insurance Scheme.

Chapter 11: Younger People in Residential Aged Care

Recommendation 74: No younger people in residential aged care

The Australian Government should immediately put in place the means to achieve, and to monitor and report on progress towards, the commitments announced by the Australian Prime Minister on 25 November 2019 to ensure that:

- a. no person under the age of 65 years enters residential aged care from 1 January 2022
- b. no person under the age of 45 years lives in residential aged care from 1 January 2022
- c. no person under the age of 65 years lives in residential aged care from 1 January 2025

by:

- d. referring for assessment by the agency most appropriate for the assessment of the person concerned, such as the National Disability Insurance Agency, and not an Aged Care Assessment Team or Aged Care Assessment Service, any younger person who is at risk of entering residential aged care
- e. developing hospital discharge protocols with State and Territory Governments to prevent discharge into residential aged care of any younger person
- f. developing, funding and implementing with State and Territory Governments programs for short-term and long-term accommodation and care options for any younger person who is:
 - i. living in or at risk of entering residential aged care and
 - ii. not eligible to be a participant in the National Disability Insurance Scheme
- g. requiring the National Disability Insurance Agency to publish an annual Specialist Disability Accommodation National Plan setting out, among other things, priority locations and proposed responses to thin or underdeveloped markets

- h. providing directly for, where appropriate and necessary, accommodation in the Specialist Disability Accommodation market, particularly in thin or underdeveloped markets
- i. funding dedicated and individualised advocacy services for younger people who are living in, or at risk of entering, residential aged care
- j. collecting data on an ongoing basis, and publishing up-to-date collected data each quarter, on, for each State and Territory, the number of younger people living in residential aged care and, among other things:
 - i. their age ranges
 - ii. the average length of time in residential aged care
 - iii. the numbers of admissions into and discharges from residential aged care, and
 - iv. the reasons for younger people exiting from residential aged care, such as death, turning 65 years or moving into the community
- k. having the responsible Minister report to the Parliament every six months about progress towards achieving the announced commitments, and
- l. ensuring that a younger person will only ever live in residential aged care if it is in the demonstrable best interests of the particular person (and is independently certified to be such by someone with suitable skills, experience, training and knowledge of the person) in limited and exceptional circumstances such as, for instance, where:
 - i. the person will turn 65 years within a short period of time, being no more than three months, after entering into residential aged care
 - ii. the person's close relatives over 65 years live in a residential aged care facility and the person would suffer serious hardship on being separated from those relatives
 - iii. an Aboriginal or Torres Strait Islander person between the age of 50 and 64 years elects to live in residential aged care.

Chapter 12: The Aged Care Workforce

Recommendation 75: Aged care workforce planning

1. The Australian Government should establish an Aged Care Workforce Planning Division within the Australian Department of Health by 1 January 2022. If an Australian Aged Care Commission is established, the Aged Care Workforce Planning Division should be transferred into that Commission upon its establishment. The Division should be responsible for developing workforce strategies for the aged care sector through:
 - a. obtaining up to date data about the aged care workforce with a census that Commissioner Briggs recommends takes place every 2 years
 - b. long-term workforce modelling on the supply of and demand for health professionals, including allied health professionals, and care workers
 - c. consultation with the providers of education and training for health professionals and personal care workers, in partnership with the State and Territory Governments, universities, registered training organisations, National Boards, professional associations, and colleges
 - d. ensuring 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
 - e. aged care workforce planning, including through modelling, consultation with providers and consideration of immigration.
2. By 1 July 2022, the Aged Care Workforce Planning Division should prepare an interim workforce strategy and planning framework for 2022–25.
3. By 1 July 2025, the Aged Care Workforce Planning Division within the System Governor should prepare a 10-year workforce strategy and planning framework for 2025–35, following the interim 3-year Workforce Strategy.
4. The Aged Care Workforce Planning Division should be supported by an Aged Care Workforce Fund, which Commissioner Briggs recommends should be \$100 million per year in line with previous arrangements, that can be used to support training, clinical placements, scholarships and other initiatives to respond in a targeted manner to the workforce challenges that the Division identifies.

Recommendation 76: Aged Care Workforce Industry Council Limited

1. By 1 July 2021, the Aged Care Workforce Industry Council Limited should:
 - a. invite the Australian Government to become a member
 - b. review membership of the Council to ensure it is comprised of individuals, including worker representatives, who represent the breadth and diversity of the aged care workforce with an appropriate mix of skills and experience to lead and drive change across the sector.
2. By 30 June 2022, the Aged Care Workforce Industry Council Limited should:

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Briggs**

 - a. review the qualifications and skills framework to address current and future competency and skill requirements and to create longer-term career paths for aged care workers, in conjunction with the work to be undertaken to seek review of award rates in aged care
 - b. review all aged care occupational groups, jobs and job grades to ensure they reflect the skills, capabilities, knowledge and competencies as well as the structure required in the new aged care system
 - c. revise the competency and accreditation requirements for all job grades in the aged care sector to ensure education and training builds the required skills and knowledge
 - d. standardise job titles, job designs, job grades and job definitions for the aged care sector, and
 - e. lead the Australian Government and the aged care sector to a consensus to support applications to the Fair Work Commission to improve wages based on work value and/or equal remuneration, which may include redefining job classifications and job grades in the relevant awards.
3. The Aged Care Workforce Council Limited should work collaboratively with the Aged Care Workforce Planning Division so that its work complements aged care workforce design and planning.
4. From 1 July 2022, the Aged Care Workforce Industry Council Limited should map career pathways for the aged care sector. These career pathways should:
 - a. highlight opportunities for nurses to advance in clinical and managerial roles in the aged care sector
 - b. facilitate personal care workers having opportunities to move laterally across aged care, disability care, community care and primary health care and vertically in aged care by advancing into nursing, specialist care roles and supervisory or managerial roles
 - c. develop and document career opportunities in the aged care sector for non-direct care workers, including kitchen hands, cooks, cleaners, gardeners, drivers, security and people performing administrative roles.

5. By 1 July 2022, the Aged Care Workforce Industry Council Limited should lead a national multimedia campaign aimed at raising awareness of career paths and opportunities in aged care.
6. The Australian Government should provide the necessary funding and resources to enable the Aged Care Workforce Industry Council Limited to implement the workforce recommendations of this Royal Commission and to build on its work implementing the Aged Care Workforce Strategy Taskforce's strategic actions.

Recommendation 77: National registration scheme

1. By 1 July 2022, the Australian Government should establish a national registration scheme for the personal care workforce with the following key features:
 - a. a mandatory minimum qualification of a Certificate III
 - b. ongoing training requirements
 - c. minimum levels of English language proficiency
 - d. criminal history screening requirements
 - e. 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.
2. 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.
3. By 1 July 2021, the Australian Health Practitioner Regulation Agency should start a process to examine the feasibility of a registration scheme under the National Registration and Accreditation Scheme for the occupation of 'personal care worker (health)' or 'assistant in nursing', to inform the National Cabinet Health Council deliberations in Recommendation 77.4.
4. By 1 July 2023, the Australian Government should request that the National Cabinet Health Council determine whether to regulate the occupation of 'personal care worker (health)' or 'assistant in nursing' under the National Registration and Accreditation Scheme, established and governed under the Health Practitioner Regulation National Law.

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Recommendation 78: Mandatory minimum qualification for personal care workers

1. A Certificate III should be the mandatory minimum qualification required for personal care workers performing paid work in aged care.
2. If a Personal Care Worker National Board is established, it should establish an accreditation authority to:
 - a. develop and review accreditation standards for the mandatory minimum qualification
 - b. assess programs of study and education providers against the standards, and
 - c. provide advice to the National Board on accreditation functions.
3. The National Board should approve the accredited program of study, and review the need for personal care workers in home care to have specialised skills or competencies.

**Commissioner
Briggs**

Recommendation 79: Review of certificate-based courses for aged care

1. By January 2022, the Aged Care Services Industry Reference Committee, working with the Australian Government Human Services Skills Organisation as required, should:
 - a. review the need for specialist aged care Certificate III and IV courses, and
 - b. regularly review the content of the Certificate III and IV courses and consider if any additional units of competency should be included.
2. As part of any such review, the Aged Services Industry Reference Committee, working with the Australian Government Human Services Skills Organisation as required, should consider if any of the following additional units of competency should be included as core competencies:
 - a. 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
 - b. quality of life and wellbeing, including the use of technology, interventions for older people at risk, and recognising and responding to crisis situations.

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Recommendation 80: Dementia and palliative care training for workers

By 1 July 2022, the Australian Government should implement as a condition of approval of aged care providers, that all workers engaged by providers 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.

Recommendation 81: Ongoing professional development of the aged care workforce

From 1 July 2021, the Australian Government and the States and Territories, through the Skills National Cabinet Reform Committee, should fast-track the development by the Australian Industry and Skills Committee of accredited, nationally recognised short courses, skills sets and micro-credentials for the aged care workforce. The courses should be designed to:

- a. improve opportunities for learning and professional development, and
- b. upgrade the skills, knowledge and capabilities of the existing workforce.

Recommendation 82: Review of health professions' undergraduate curricula

In conducting their regular scheduled reviews of accreditation standards, the relevant accreditation authorities should consider any changes to the knowledge, skills and professional attributes of health professionals so that the care needs of older people are met.

Recommendation 83: Funding for teaching aged care programs

By 1 July 2023, the Australian Government should fund teaching aged care programs for delivery to students in both residential aged care and home care settings. The teaching aged care programs should have designated catchment areas and should:

- a. collaborate with educational institutions and research entities
- b. facilitate clinical placements for university and vocational education and training sector students

- c. act as a centre of research and training for aged care in a catchment area
- d. act as a hub for approved providers in a particular region and support training of aged care workers from surrounding aged care services.

Recommendation 84: Increases in award wages

Employee organisations entitled to represent the industrial interests of aged care employees covered by the *Aged Care Award 2010*, the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2010* should collaborate with the Australian Government and employers and apply to vary wage rates in those awards to:

- a. reflect the work value of aged care employees in accordance with section 158 of the *Fair Work Act 2009* (Cth), and/or
- b. seek to ensure equal remuneration for men and women workers for work of equal or comparable value in accordance with section 302 of the *Fair Work Act 2009* (Cth).

Recommendation 85: Improved remuneration for aged care workers

In setting prices for aged care, the Pricing Authority should take into account the need to deliver high quality and safe care, and 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.

Recommendation 86: Minimum staff time standard for residential care

1. The Australian Government should require approved providers of residential aged care facilities to meet a minimum staff time quality and safety standard. This requirement should take the form of a quality and safety standard for residential aged care. The minimum staff time standard should allow approved providers to select the appropriate skills mix for delivering high quality care in accordance with their model of care.
2. From 1 July 2022, the minimum staff time standard should require approved providers to engage registered nurses, enrolled nurses, and personal care workers for at least 200 minutes per resident per day for the average resident, with at least 40 minutes of that staff time provided by a registered nurse.

3. In addition, from 1 July 2022, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility for the morning and afternoon shifts (16 hours per day).
4. From 1 July 2024, the minimum staff time standard should increase to require approved providers to engage registered nurses, enrolled nurses, and personal care workers for the average resident for at least 215 minutes per resident per day for the average resident, with at least 44 minutes of that staff time provided by a registered nurse.
5. In addition, from 1 July 2024, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility at all times.
6. The minimum staff time standard should be linked to the casemix-adjusted activity based funding model for residential aged care facilities. This means that approved providers with a higher than average proportion of high needs residents would be required to engage additional staff, and vice versa.
7. Approved providers should be able to apply to the System Governor for an exemption from the quality and safety standard relating to staff skills mix, but not the standard relating to numbers of staff. Any exemption should be granted for a limited time, and details of the exemption should be published on My Aged Care. The grounds for granting an exemption should include:
 - a. specific purpose residential aged care facilities, such as specialist homeless facilities, where the profile of the residents is such that it may be appropriate to substitute a registered nurse with another qualified health professional
 - b. residential aged care facilities that are co-located with a health service, such as Multi-Purpose Services, where registered and enrolled nurses are present at the co-located health service
 - c. regional, rural and remote residential aged care facilities, where the approved provider can demonstrate it has been unable to recruit sufficient numbers of staff with the requisite skills, and
 - d. residential aged care facilities where an alternative skills mix is being trialled and it would be appropriate to substitute a registered nurse with another qualified health professional. There should be a requirement for any such trial to be comprehensively evaluated and publicly reported.
8. The Australian Commission on Safety and Quality in Health and Aged Care should review and update this standard as appropriate. At a minimum, this should occur in line with significant revisions of the casemix classification for residential aged care facilities, or at least every five years.

Recommendation 87: Employment status and related labour standards as enforceable standards

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1. By 1 January 2022, the Australian Government should require as an ongoing condition of holding an approval to provide aged care services that
 - a. approved providers: have policies and procedures that preference the direct employment of workers engaged to provide personal care and nursing services on their behalf
 - b. where personal care or nursing work is contracted to another entity, that entity has policies and procedures that preference direct employment of workers for work performed under that contract.
2. From 1 January 2022, quality reviews conducted by the Quality Regulator must include assessing compliance with those policies and procedures and record the extent of use of independent contractors.

Chapter 13: Provider Governance

Recommendation 88: Legislative amendments to improve provider governance

1. By 1 January 2022, the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth) should be amended to require that:
 - a. the governing body of an approved provider providing personal care services must have a majority of independent non-executive members (unless the provider has applied to the Aged Care Quality and Safety Commissioner for an exemption and the exemption has been granted)
 - b. the constitution of an approved provider must not authorise a member of the governing body to act other than in the best interests of the provider
 - c. an applicant for approval to provide aged care services must notify the Aged Care Quality and Safety Commissioner of its key personnel, and an approved provider must notify the Commissioner of any change to key personnel within 10 business days of the change
 - d. a 'fit and proper person' test (as set out in the text below) apply to key personnel in place of the 'disqualified individual' test
 - e. an approved provider must provide an annual report to the Secretary of the Australian Department of Health containing information (as set out in the text below) to be made publicly available through My Aged Care.

2. By 1 January 2022, the *Freedom of Information Act 1982* (Cth) should be amended to remove from Schedule 3 to that Act references to provisions in the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth), thereby ensuring that the exemption in section 38 of the *Freedom of Information Act 1982* (Cth) does not apply to ‘protected information’ under aged care legislation merely on the grounds that it is information that relates to the affairs of:
 - a. an approved provider
 - b. an applicant for a grant under Chapter 5 of the *Aged Care Act 1997* (Cth)
 - c. a service provider of a Australian Government-funded aged care service, or
 - d. an applicant for approval under section 63B of the *Aged Care Quality and Safety Commission Act 2018* (Cth).

Recommendation 89: Leadership responsibilities and accountabilities

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By 1 July 2021, the Aged Care Quality and Safety Commission (and any successor body) should, as part of its approval of aged care providers and accreditation of aged care services, require governing bodies to:

- a. ensure that their leaders and managers have professional qualifications or high-level experience in management roles
- b. ensure that employment arrangements for the executive and other senior managers include performance appraisal against the demonstration of leadership, team development and support for organisational culture and practice consistent with the new Act, and
- c. adopt and implement a plan to manage and support staff training, professional development and continuous learning, staff feedback and engagement, and team building.

Recommendation 90: New governance standard

Any governance standard for aged care providers developed by the Australian Commission on Safety and Quality in Health and Aged Care should require every approved provider to:

- a. have members of the governing body who possess between them the mix of skills, experience and knowledge of governance responsibilities, including care governance, required to provide governance over the structures, systems and processes for ensuring the safety and high quality of the care delivered by the provider
- b. have a care governance committee, chaired by a non-executive member with appropriate experience in care provision, to monitor and ensure accountability for the quality of care provided, including clinical care, personal care and services, and supports for daily living
- c. allocate resources and implement mechanisms to support regular feedback from, and engagement with, people receiving aged care, their representatives, and staff to obtain their views on the quality and safety of the services that are delivered and the way in which they are delivered or could be improved
- d. have a system for receiving and dealing with complaints, including regular reports to the governing body about complaints, and containing, among other things, an analysis of the patterns of, and underlying reasons for, complaints
- e. have effective risk management practices covering care risks as well as financial and other enterprise risks, and give particular consideration to ensuring continuity of care in the event of default by contractors or subcontractors
- f. have a nominated member of the governing body:
 - i. attest annually on behalf of the members of the governing body that they have satisfied themselves that the provider has in place the structures, systems and processes to deliver safe and high quality care, and
 - ii. if such an attestation cannot be given, explain the inability to do so and how it will be remedied.

Recommendation 91: Program of assistance to improve governance arrangements

The Australian Government should establish an ongoing program, commencing in the 2021–22 financial year, to provide assistance to approved providers to improve their governance arrangements, including their care governance arrangements.

Chapter 14: Quality Regulation and Advocacy

Recommendation 92: Approval of providers

1. The new Act should provide for the commencement by 1 July 2024 of new approval requirements for all aged care providers to ensure their suitability, viability and capability to deliver the kinds of services for which they receive subsidies.
2. Applicants for approval as a provider or existing approved providers may seek approval from the Quality Regulator to provide particular kinds of aged care services, or general approval to provide all kinds of aged care services attracting Australian Government funding.
3. An existing approved provider should be taken to be approved to provide the kinds of services it has been regularly providing in the 12 months prior to the commencement of the new Act (or since their approval, whichever is more recent), and there should be an administrative process to record each such approved provider's scope of approval.
4. When assessing the suitability of new or existing providers, the Quality Regulator should consider (in addition to the matters referred to in sections 63D and 63J of the *Aged Care Quality and Safety Commission Act 2018* (Cth)), the fitness and propriety of the provider and its key personnel, the provider's capacity to deliver high quality and safe services within its scope of approval, and, where relevant, the provider's performance in delivering high quality and safe services of the kinds for which they are approved.

Recommendation 93: Accreditation of high-level home care services

1. By 1 July 2024, the new Act should require a home care service that provides care management, personal care, clinical care, enabling and therapeutic care, or palliative and end-of-life care to be accredited in order to receive Australian Government subsidies.
2. Accreditation periods should vary based on an analysis of performance and risk. Initial accreditation for a new home care service should be for no more than one year, and subsequent accreditation should be for no more than three years.
3. The Quality Regulator should have the power to limit the range of aged care services that a provider may deliver through the approval, accreditation and sanctions processes.

Recommendation 94: Greater weight to be attached to the experience of people receiving aged care

From 1 July 2021 onwards, the Aged Care Quality and Safety Commissioner (and from the commencement of a successor body, that body) should:

- a. periodically publish a report on the experience of people receiving care from an aged care service
- b. ensure that these reports are informed by interviews with at least 20% of people receiving aged care through the service (or their nominated representative)
- c. take into account information from people receiving aged care services and their representatives in accreditation assessments and other compliance monitoring processes
- d. establish channels (including an online mechanism) to allow people receiving aged care services and their families to report their experiences of aged care and the performance of aged care providers, year round.

Recommendation 95: Graded assessments and performance ratings

From 1 July 2022, the Quality Regulator should adopt a graded assessment of service performance against the Aged Care Quality Standards.

Recommendation 96: Responding to Coroner's reports

The new Act should provide that the System Governor is required to:

- a. maintain a publicly available register of reports sent to the relevant body by a State or Territory Coroner that concern the death of a person in connection with the receipt of aged care services
- b. where a Coroner has made a recommendation to the relevant body in the report, within three months of receiving the report, publish a response to the recommendation stating what action it has taken, or intends to take, in relation to the recommendation
- c. in any other case, publish a response to the report on the register within three months of its receipt
- d. provide annual reports to the Inspector-General of Aged Care detailing any action taken in response to Coroner's reports, and an assessment of the impact of such action.

Recommendation 97: Strengthened monitoring powers for the Quality Regulator

From 31 December 2021, the *Aged Care Quality and Safety Commission Act 2018* (Cth) should be amended to confer on the Aged Care Quality and Safety Commissioner (and from the commencement of a successor body, that body) the following additional statutory functions and powers, to be exercised in connection with, or for the purposes of, its functions conferred by that Act:

- a. the function of conducting inquiries into issues connected with the quality and safety of aged care, including matters raised in complaints or reported serious incidents
- b. a power to authorise in writing an officer to enter and remain on any premises of an approved provider at all reasonable times without warrant or consent, and a 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
- c. full and free access to documents, goods or other property of an approved provider, and powers to inspect, examine, make copies of or take extracts from any documents.

Recommendation 98: Improved complaints management

1. Complaints about aged care should be managed by a Complaints Commissioner in the Quality Regulator, who should
 - a. be designated to exercise and perform the functions of:
 - i. handling complaints about an issue arising in connection with the provision of aged care services
 - ii. complaints referral and coordination
 - iii. promoting open disclosure and better practice in complaint handling
 - iv. consideration and determination of requests to maintain confidentiality of the identity of complainants
 - b. in relation to these functions, have powers to:
 - i. accept enforceable undertakings, under which the respondent agrees to take certain steps or actions
 - ii. issue directions to respondents to remedy an issue
 - iii. refer complaints to a more appropriate complaints body or regulator, and to obtain information on the action taken, if any, by that complaints body or regulator
 - c. before deciding to close a complaint after undertaking a resolution process, have a duty to advise a complainant of the proposed outcome of the complaint, and seek their views on:
 - i. the way the process has been handled by the Commission
 - ii. the respondent's response to the process
 - iii. the proposed outcome of the process.
2. The new Act should provide that complaints may be made to the Quality Regulator. If a complainant or a respondent is not satisfied with the Complaints Commissioner's handling of a complaint or the outcome, the complainant or respondent may refer the matter to the Inspector-General. The Commissioner should refer to the Inspector-General any complaints about the Quality Regulator, its performance of its functions and exercise of its powers.
3. The Inspector-General should have the same powers and be subject to the same requirements as the Complaints Commissioner in relation to complaint handling.

4. The Complaints Commissioner should have a duty to publish a report at least every six months on:
 - a. the number of complaints received and dealt with by the Quality Regulator and the Inspector-General at first instance and on review
 - b. the subject matter of complaints by general topic
 - c. the number of complaints by provider and service
 - d. the average time for conclusion of complaints, against the standard of a substantive response within 60 days
 - e. the outcomes of complaints
 - f. satisfaction with the outcomes of the complaint handling process
 - g. requests for review.
5. The new Act should set out the role of advocacy services in the complaint handling processes of approved providers, the Quality Regulator and the Inspector-General.

Recommendation 99: Protection for whistleblowers

The new Act should contain comprehensive whistleblower protections for:

- a. a person receiving aged care, their family, carer, independent advocate or significant other
- b. an employee, officer, contractor, or member of the governing body of an approved provider

who makes a complaint or reports a suspected breach of the Quality Standards or another requirement of or under the Act.

Recommendation 100: Serious incident reporting

The Australian Government should, in developing a new and expanded serious incident reporting scheme:

- a. ensure that the scheme:
 - i. addresses all serious incidents, including in home care, regardless of whether the alleged perpetrator has a cognitive or mental impairment
 - ii. enables the matching of names of individuals accused of being involved in a serious incident with previous serious incident reports

- b. require the Quality Regulator to publish the number of serious incident reports on a quarterly basis at a system-wide level, at a provider level, and at a service or facility level
- c. impose a requirement on an approved provider to provide a plan detailing the action it intends to take in response to a reported incident and the report of any investigation of the incident the provider has undertaken or caused to be undertaken
- d. confer statutory powers on the Quality Regulator to enable it to:
 - i. require a provider to take specified remedial action in relation to an incident within a specified period
 - ii. require a provider to investigate an incident in a manner and within a timeframe specified
 - iii. oversee the investigation of and response to a serious incident by a provider
 - iv. require a provider to take other action in relation to the incident that the Quality Regulator considers reasonable in the circumstances
 - v. investigate the circumstances surrounding the incident.

Recommendation 101: Civil penalty for certain contraventions of the general duty

1. The new Act should provide that, on application by the Quality Regulator to a court of competent jurisdiction, a breach by an approved provider of the general duty to provide high quality safe aged care is a contravention of the Act attracting a civil penalty if:
 - a. the act, omission or conduct giving rise to the breach also gives rise to a failure to comply with one or more of the Aged Care Quality Standards, and
 - b. the breach gives rise to harm, or a reasonably foreseeable risk of harm, to a person to whom the provider is providing care or engaged under a contract or understanding to provide care.
2. The new Act should also provide that such a contravention attracts accessorial liability for key personnel who:
 - a. aids, abets, counsels or procures the approved provider to commit the contravention, or
 - b. is in any other way, directly or indirectly, knowingly concerned in, or party to, the contravention by the approved provider.

Recommendation 102: Compensation for breach of certain civil penalty provisions

The new Act should provide:

- a. that an order may be made on the application of the Quality Regulator to a court of competent jurisdiction that an approved provider that has contravened a civil penalty provision, or a person involved in the contravention, pay damages for any loss and damage suffered by a person receiving aged care services as a direct result of the contravention, and
- b. for a private right of action for damages in a court of competent jurisdiction by, or on behalf of, a person receiving aged care services who has suffered loss and damage as a direct result of a contravention of a civil penalty provision, in which proceeding any findings or admissions of the contravention in another proceeding may be adduced in evidence as proof that the contravention occurred.

Recommendation 103: A wider range of enforcement powers

The new Act should confer on the Quality Regulator:

- a. a wider range of enforcement powers, including enforceable undertakings, infringement notices and banning orders
- b. the power to suspend or remove one or more of the people responsible for the executive decisions of a provider in response to non-compliance, where the Quality Regulator is satisfied that there is an immediate and severe risk to the safety, health and wellbeing of one or more people receiving care, and appoint an external manager
- c. the power to impose a sanction revoking the provider's approval unless the provider agrees to the appointment of an external manager.

Recommendation 104: Aged Care Quality and Safety Commission capability review

1. By 1 May 2021, the Australian Government should commission an independent review of the capabilities of the Aged Care Quality and Safety Commission.
2. By 1 January 2022, the Australian Government should implement the recommendations of the review and provide the resources identified in the review that are needed for the Quality Regulator to engage and develop a skilled and dedicated compliance and enforcement workforce, with the regulatory and investigatory skills, clinical knowledge, assessment skills, and enforcement skills required for it to meet its regulatory mandate.

Recommendation 105: Transparency around the performance of the Quality Regulator

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1. By 1 July 2021, the Aged Care Quality and Safety Commission (and from the commencement of a successor body, that body) should provide additional information in its public reporting on the effectiveness of the regulatory system and its performance in safeguarding the quality of life and quality of care provided to people receiving aged care. This reporting should include:
 - a. performance against a standard suite of commonly applied measures of regulatory performance, such as complaints, serious incident reports, reviews and inquiries, enforceable undertakings, notices of non-compliance, sanctions including civil penalties, disqualification of individuals, appointment of administrators, withdrawal of accreditation or approved provider status
 - b. information on the experience of people receiving care and their families
 - c. actions taken to improve the quality and safety of services, including those directed to Aboriginal and Torres Strait Islander people and other vulnerable groups
 - d. information on enforcement actions against regulated entities
 - e. measurable indicators on the outcomes of the regulatory actions taken by the regulator, and
 - f. changes in regulatory outcomes over time.
2. There should be a statutory obligation on the Aged Care Safety and Quality Authority to provide information to the System Governor, for inclusion in the national information service, on compliance and enforcement, serious incident reporting and complaints by provider and service.

Recommendation 106: Enhanced advocacy

1. By 1 July 2022, the Australian Government should, through the implementation unit responsible for implementation of the Royal Commission's recommendations, complete a consultation with the contracted provider of services under the National Aged Care Advocacy Program to determine the extent of unmet demand for prompt advocacy services by people seeking or receiving aged care services. The consultation should also consider the need for:
 - a. additional funding for the provision of education and systemic advocacy by the contracted provider of services.
 - b. capacity building of advocacy services.
2. In light of the conclusions reached by the implementation unit after that consultation, the Australian Government should increase the funding of the National Aged Care Advocacy Program to establish a sustainable funding base that provides for increased coverage of the program to meet currently unmet demand for prompt advocacy services, including education, and systemic advocacy, as well as the infrastructure required to support an effective national network of advocacy organisations.
3. As an interim measure, by 1 July 2021 the Australian Government should provide additional funding and other supports to enable the development of an effective national advocacy network. To this end, the National Aged Care Advocacy Program should be provided with an immediate funding increase to:
 - a. enable a minimum of 5% of older people to access advocacy services
 - b. enable advocacy networks to
 - i. provide education;
 - ii. undertake systemic advocacy
 - c. support capacity building of the advocacy network through training of formal advocates and the development of clear guidelines and processes to support a nationally consistent advocacy service.

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Recommendation 107: Aged Care Research and Innovation Fund

1. The new Act should provide for the establishment of an Aged Care Research and Innovation Fund to be administered by the System Governor.
2. The Australian Government should provide funding equal to 1.8% of total Australian Government expenditure on aged care to the Aged Care Research and Innovation Fund each year, without derogating from the amount of funding available for research and innovation through the Australian Research Council and the National Health and Medical Research Council. Researchers in ageing and aged care should continue to have equal right of access to the funds administered by these other research councils.
3. By 1 July 2022, the Australian Government should establish and fund a dedicated Aged Care Research and Innovation Council.
4. The Aged Care Research and Innovation Council should be funded to:
 - a. make recommendations to the System Governor on expenditure from the Aged Care Research and Innovation Fund
 - b. set the strategy and agenda for:
 - i. research into, and innovation in, the delivery of aged care, including workforce-related research and technology
 - ii. research into the socioeconomics of ageing
 - iii. research into, and innovation in, the prevention and treatment of ageing-related health conditions
 - c. facilitate networks between research bodies, academics, community organisations, industry, government and the international community for research, technology pilots and innovation projects, to assist with the translation of research into practice to improve aged care and to address issues associated with ageing in Australia
 - d. work with the Australian Research Council, the National Health and Medical Research Council, participants in teaching aged care programs, and health and research networks to facilitate the sharing and application of research outcomes with policymakers, research bodies, health care bodies, approved providers and the community.

5. The Aged Care Research and Innovation Council should be chaired by a member appointed by the majority of Council members. The Council should consist of eight members appointed by the Australian Government for (renewable) periods of up to three years on the basis of their distinguished research records or achievements in research and development. The remuneration of the members of the Aged Care Research and Innovation Council should be determined by the Remuneration Tribunal.
6. On the advice of the Aged Care Research and Innovation Council, the System Governor should make grants from the Aged Care Research and Innovation Fund to support:
 - a. research into, and innovation in, the delivery of aged care, including through co-funding arrangements with industry and aged care providers, and through workforce-related research and technology
 - b. research into the socioeconomics of ageing
 - c. research into, and innovation in, the prevention and treatment of ageing-related health conditions.

7. The Aged Care Research and Innovation Council and the System Governor should, in performing their functions in relation to grants from the Aged Care Research and Innovation Fund, be guided by the following aims:

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- a. about half of the funding allocated at any given time should be for research into, and innovation in, the delivery of aged care, with:
 - i. about half of that funding allocated to projects supported by substantial co-funding arrangements with industry and aged care providers, and
 - ii. priority given to research and innovation that involves co-design with older people, their families and the aged care workforce
- b. about 10% of the funding allocated at any given time should be for research into the socioeconomics of ageing
- c. about 20% of the funding allocated at any given time should be for research into, and innovation in, the prevention and treatment of ageing-related health conditions.

8. The Aged Care Research and Innovation Council and the System Governor should, in performing their functions in relation to grants from the Aged Care Research and Innovation Fund, be guided by the following aims:

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- a. the total funding allocated to the Aged Care Research and Innovation Fund should be split equally between ageing-related health research and aged care-related research

- b. the aged care-related research funding should be allocated in the following way:
 - i. about two-thirds of the funding allocated at any given time should be for research into, and innovation in, the delivery of aged care, with:
 - A. about half of that funding allocated to projects supported by substantial co-funding arrangements with industry and aged care providers, and
 - B. priority given to research and innovation that involves co-design with older people, their families and the aged care workforce, and
 - ii. about one-third of the funding allocated at any given time should be for research into the socioeconomics of ageing.

Recommendation 108: Data governance and a National Aged Care Data Asset

1. By 1 July 2022, the *Australian Institute of Health and Welfare Act 1987* (Cth) should be amended to require and empower the Australian Institute of Health and Welfare to perform the below functions, which should be funded from the Aged Care Research and Innovation Fund.
2. The new functions of the Australian Institute of Health and Welfare will be:
 - a. to collect (directly or in association with other bodies or people), store and manage aged care-related information and statistics (including information on the aged care workforce, the economics of aged care, the operation of the aged care market, and the delivery of aged care services), in consultation with the Australian Bureau of Statistics if necessary
 - b. to coordinate the collection and production of aged care-related information and statistics by other bodies or persons
 - c. to publish aged care-related information and statistics, whether by itself or in association with other bodies or persons
 - d. subject to the enactment and commencement of the proposed *Data Availability and Transparency Act* (Cth), to develop and enter into data sharing agreements, in accordance with that proposed Act, with accredited users and data service providers to obtain and provide access to the use of aged care-related data

- e. to develop methods and undertake studies designed to assess the provision, use, cost and effectiveness of aged care services and aged care technologies
 - f. to conduct and promote research into aged care services in Australia
 - g. to develop, in consultation with the Australian Bureau of Statistics and the Australian e-Health Research Centre, specialised statistical standards and classifications relevant to aged care services (including national minimum datasets), and to advise the Bureau on the data to be used by it for the purposes of aged care-related statistics
 - h. to oversee the development of a standard format for presentation of aged care data, including consideration of data interoperability with the health care sector
 - i. to curate and make publicly available a National Aged Care Data Asset, which should at a minimum include data on:
 - i. the demographics, clinical characteristics and care needs of aged care recipients, and the aged and health care services they use
 - ii. the demographics, skills and wages and conditions of the aged care workforce
 - iii. the financial performance of aged care providers, the quality of care provided, and their ownership types, operating segments, size and any other characteristics deemed relevant by the Australian Institute of Health and Welfare to analyse the aged care sector's functioning
 - j. to publish information about the quality and safety of aged care services at facility or service level
 - k. to ensure that Australian Government entities with responsibility for or involvement in aged care, researchers, and other bodies as appropriate, have access to aged care-related information and statistics held by the Institute or by bodies or persons with whom contracts or arrangements have been entered into by the Institute
 - l. to publish methodological and substantive reports on work carried out by or in association with the Institute under this recommendation
 - m. to make recommendations to the System Governor, as well as to the responsible Minister, on the improvement and promotion of aged care services in Australia.
3. The Australian Institute of Health and Welfare should have appropriate government funding and resourcing for the employees and information and communications technology needed to perform its functions, including 'business to government' and 'government to government' data sharing in or near real time.

4. For the avoidance of doubt, nothing in the above is intended to prevent the System Governor or the Quality Regulator from collecting and analysing data in administering the aged care system, or commissioning research on the aged care system.
5. The new Act should require that:
 - a. the System Governor
 - b. the Quality Regulator
 - c. the Pricing Authority, and
 - d. approved providers of aged care

provide data to the Australian Institute for Health and Welfare in accordance with its requirements within three months of the end of the relevant reporting period, and that they respond to other requests for aged care-related data by the Australian Institute for Health and Welfare in a timely manner.
6. The Australian Institute of Health and Welfare should store, manage and refine for presentation, and regularly publish, the National Aged Care Data Asset, with the first such publication by 1 July 2025. The Institute is to accredit software used for collection of data for the data asset, quality indicator data and data relating to compliance with the Aged Care Quality Standards.
7. The System Governor should be responsible for the following additional functions:
 - a. to facilitate the development of software and Information and Communications Technology systems to enable automatic reporting by approved providers on mandatory reporting obligations, quality indicators, prudential arrangements, data for the Aged Care National Data Asset and other responsibilities
 - b. to establish arrangements consistent with the 'collect once, use many times' principle, including:
 - i. information and communications technology interoperability arrangements between the System Governor and the Australian Commission on Safety and Quality in Health and Aged Care to enable the sharing of data related to aged care
 - ii. ensuring administrative data relevant to approved providers, such as assessment data, is made available to providers
 - iii. ensuring a mechanism exists for approved providers to transfer, in an effective and secure manner, information about an individual when the individual changes service providers.

8. In carrying out its functions, the Australian Institute of Health and Welfare should be guided by the principle that de-identified data is to be made publicly available to support research into, and scrutiny of, the provision of aged care services, but personal information must not be released.

9. From 1 July 2022, the System Governor should establish and chair a 'management group' of senior representatives from:

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- a. the Australian Institute of Health and Welfare
- b. the Pricing Authority
- c. the Australian Commission on Safety and Quality in Health and Aged Care
- d. the Australian Bureau of Statistics

to manage the development of a framework for the national minimum aged care datasets, informed by reference to the aged care quality indicators that are to be developed by the Australian Commission on Safety and Quality in Health and Aged Care, and the development of the datasets themselves.

Chapter 16: Data, Research, Innovation and Technology | Commissioner Briggs

Recommendation 108: Data governance and a National Aged Care Data Asset

See above.

Recommendation 107: Aged Care Research and Innovation Fund

See above.

Recommendation 109: ICT Architecture and investment in technology and infrastructure

Commissioner
Briggs

1. From 1 July 2022, the Australian Government should invest in technology and information and communications systems to support the new aged care system. That investment should have the following elements:
 - a. systems that are designed to enable better services for older people, including
 - i. a new service-wide client relationship management system interoperable with My Health Record for care management, case monitoring and reporting systems built around older people's care, that would move progressively to real-time and automated reporting within five years
 - ii. data and information that is accessible, complete, accurate and up to date, and
 - iii. standardised systems and tools to make the user experience easy and efficient, with minimal separate portals and a single point of entry for older people and approved providers
 - b. pre-certified assistive technologies and smart technology to support both care and functional needs and manage safety, and to support the quality of life of older people. These technologies are to:
 - i. be universally available and enabled through internet and wifi access, and funded by the Australian Government
 - ii. be put into older people's homes to help in the provision of care and improve older people's level of social engagement, and
 - iii. support the development and use of mobile care finder and mobile assessment applications
 - c. interoperability of information and communications systems to enable the sharing of data and information about people receiving care between aged care and health care providers and relevant government agencies. Where appropriate, this interoperability should be enabled by expanding the scope of the Aged Care Data Compare project to encompass care in the home so that a full set of Fast Health Care Interoperability Resources data standards is developed for aged care assessment and services.
2. By July 2022, 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.

Chapter 17: Funding the Aged Care System | Commissioner Pagone

Recommendation 110: Amendments to residential aged care indexation arrangements

1. Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for residential aged care so that all care subsidies, and the viability supplement, are increased on 1 July each year by the weighted average of:
 - a. 60% of the yearly percentage increase to the minimum wage for an Aged Care employee – Level 3 under the *Aged Care Award 2010* (clause 14.1) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
 - b. 30% of the yearly percentage increase to the minimum wage for a Registered nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
 - c. 10% of the yearly percentage (to the 31 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.
2. Whenever the Fair Work Commission makes a change to a minimum wage in either the *Aged Care Award 2010* or the *Nurses Award 2010* other than as part of the annual review of award minimum wages, subsidies should be indexed from the operative date of those increases by the weighted average of:
 - a. 60% of the percentage increase to the minimum wage for an Aged Care employee – Level 3 under the *Aged Care Award 2010* (clause 14.1) that is determined by the Fair Work Commission
 - b. 30% of the percentage increase to the minimum wage for a Registered nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission.
3. The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Pricing Authority has commenced independent determination of prices for residential care.

Recommendation 111: Amendments to aged care in the home and Commonwealth Home Support Programme indexation arrangements

1. Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for home care and the Commonwealth Home Support Programme so that subsidy rates are increased on 1 July each year by the weighted average of:
 - a. 55% of the yearly percentage increase to the minimum wage for a Home Care employee – Level 3 pay point 1 under the *Social, Community, Home Care and Disability Services Industry Award 2010* (clause 17.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
 - b. 15% of the yearly percentage increase to the minimum wage for a Registered Nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission immediately prior to 1 July as part of the annual review of award minimum wages
 - c. 30% of the yearly percentage (to the 31 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.
2. Whenever the Fair Work Commission makes a change to a minimum wage in either the *Social, Community, Home Care and Disability Services Industry Award 2010* or the *Nurses Award 2010* other than as part of the annual review of award minimum wages, subsidies should be indexed from the operative date of those increases by the weighted average of:
 - a. 55% of the percentage increase to the minimum wage for a Home Care employee – Level 3 pay point 1 under the *Social, Community, Home Care and Disability Services Industry Award 2010* (clause 17.3) that is determined by the Fair Work Commission
 - b. 15% of the percentage increase to the minimum wage for a Registered Nurse Level 2 – pay point 1 under the *Nurses Award 2010* (clause 14.3) that is determined by the Fair Work Commission.
3. The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Pricing Authority has commenced independent determination of prices for aged care in the home.

Recommendation 112: Immediate changes to the Basic Daily Fee

1. The Australian Government should, no later than 1 July 2021, offer to provide funding to each approved provider of residential aged care adding to the base amount for the Basic Daily Fee by \$10 per resident per day, for all residents. The additional funding should be provided only on a written undertaking that:
 - a. the provider will conduct an annual review of the adequacy of the goods and services it has provided to meet the basic living needs of residents, and in particular their nutritional requirements, throughout the preceding 12 months, and prepare a written report of the review
 - b. the review report will set out:
 - i. details of the provider's expenditure to meet the basic needs of residents, especially their nutritional needs, and will include spending on raw food, pre-processed food, bought-in food, kitchen staff (costs and hours), and the average number of residents
 - ii. changes in expenditure compared with the preceding financial year
 - iii. the number of residents who have experienced unplanned weight loss or incidents of dehydration
 - c. by 31 December each year, commencing in 2021, the governing body of the provider will attest that the annual review has occurred, and will give the review report and a copy of the attestation, to the System Governor
 - d. the System Governor should make the annual review report publicly available
- e. in the event of failure to comply with the above requirements, the provider will be liable to repay the additional funding to the Australian Government, and agrees that this debt may be set-off against any future funding as a means of repayment.
2. The Australian Government will commence payment of the additional funding to a provider within one month of the provider giving its written undertaking.
3. The results of any review may be taken into account in any reviews of the compliance of the provider with the Aged Care Quality Standards.
4. This measure should continue until such time as the Pricing Authority has commenced its independent determination of prices for aged care.

Commissioner
Briggs

Recommendation 113: Amendments to the Viability Supplement

1. With immediate effect, the Australian Government should continue the 30% increase in the Viability Supplement that commenced in March 2020, as paid in respect of each residential aged care service and person receiving home care, until the Pricing Authority has determined new arrangements to cover the increased costs of service delivery in regional, rural and remote areas and has commenced independent determination of prices.
2. The increased indexation arrangements proposed in Recommendations 110 and 111 should apply in addition to the measure in this recommendation.

Recommendation 114: Immediate funding for education and training to improve the quality of care

1. The Australian Government should establish a scheme, commencing on 1 July 2021, to improve the quality of the current aged care workforce. The scheme should operate until independent pricing of aged care services by the Pricing Authority commences. The scheme should reimburse providers of home support, home care and residential aged care for the cost of education and training of the direct care workforce employed (either on a part-time or full-time basis, or on a casual basis for employees who have been employed for at least three months) at the time of its commencement or during the period of its operation. Eligible education and training should include:
 - a. Certificate III in Individual Support (residential care and home care streams) and Certificate IV in Ageing Support
 - b. continuing education and training courses (including components of training courses, such as 'skill sets' and 'micro-credentials') relevant to direct care skills, including, but not limited to, dementia care, palliative care, oral health, mental health, pressure injuries and wound management.
2. Reimbursement should also include the costs of additional staffing hours required to enable an existing employee to attend the training or education. The scheme should be limited to one qualification or course per worker.

Recommendation 115: Functions and objects of the Pricing Authority

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| <ol style="list-style-type: none"> 1. Before the commencement of independent pricing of aged care services by the Pricing Authority, preliminary work on estimating the costs of providing high quality aged care should be undertaken by or at the direction of the implementation unit or taskforce referred to elsewhere in these recommendations. 2. Upon its establishment, by 1 July 2023, under the new Act, the Pricing Authority should take over that work and all resources developed by the implementation unit. | <div style="border-left: 1px solid black; padding-left: 10px;"> <p>Commissioner Pagone</p> </div> |
|--|--|
3. The functions of the Pricing Authority should include:
 - a. 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
 - b. reviewing data and conducting studies relating to the costs of providing aged care services
 - c. determining prices for particular aged care services based on estimates of the amounts (whether constituted by government subsidies or user payments or both) appropriate to the provision of high quality and safe aged care services
 - d. evaluating, or assisting the System Governor to evaluate, the extent of competition in particular areas and markets
 - e. advising on appropriate forms of economic regulation, and, where necessary, implementation of such regulation.
 4. In undertaking its functions, the Pricing Authority should be guided by the following objects:
 - a. ensuring the availability and continuity of high quality and safe aged care services for people in need of them
 - b. ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services, taking into account the principles of competitive neutrality
 - c. promoting efficient investment in the means of supply of high quality and safe aged care services in the long-term interests of people in need of them
 - d. promoting the development and retention of a highly motivated and appropriately skilled and numerous workforce necessary for the provision of high quality and safe aged care services in the long-term interests of people in need of them.

Recommendation 116: Requirement to participate in Pricing Authority activities

1. By 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require participation by approved providers in cost data reviews.
2. By 1 July 2023, the new Act should require that as a condition of approval or continued approval, aged care providers are required to participate in any activities the Pricing Authority requires to undertake its functions, including transmitting cost data in a format required by the Authority for the purposes of costing studies. The Authority should take costs associated with these activities into account when determining funding levels.

Recommendation 117: Grant funding for support services to be funded through a combination of block and activity based funding

1. The Pricing Authority should advise the System Governor on the combination and form of block and activity based grants that should be adopted for social supports, respite, and assistive technology and home modifications, having regard to the characteristics of these services and market conditions where they are delivered.
2. Growth funding of 3.5% should continue to be provided for these service categories until a demand-driven planning regime is in place.
3. The Australian Government should grant fund these services from 1 July 2022.

**Commissioner
Briggs**

Recommendation 118: New funding model for care at home

1. By 1 July 2024, the Australian Government should pay subsidies for service provision within the care at home category through a new funding model that takes the form of an individualised budget or casemix classification. The new funding model should provide an entitlement to care based on assessed need across the following domains:
 - a. care management
 - b. living supports—cleaning, laundry, preparation of meals, shopping for groceries, gardening and home maintenance

- c. personal, clinical, enabling and therapeutic care, including nursing care, allied health care and restorative care interventions
 - d. palliative and end-of-life care.
- 2. The funding model should be developed as part of the development of the new care at home category (see Recommendation 35). Ongoing evidence-based reviews should be conducted thereafter to refine the model iteratively, and ensure that it provides accurate classification and funding to meet assessed needs.

Recommendation 119: Maximum funding amounts for care at home

- 1. With effect from 1 July 2024, the Australian Government should provide funding for a person receiving care at home in accordance with their assessed needs, subject to the following limitation.
- 2. The funding available for a person receiving care at home should be no more than the funding amount that would be made available to provide care for them if they were assessed for care at a residential aged care service.

Recommendation 120: Casemix-adjusted activity based funding in residential aged care

By 1 July 2022, the Australian Government should fund approved providers for delivering residential aged care through a casemix classification system, such as the Australian National Aged Care Classification model. The classification system should take into account the above recommendations for high quality aged care. Ongoing evidence-based reviews should be conducted thereafter to refine the model iteratively, for the purpose of ensuring that the model provides accurate classification and funding to meet assessed needs.

Recommendation 121: Incentives for an enablement approach to residential care

From 1 July 2022, the following incentives should be incorporated into the rules, principles and guidelines for assessment and funding eligibility:

- a. an approved provider should be paid retrospectively from the date when a reassessment was requested where it is determined on reassessment that a person is entitled to a higher level of funding, and the provider can demonstrate that it has been providing the higher level of care
- b. a resident should not be required to be reassessed for funding eligibility if their condition improves under the care of a provider.

Recommendation 122: Reporting of staffing hours

1. From 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require all approved providers of residential aged care to report, on a quarterly basis, setting out total direct care staffing hours provided each day at each facility they conduct, specifying the different employment categories (including personal care workers, enrolled nurses engaged in direct care provision, registered nurses engaged in direct care provision, and allied health care professionals engaged in direct care provision).
2. The System Governor should assess the reports against the minimum staffing requirements, and initiate appropriate action in cases of non-compliance.

Recommendation 123: Payment on accruals basis for care at home

The Australian Government should pay home care providers for services delivered or liabilities incurred from Home Care Packages on accrual.

Recommendation 124: Standardised statements on services delivered and costs in home care

1. The Australian Government should develop and implement a standardised statement format for home care providers to record services delivered and costs incurred on behalf of Home Care Package holders.
2. From 1 July 2022, providers should be required to issue completed statements in the standardised format to people receiving their care on a monthly basis.
3. From 1 July 2022, providers should be required to provide reports on a quarterly basis in a standard format setting out total direct care staffing hours provided each day at each home they service, specifying the different employment categories (including personal care workers, enrolled nurses engaged in direct care provision, registered nurses engaged in direct care provision, and allied health care professionals engaged in direct care provision).

**Commissioner
Briggs**

Recommendation 125: Abolition of contributions for certain services

1. Individuals who are assessed as needing social supports, assistive technologies and home modifications, or care at home should not be required to contribute to the costs of that support.
2. Individuals who are assessed as needing residential care should not be required to contribute to the costs of the care component of that support.

Recommendation 126: Fees for respite care

1. Individuals receiving respite care under the new Act should only be required to contribute to the costs of the services that they receive associated with ordinary costs of living (as defined in Recommendation 127, below) up to a maximum of 85% of the single basic age pension, and any additional services they choose to receive. They should not be required to contribute to the costs of the accommodation and care services that they receive.
2. The level of the maximum amount that respite providers may recover for the ordinary costs of living should be determined by the Pricing Authority.

3. The new Act should also contain provisions that ensure that individuals who are unable to pay the co-payments toward the ordinary costs of living are not denied access to the high quality respite care that they have been assessed as needing.
4. The Australian Government should pay each approved provider of respite to a person an amount representing the difference between the contribution the person makes to their ordinary costs of living in accordance with paragraph 126.1 and the amount that the respite provider may recover (which may not exceed the amount calculated by the Pricing Authority in accordance with paragraph 126.2).

Recommendation 127: Fees for residential aged care—ordinary costs of living

1. Individuals receiving residential aged care under the new Act should be required, subject to the other parts of this recommendation, to contribute to the costs of the goods and services that they receive to meet their ordinary living needs, comprising all the goods and services currently specified in Part 1 of Schedule 1 of the *Quality of Care Principles 2014* (Cth) (the ordinary costs of living).
2. The Pricing Authority should determine the maximum amount payable for residents' ordinary costs of living based on an analysis of the efficient costs of delivering high quality goods and services to meet their ordinary living needs (the Services Fee Amount).
3. The maximum level of the fee that an individual resident can be asked to pay toward the ordinary costs of living (Basic Daily Fee) should be determined in accordance with provisions in the new Act and should equal the sum of:
 - a. a base fee equal to 85% of the maximum amount of the basic age pension, and
 - b. a means tested amount determined in accordance with Recommendation 129 or 141,
 and must not exceed the Services Fee Amount most recently determined by the Pricing Authority in accordance with Recommendation 127.2 above.
4. The new Act should contain provisions that ensure that individuals who are unable to pay the Basic Daily Fee are not denied access to high quality residential aged care.

5. The new Act should also provide that where:
 - a. an approved provider provides residential care to an individual and charges an amount for that individual's ordinary costs of living, and
 - b. the amount charged does not exceed the Services Fee Amount most recently determined by the Pricing Authority in accordance with Recommendation 127.2, and
 - c. the Basic Daily Fee payable by the individual is below the amount charged by the approved provider for the individual's ordinary costs of living, then
 - d. the Australian Government will pay the approved provider the difference (Ordinary Cost of Living Top-up Subsidy) between:
 - i. the Basic Daily Fee for the individual, and
 - ii. the amount charged by the approved provider for the individual's ordinary costs of living.

Recommendation 128: Fees for residential aged care accommodation

**Commissioner
Pagone**

1. Individuals receiving residential aged care under the new Act should be required, subject to the other parts of this recommendation, to contribute to the costs of their accommodation.
2. The new Act should recognise two categories of residents for the purposes of regulation of amounts payable for accommodation: residents for whose accommodation the Australian Government will pay or contribute (eligible residents) and residents for whose accommodation the Australian Government will not make any contribution.

Eligible residents

3. The Pricing Authority should from time to time determine the maximum amount or amounts payable for the accommodation of eligible residents, based on an analysis of the efficient costs of delivering high quality accommodation and a reasonable rate of return on capital investment (Accommodation Supplement). In doing so, the Pricing Authority may at its discretion determine one uniform amount to apply in all cases, or a number of different amounts based on factors such as the date of construction or refurbishment of the facility, the size or other features of the room, and the region or degree of remoteness of the location of the facility.

4. Subject to Recommendation 128.6, the new Act should provide that the maximum amount an approved provider may receive for the accommodation of a resident should be the Accommodation Supplement determined by the Pricing Authority in Recommendation 128.3 above, payment of which will comprise:
 - a. a means tested fee for accommodation determined in accordance with Recommendation 129, payable directly by the individual resident, and
 - b. funding of the difference between the means tested fee for accommodation and the maximum level determined by the Pricing Authority in Recommendation 128.3 above, payable by the Australian Government (Accommodation Top-up Supplement).
5. The new Act should contain provisions that ensure that individuals who are unable to pay for accommodation are not denied access to high quality residential aged care.

Other residents

6. Where an individual is determined in accordance with Recommendation 129 to have a means tested fee for accommodation greater than the Accommodation Supplement determined by the Pricing Authority in accordance with Recommendation 128.3 above, then
 - a. no Accommodation Top-Up Supplement is payable in respect of such a resident, and
 - b. the fee that the individual may be charged is not limited to the Accommodation Supplement, but subject to Recommendation 128.7 should be subject to a provisional upper limit (to be determined by the Pricing Authority from time to time) (Provisional Accommodation Charge Limit).
7. The Pricing Authority:
 - a. should from time to time determine the Provisional Accommodation Charge Limit, based on an analysis of the efficient costs of delivering high quality accommodation and a reasonable rate of return on capital investment, being either a uniform amount that will apply in all cases, or a number of different amounts that will apply in different cases, based on factors such as the date of construction or refurbishment of the facility, the size or other features of the room, and the region or degree of remoteness of the location of the facility
 - b. may, on the application of an approved provider, and after consideration of factors including the cost of investment and any particular constraints on supply of residential aged care services in the relevant area, determine that the Provisional Accommodation Charge Limit for one or more rooms of a facility should be varied to a different amount.

Recommendation 129: Changes to the means testCommissioner
Pagone

1. For each individual receiving residential aged care under the new Act, a means tested amount should be determined in accordance with the following parts of this recommendation.
2. If the individual is in receipt of an *income support payment* or a *service pension* or an *income support supplement* or a *veteran payment* (as defined in the *Social Security Act 1991* (Cth) and the *Veterans' Entitlements Act 1991* (Cth)), then their means tested amount is zero.
3. If the individual is not in receipt of an *income support payment* or a *service pension* or an *income support supplement* or a *veteran payment*, then their means tested amount is determined as the maximum of the following two amounts:
 - a. the *income tested amount* referred to in Recommendation 129.4 below, and
 - b. the *asset tested amount* referred to in Recommendation 129.5 below.
4. The *income tested amount* for the individual is calculated as follows:
 - a. the income tested amount is equal to 50% of the difference between the individual's *total assessable income* and the individual's *total assessable income-free area*
 where:
 - b. the individual's *total assessable income* is the amount that would be worked out as the care recipient's ordinary income for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991* (Cth)
 - c. the individual's *total assessable income-free area* is the maximum level that a person's ordinary income could be for the purpose of applying Module E of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991* (Cth) where that person remains eligible for a pension.
5. The *asset tested amount* is calculated as follows:
 - a. The annual *asset tested amount* is equal to 7.8% of the difference between the individual's *total assessable assets* and the individual's *total assessable asset free area*

where:

- b. the individual's *total assessable assets* is the amount that would be worked out as the care recipient's ordinary income for the purpose of applying Module G of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991* (Cth)
 - c. the individual's *total assessable asset free area* is the maximum level that a person's assessable assets could be for the purpose of applying Module G of Pension Rate Calculator A at the end of section 1064 of the *Social Security Act 1991* (Cth) where that person remains eligible for a pension.
- 6. Where that means tested amount is less than or equal to the maximum rate of the Ordinary Cost Of Living Top-up Subsidy (as determined under Recommendation 127) then:
 - a. the individual is required to pay a means tested ordinary cost of living fee for the purpose of Recommendation 127.3 equal to the means tested amount
 - b. the individual is not required to pay a means tested accommodation fee for the purpose of Recommendation 128.4
 - c. the approved provider receives an Ordinary Cost of Living Top-up Subsidy equal to the difference between the maximum rate of the top-up subsidy and the means tested amount, and
 - d. the provider receives the maximum rate of the Accommodation Top-up Supplement.
- 7. Where that means tested amount is greater than the maximum rate of the Ordinary Cost of Living Top-up Subsidy (as determined under Recommendation 127) and less than or equal to the sum of the maximum rates of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Supplement then:
 - a. the individual is required to pay a means tested ordinary cost of living fee for the purpose of Recommendation 127.3 equal to the maximum rate of the Ordinary Cost of Living Top-up Subsidy
 - b. the individual is required to pay a means tested accommodation fee for the purpose of Recommendation 128.4 equal to the means tested amount minus the maximum rate of the Ordinary Cost of Living Top-up Subsidy
 - c. the provider receives no Ordinary Cost of Living Top-up Subsidy, and
 - d. the provider receives an Accommodation Top-up Supplement equal to the difference between the sum of the maximum rates of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Subsidy and the means tested amount.

8. Where that means tested amount is greater than sum of the maximum rates of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Supplement then:
 - a. the individual is required to pay a means tested ordinary cost of living fee for the purpose of Recommendation 127.3 equal to the maximum rate of the Ordinary Cost of Living Top-up Subsidy, and
 - b. the individual's accommodation fees are subject to Recommendations 128.6 and 128.7 above, and
 - c. the provider receives no Ordinary Cost of Living Top-up Subsidy, and
 - d. the provider receives no Accommodation Top-up Supplement.

Chapter 19: Prudential Regulation and Financial Oversight | Commissioner Pagone

Recommendation 130: Responsibility for prudential regulation

1. From 1 July 2023, the System Governor should be given by statute the role of the Prudential Regulator for aged care with responsibility for ensuring that, under all reasonable circumstances, providers of aged care have the ongoing financial capacity to deliver high quality care and meet their obligations to repay accommodation lump sums as and when the need arises.
2. The System Governor should also be given by statute the role of developing and implementing an effective financial reporting framework for the aged care sector that complements the purposes of the prudential standards.

Recommendation 131: Establishment of prudential standards

From 1 July 2023, the Prudential Regulator should be empowered under statute to make and enforce standards relating to prudential matters that must be complied with by approved providers, relating to:

- a. the conduct of the affairs of providers in such a way as to:
 - i. ensure that they remain in a sound financial position, and
 - ii. ensure continuity of care in the aged care system, or
- b. the conduct of the affairs of approved providers with integrity, prudence and professional skill.

Recommendation 132: Liquidity and capital adequacy requirements

From 1 July 2023, the Prudential Regulator should be empowered under statute to impose liquidity and capital adequacy requirements on approved providers, for the purpose of identifying and managing risks relating to whether:

- a. providers have the financial viability to deliver ongoing high quality care
- b. providers of residential care services that hold Refundable Accommodation Deposits are able to repay those deposits promptly as and when required.

Recommendation 133: More stringent financial reporting requirements

1. From 1 July 2023, the Prudential Regulator should be empowered under statute to require approved providers to submit financial reports.
2. The frequency and form of the reports should be prescribed by the Prudential Regulator.

Recommendation 134: Strengthened monitoring powers for the Prudential Regulator

From 1 July 2023, the Prudential Regulator should have the following additional statutory functions and powers, to be exercised in connection with, or for the purposes of, its prudential regulation and financial oversight functions:

- a. the power to conduct inquiries into issues connected with prudential regulation and financial oversight in aged care
- b. the power to authorise in writing an officer to enter and remain on any premises of an approved provider at all reasonable times without warrant or consent
- c. full and free access to documents, goods or other property of an approved provider, and powers to inspect, examine, make copies of or take extracts from any documents.

Recommendation 135: Continuous disclosure requirements in relation to prudential reporting

1. From 1 July 2023, every approved provider should be required under statute to comply with continuous disclosure requirements to inform the Prudential Regulator of material information of which the provider becomes aware that:
 - a. affects the provider's ability to pay its debts as and when they become due and payable, or
 - b. affects the ability of the provider or any contractor providing services on its behalf to continue to provide aged care that is safe and of high quality to individuals to whom it is currently contracted or otherwise engaged to provide aged care.
2. The Prudential Regulator should also have the power under statute to designate events, facts or circumstances that may give rise to continuous disclosure obligations.

Recommendation 136: Tools for enforcing the prudential standards and guidelines and financial reporting obligations of providers

1. From 1 July 2023, the Prudential Regulator should have the powers to take such action, and impose such obligations upon approved providers, as it considers necessary to deal with any breach of the new prudential standards or the financial reporting requirements, including a failure to comply with the continuous disclosure requirements.
2. The powers which the Prudential Regulator should be given should include:
 - a. the power to give directions to a provider that mirror those that can be made by the Australian Prudential Regulation Authority pursuant to the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth)
 - b. the power to impose administrative penalties in respect of any breach
 - c. the power to apply to a court of competent jurisdiction for a civil penalty in respect of any relevant alleged contravention
 - d. the ability to accept enforceable undertakings
 - e. the ability to impose sanctions to limit the ability of the provider to expand its services, revoke accreditation for a service, or revoke approved provider status.

Recommendation 137: Building the capability of the regulator

The Australian Government should ensure that the Prudential Regulator has prudential capability in relation to the aged care sector that includes the following:

- a. an effective program to recruit and retain senior forensic accountants and specialists with prudential regulatory experience, and sufficient numbers of supporting employees who have either accounting qualifications or other financial skills
- b. systems and processes to capture, collate, analyse and share regulatory intelligence from internal and external sources to build a risk profile of approved providers
- c. a system and processes to monitor indicators of risk revealed by providers' financial reporting tailored to the aged care sector and to respond to them in a timely manner
- d. an electronic forms and lodgement platform for the use of all large operators, with an optional alternative electronic filing system available for smaller operators
- e. appropriate resourcing of the above system and processes, including design expertise, information and communications technology requirements, technical support, and recruitment and training of sufficient numbers of appropriately skilled staff.

Chapter 20: Financing the New Aged Care System | Commissioner Pagone

Recommendation 138: Productivity Commission investigation into financing of the aged care system through an Aged Care Levy

Commissioner
Pagone

By 1 July 2021, the Australian Government should refer to the Productivity Commission for inquiry and report under the *Productivity Commission Act 1998* (Cth) s 11 the potential benefits and risks of adoption of an appropriately designed financing scheme based upon the imposition of a hypothecated levy through the taxation system.

Chapter 21: Funding the Aged Care System | Commissioner Briggs

Recommendation 115: Functions and objects of the Pricing Authority
See above.

Recommendation 139: Parliamentary scrutiny of determinations by the Pricing Authority

Commissioner
Briggs

1. The determination of prices by the Pricing Authority under Recommendation 115.3(c) should be in the form of a legislative instrument subject to Parliamentary disallowance.
2. If the determination by the Pricing Authority is disallowed, legislation should provide for the Minister to make a new determination in the form of a legislative instrument subject to Parliamentary disallowance.

Recommendation 116: Requirement to participate in Pricing Authority activities
See above.

Recommendation 117: Grant funding for support services to be funded through a combination of block and activity based funding
See above.

Recommendation 118: New funding model for care at home
See above.

Recommendation 119: Maximum funding amounts for care at home
See above.

Recommendation 120: Casemix-adjusted activity based funding in residential aged care

See above.

Recommendation 121: Incentives for an enablement approach to residential care

See above.

Recommendation 122: Reporting of staffing hours

See above.

Recommendation 123: Payment on accruals basis for care at home

See above.

Recommendation 124: Standardised statements on services delivered and costs in home care

See above.

Recommendation 110: Amendments to residential aged care indexation arrangements

See above.

Recommendation 111: Amendments to aged care in the home and Commonwealth Home Support Programme indexation arrangements

See above.

Recommendation 112: Immediate changes to the Basic Daily Fee

See above.

Recommendation 113: Amendments to the Viability Supplement

See above.

Recommendation 114: Immediate funding for education and training to improve the quality of care

See above.

Chapter 22: Personal Contributions and Means Testing | Commissioner Briggs

Recommendation 125: Abolition of contributions for certain services

See above.

Recommendation 126: Fees for respite care

See above.

Recommendation 127: Fees for residential aged care—ordinary costs of living

See above.

Recommendation 140: Fees for residential aged care accommodation

Commissioner Briggs

1. Individuals receiving residential aged care under the new Act should be required, subject to the other parts of this recommendation, to contribute to the costs of their accommodation.
2. The Pricing Authority should from time to time determine the Accommodation Supplement as the maximum amount or amounts payable for the accommodation of a resident eligible to receive the supplement under the means test (an eligible resident), based on an analysis of the efficient costs of delivering high quality accommodation and a reasonable rate of return on capital investment. The Pricing Authority may determine one uniform amount to apply in all cases, or a number of different amounts based on factors such as the date of construction or refurbishment of the facility, the size or other features of the room, and the region or degree of remoteness of the location of the facility.

3. The new Act should provide that the maximum amount an approved provider may receive for the accommodation of an eligible resident should be the Accommodation Supplement determined by the Pricing Authority in Recommendation 140.2 above, payment of which will comprise:
 - a. a means tested amount paid for accommodation determined in accordance with Recommendation 141, payable directly by the individual resident, and
 - b. funding of the difference between the means tested fee for accommodation and the maximum level determined by the Pricing Authority in Recommendation 140.2 above, payable by the Australian Government (Accommodation Top-up Supplement).
4. The Pricing Authority should:
 - a. from time to time determine the Provisional Accommodation Charge Limit (as a lump sum or an equivalent daily amount) applicable to a facility based on factors such as the date of construction or refurbishment of the facility, the size or other features of the room, and the region or degree of remoteness of the location of the facility. The daily amount of the Provisional Accommodation Charge Limit should be based on an analysis of the efficient costs of delivering high quality accommodation and a reasonable rate of return on capital investment
 - b. on the application of an approved provider, and after consideration of factors including the cost of investment and any particular constraints on supply of residential aged care services in the relevant area, determine that the Provisional Accommodation Charge Limit for one or more rooms of a facility should be varied to a different amount.
5. Until Refundable Accommodation Deposits are phased out under Recommendation 142, approved providers may charge residents who are not eligible for the Accommodation Supplement a Refundable Accommodation Deposit (or an equivalent Daily Accommodation Payment) up to the Provisional Accommodation Charge Limit.
6. After Refundable Accommodation Deposits are phased out under Recommendation 142, approved providers may charge residents who are not eligible for the Accommodation Supplement a Daily Accommodation Payment up to the level of the Provisional Accommodation Charge Limit.
7. The new Act should contain provisions that ensure that individuals who are unable to pay for accommodation are supported by the Australian Government and not denied access to high quality residential aged care.

Recommendation 141: Changes to the means test**Commissioner
Briggs**

1. The means test will determine a means tested amount for each individual receiving residential aged care under the new Act who is not in receipt of an income support payment or a service pension or an income support supplement or a veteran payment (as defined in the *Social Security Act 1991* (Cth) and the *Veterans' Entitlements Act 1991* (Cth)).
2. An individual's means tested amount will be the greater of an amount worked out under the income test or the asset test.
3. An individual's means tested amount under the income test is 25% or 50% of the amount by which their assessable income exceeds the maximum income point at which a part pension is payable.
4. An individual's means tested amount under the assets test is 3.9% or 7.8% of the amount by which their assessable assets exceed the maximum level of assets at which a part pension is payable.
5. The means tested amount is applied first to reduce the Ordinary Cost of Living Top-up Subsidy (as determined under Recommendation 127).
6. If the means tested amount is greater than the maximum rate of the Ordinary Cost of Living Top-up Subsidy it is then applied to reduce the Accommodation Top-up Supplement (as determined under Recommendation 140).
7. If the means tested amount is greater than sum of the Ordinary Cost of Living Top-up Subsidy and the Accommodation Top-up Supplement then the individual's accommodation fees are subject to Recommendations 140.5 and 140.6 above.
8. The lifetime caps on the amount of means tested contributions payable by an individual should be removed.

Chapter 23 Capital Financing for Residential Aged Care | Commissioner Briggs

Recommendation 142: Phasing out of Refundable Accommodation Deposits

Commissioner Briggs

The Australian Government should:

- a. from 1 July 2025, begin to phase out Refundable Accommodation Deposits for new residents
- b. assist providers with the transition away from Refundable Accommodation Deposits as a source of capital by establishing an aged care accommodation capital facility, with the terms and conditions of assistance designed to create incentives for providers to develop small household models of accommodation.

Chapter 24: Financial Oversight and Prudential Regulation | Commissioner Briggs

Recommendation 130: Responsibility for prudential regulation

See above.

Recommendation 131: Establishment of prudential standards

See above.

Recommendation 133: More stringent financial reporting requirements

See above.

Recommendation 134: Strengthened monitoring powers for the Prudential Regulator

See above.

Recommendation 135: Continuous disclosure requirements in relation to prudential reporting

See above.

Recommendation 132: Liquidity and capital adequacy requirements

See above.

Recommendation 136: Tools for enforcing the prudential standards and guidelines and financial reporting obligations of providers

See above.

Recommendation 137: Building the capability of the regulator

See above.

Recommendation 143: Implementation of new arrangements for financial oversight and prudential regulation

**Commissioner
Briggs**

If the Government Leadership model is adopted, implement the reforms to financial oversight and prudential regulation arrangements set out in Recommendations 130, 131, 132, 133, 134, 135, 136, and 137 from 1 July 2022.

Chapter 25: Financing the New Aged Care System | Commissioner Briggs

Recommendation 144: Introduce a new earmarked aged care improvement levy

Commissioner
Briggs

1. By 1 July 2022, the Australian Government should introduce legislation to Parliament to establish an aged care improvement levy of a flat rate of 1% of taxable personal income. The levy imposed should be levied, and paid, for the financial year commencing on 1 July 2023 and for all subsequent financial years until the Parliament otherwise provides.
2. The legislation introducing the levy should be based on the *Medicare Levy Act 1986* (Cth).

Chapter 26: Oversight, Implementation and Monitoring

Recommendation 145: Report on recommendations

By 31 May 2021, the Australian Government should report to Parliament about its response to the recommendations in our final report. The report should indicate whether each recommendation directed to the Australian Government is accepted, accepted in principle, rejected or subject to further consideration. The report should also include some detail about how the recommendations that are accepted will be implemented and should explain the reasons for any rejections.

Recommendation 146: An implementation unit

Commissioner
Pagone

1. Pending the establishment under the new Act of the Australian Aged Care Commission, an administrative unit or body should forthwith be established by the Australian Government (through the Australian Department of the Prime Minister and Cabinet) and properly staffed and resourced to implement and direct implementation of the Royal Commission's recommendations (implementation unit).
2. From the commencement of the new Act, the Australian Aged Care Commission should implement and direct implementation of the recommendations of the Royal Commission.

Recommendation 147: An implementation taskforce**Commissioner
Briggs**

The Australian Department of Health and Aged Care should promptly establish a taskforce to implement and direct implementation of the Royal Commission's recommendations, supported by a cross-department Deputy Secretary Steering Committee on Aged Care Reform.

Recommendation 148: Evaluation of effectiveness

1. The Inspector-General of Aged Care should monitor the implementation of recommendations and should report to the responsible Minister and directly to the Parliament at least every six months on the implementation of the recommendations.
2. The Inspector-General of Aged Care should undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations of the Royal Commission, five and 10 years after the tabling of the Final Report.
3. The Inspector-General of Aged Care should report on these evaluations five and 10 years after the tabling of the Final Report.

Endnotes

- 1 References to conferral of statutory functions on the 'Department' should be read as recommendations that the relevant statutory functions be conferred on the Secretary of the Department (who may delegate to the Associate Secretary or other person).

4. Glossary

Note: the definitions in this glossary are not legal definitions but general usage definitions.

accommodation bond

A lump sum payment for accommodation in a residential care facility paid by a person who first entered permanent residential care before 1 July 2014.

Accommodation Payment Guarantee Scheme

An Australian Government scheme providing a guarantee to all residential aged care consumers that the value of any lump sum accommodation payments they have paid to an aged care provider will be returned to them, in the event that the provider becomes insolvent.

Accommodation Supplement

A means tested supplement paid to residential aged care providers by the Australian Government on behalf of some residents to assist with some or all of their accommodation costs.

activities of daily living

A core set of self-care or personal care activities that include bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management.

activities of daily living domain

A domain under the Aged Care Funding Instrument which assesses a person's capacity in relation to nutrition, mobility, personal hygiene, toileting and continence.

Aged Care Advisory Council

See Recommendation 7.

Aged Care Approvals Round

An application process which enables aged care providers to apply for a limited number of Australian Government-subsidised places and/or capital grants.

Aged Care Assessment Service

See *Aged Care Assessment Team*.

Aged Care Assessment Team

A team of medical and allied health professionals employed by State and Territory Governments who assess older people for eligibility and level of subsidised aged care services. In Victoria, it is known as the Aged Care Assessment Service.

Aged Care Diversity Framework

An Australian Government strategy aimed at ensuring aged care services meet the needs of people from diverse backgrounds.

Aged Care Financial Report

An annual financial report that all approved providers must provide to the Australian Government.

Aged Care Financing Authority

A Committee, established under the *Aged Care Act 1997* (Cth), to provide independent advice to the Australian Government on aged care funding and financing in consultation with people in aged care, the aged care sector and the finance sectors.

Aged Care Funding Instrument

A tool used to determine the basic subsidy amount a residential aged care provider receives in relation to a resident in its care.

Aged Care Pricing Authority

See Recommendation 6.

Aged Care Pricing Commissioner

An independent statutory office holder who reviews and approves Refundable Accommodation Deposits in residential aged care that are more than \$550,000 and extra service fee increases or decreases. The office is established under Part 6.7 of the *Aged Care Act 1997* (Cth).

Aged Care Principles

A series of legislative instruments made under the *Aged Care Act 1997* (Cth) that set out the rules for government-funded aged care, including in relation to funding, allocation of places, approval of providers, quality standards, user rights, complaints and sanctions. They include the *Accountability Principles 2014* (Cth), the *Quality of Care Principles 2014* (Cth) and the *User Rights Principles 2014* (Cth).

Aged Care Quality and Safety Commission

A Commonwealth entity established by the *Aged Care Quality and Safety Commission Act 2018* (Cth) to assist the Aged Care Quality and Safety Commissioner in the performance of the Commissioner's functions.

Aged Care Quality and Safety Commissioner

A person appointed under the *Aged Care Quality and Safety Commission Act 2018* (Cth) to regulate and promote quality and safety in the aged care system.

Aged Care Quality Standards

A set of standards for the provision of aged care that apply to all Australian Government subsidised aged care services. The standards are set out in Schedule 2 to the *Quality of Care Principles 2014* (Cth).

Aged Care Research and Innovation Council

See Recommendation 107.

Aged Care Research and Innovation Fund

See Recommendation 107.

Aged Care Safety and Quality Authority

See Recommendation 10.

Aged Care Target Provision Ratio

A target set by the Australian Government for the number of home care, residential care, and restorative care places for every 1000 people aged 70 years or over.

Annual Prudential Compliance Statement

An annual report residential aged care providers must submit to the Australian Government if they held a Refundable Accommodation Deposit, accommodation bond, or entry contribution during the reporting period.

approved provider

An organisation approved under Part 7A of the *Aged Care Quality and Safety Commission Act 2018* (Cth) to receive subsidies from the Australian Government for providing home care, residential aged care or flexible care services, or a combination of these.

assistive technology

Devices and technologies that maintain or improve an older person's functioning to facilitate safety, independence, social inclusion and enhance overall wellbeing. Examples include walking frames, shower chairs, pressure-relieving mattresses, personal and location monitoring technology or specialised software and hardware that increase hearing, vision, communication, social interaction or cognitive stimulation capacities.

Australian Aged Care Commission

See Recommendation 5.

Australian Affordable Housing Bond Aggregator

Loans provided by the National Housing Finance and Investment Corporation to registered community housing providers that are low cost, long-term loans to support the provision of more social and affordable housing.

Australian Commission on Safety and Quality in Health Care

A Commonwealth entity established by the *National Health Reform Act 2011* (Cth) to promote the quality and safety of the health care system.

Australian Commission on Safety and Quality in Health and Aged Care

See Recommendation 18.

Australian National Aged Care Classification (AN-ACC)

A proposed new assessment and funding model for residential aged care developed by the Australian Health Services Research Institute (AHSRI) at the University of Wollongong for the Australian Department of Health as part of the Resource Utilisation and Classification Study.

Basic Daily Fee

The fee people receiving a Home Care Package or residential aged care may pay for day-to-day services.

behaviour domain

A domain under the Aged Care Funding Instrument which assesses a person's cognitive skills, 'wandering', verbal behaviour, physical behaviour and level of depression.

care finders

A proposed workforce of personal advisers to older people, their families and carers that work face-to-face. Care finders will assist people seeking aged care to understand, identify and access care and supports in their local area, including following up and checking in when people commence using aged care. See Recommendation 29.

care leaver

An adult who spent time in institutional or out-of-home care as a child, including the Forgotten Australians and former child migrants.

care management

The day-to-day coordination of care, which includes creating a care plan (in conjunction with the older person and their carer), managing and organising services, monitoring the services delivered, reviewing the care plan as needs change and referring the older person for reassessment when their needs change.

Carer Gateway

A service funded by the Australian Department of Social Services which helps carers access practical information and advice and connect with services in their local area.

carer leave

Leave provided for in the National Employment Standards to allow employees to provide care or support to a member of the employee's immediate family, or a member of the employee's household, who requires care or support because of a personal illness, injury or because of an emergency affecting the member.

carers hub

Community-based hubs providing information and support for informal carers which can help reduce stress and feelings of isolation.

centre-based respite

Daytime respite delivered in a group-based setting, such as a community centre or residential aged care home.

changed behaviour

Changes in a person's behaviour that are caused by dementia. In medical literature this is sometimes referred to as 'behavioural and psychological symptoms of dementia' or BPSD.

Commonwealth Continuity of Support Programme

A government support service for people with disability who do not qualify for the National Disability Insurance Scheme and are an existing client of state-managed specialist disability services at the time the programme commenced in their region. It provides accommodation support, community support, community access and respite services. It will be replaced by the Disability Support for Older Australians Program in July 2021.

Commonwealth Home Support Programme

An entry-level program that is intended to provide ongoing or short-term care and support services to older people such as help with housework, personal care, meals, shopping, allied health, social support and planned respite.

Community controlled health service

An incorporated organisation initiated by and based in a local Aboriginal community, governed by an Aboriginal body which is elected by the local Aboriginal community, and that delivers holistic and culturally appropriate health care.

Community Visitors Scheme

Australian Government scheme that arranges visits by volunteers to older people who use aged care services.

Community Visitors Scheme auspices

Organisations that receive funding from the Community Visitor Scheme to recruit, train and support volunteers, conduct police checks, match volunteers to older people receiving care, and support relationships between volunteers and the people they visit.

complex health care domain

A domain under the Aged Care Funding Instrument which assesses a person's need for ongoing complex health procedures and activities.

compulsory reporting scheme

A scheme under the *Aged Care Act 1997* (Cth) requiring approved providers of residential aged care to report alleged or suspected assaults and circumstances when a resident is absent without explanation. See *reportable assaults*.

cottage respite

Usually overnight respite delivered in a cottage-style or home-like setting.

Council of Elders

See Recommendation 9.

Country (in relation to Aboriginal and Torres Strait Islander people)

A term indicating interlinked concepts of people, community, culture, nature, history, law and land.

Daily Accommodation Contribution

A method of payment for residential aged care accommodation that accrues daily and is paid by periodic payment (as opposed to paying a Refundable Accommodation Contribution which is paid in a lump sum). It is a rental-style payment to a residential aged care provider for the agreed daily cost of accommodation. Only partially supported residents can be asked to pay a Daily Accommodation Contribution.

Daily Accommodation Payment

A method of payment for residential aged care accommodation that accrues daily and is paid by periodic payment (as opposed to paying a Refundable Accommodation Payment which is paid in a lump sum). It is a rental-style payment to a residential aged care provider for the agreed daily cost of accommodation. Only non-supported residents can be asked to pay a Daily Accommodation Payment.

Disability Support for Older Australians Program

An Australian Government program to replace the Commonwealth Continuity of Support Programme, due to commence on 1 July 2021.

Elder (in relation to Aboriginal and Torres Strait Islander people)

A person identified and respected as a custodian of traditional language, knowledge or wisdom, who has permission to speak about these; not necessarily defined by age.

flexible care services

Flexible care services include care provided through the Multi-Purpose Services Program, Transition Care Program, Short-Term Restorative Care Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Forgotten Australians

People (including former child migrants) who as children experienced care in institutions or outside a home setting in Australia in the twentieth century.

former child migrants

More than 7000 children—mainly from the United Kingdom and a small number from Malta—who migrated to Australia under assisted child migration schemes during the twentieth century and who were adopted or lived in children's homes, institutions, orphanages or foster care.

fully supported residents

Residents of aged care facilities whose income and assets are assessed as falling below the means testing threshold so they do not have to contribute to their accommodation or care costs.

general duty to provide high quality and safe care

See Recommendation 14.

General Purpose Financial Report or General Purpose Financial Statement

An annual financial report or statement all non-government residential aged care providers must submit to the Australian Government.

Home and Community Care Program

Former program for aged care home support administered by State and Territory Governments. Replaced by the Commonwealth Home Support Programme from 2012.

home care

Care consisting of a package of personal care services and other personal assistance provided to a person who is not being provided with residential care.

Home Care Package

See *Home Care Packages Program*.

Home Care Packages Program

An Australian Government program that provides people with in-home aged care services by assigning funding directly to people receiving care (rather than to care providers). It provides four levels of supports ranging from those for people with basic care needs to those for people with high care needs.

home modifications

In an aged care context, home modification services can include installing grab and shower rails, easy-to-use tap sets, hand rails, ramps and other mobility aids, installing an emergency alarm and other safety aids, and other minor renovations.

homeless supplement

An Australian Government payment for aged care providers who specialise in caring for people who are experiencing homelessness, or are at risk of homelessness, at the time they entered permanent residential care.

Independent Hospital Pricing Authority

An agency established under the *National Health Reform Act 2011* (Cth) to determine the 'national efficient price' for health care services provided by public hospitals.

Independent Hospital and Aged Care Pricing Authority

See Recommendation 11.

informal carer

A family member or friend of an older person who provides regular, ongoing assistance with everyday personal activities.

Inspector-General of Aged Care

See Recommendation 12.

Integrated Carer Support Service

Ongoing Australian Department of Social Services program commenced 1 July 2015 aiming to consolidate a wide range of carer support services.

interim Home Care Package

A Home Care Package of a lower level than the one approved to be received.

LGBTI

Lesbian, Gay, Bisexual, Trans and Intersex.

Local Hospital Network

A government-funded entity established by a State or Territory Government to manage a single public hospital service or a small group of public hospital services. Local Hospital Network is the term mainly used in the report and, unless otherwise indicated, is inclusive of Local Health Districts, Local Health Networks, Hospital and Health Services, and Health Services.

long-term care

A term used in some overseas jurisdictions for aged care. It often also includes disability care.

lump sum deposits

See *Refundable Accommodation Deposit*.

mandatory quality indicators

See *National Aged Care Mandatory Quality Indicator Program*.

Maximum Permissible Interest Rate

An Australian Government-set maximum interest rate a residential aged care provider can use to calculate daily accommodation rates based on agreed room price.

Multi-Purpose Services Program

A program combining funding for aged care services from the Australian Government and State and Territory health services, to support small regional and remote communities to offer flexible aged care services.

My Aged Care

An Australian Government service providing a single entry-point to aged care. It includes a national contact centre with a single phone number, a website describing services, assessment forms and guidelines, centralised client records, and web based portals for clients, assessors and service providers.

My Health Record

A national digital health record system containing information about individuals' health care assessments, procedures, treatments and consultations that is administered by the Australian Digital Health Agency.

National Aged Care Advocacy Program

An Australian Department of Health initiative that provides free and confidential advocacy support to older people and their carers.

National Aged Care Mandatory Quality Indicator Program

A program that collects certain quality indicator data from residential aged care services.

National Health Reform Agreement

An agreement between the Australian Government and all State and Territory Governments under which the Australian Government contributes funds to State and Territories for public hospital services.

National Prioritisation System for Home Care Packages

A process used by the Australian Government to prioritise and allocate Home Care Packages to people who have been assessed eligible for a package. The system commenced on 27 February 2017.

National Safety and Quality Health Service Standards

The standards established by the Australian Commission on Safety and Quality in Health Care that apply to all health service providers in Australia, designed to protect the public from harm and improve the quality of service provision.

NATSIFACP (National Aboriginal and Torres Strait Islander Flexible Aged Care Program)

The program that provides flexible, block funding for provision of culturally safe aged care services to Aboriginal and Torres Strait Islander people in home, community and residential settings.

NDIS (National Disability Insurance Scheme)

A national scheme established by the *National Disability Insurance Scheme Act 2013* (Cth) that provides support to eligible people with intellectual, physical, sensory, cognitive and psychosocial disability.

non-supported residents

See *unsupported residents*.

partially supported residents

Residents of aged care facilities whose income and assets are assessed under the means test as high enough to require them to pay for some of their accommodation costs, but not their care costs.

personal care worker

An occupational title assigned to people who provide care to older people, people with disability and health care patients in a range of settings, including private homes, hospitals and residential aged care facilities. Personal care workers are not registered health practitioners. A wide variety of other titles are used to describe personal care workers, including personal care attendant, assistant in nursing, community care worker, home support worker and home care employee.

Pricing Authority

See explanation on pages 83–84 of Volume 1.

Primary Health Network

An administrative health region established to deliver access to primary care services (such as general practitioners) and coordinate with local hospitals to improve the overall operational efficiency of the network.

protected person

A person, such as a partner of an aged care resident, whose presence in the aged care resident's principal residence enables that residence to be exempted from the aged care assets test (See s 44-26A(6) of the *Aged Care Act 1997*).

Prudential Regulator

See explanation on pages 83–84 of Volume 1.

Quality Regulator

See explanation on pages 83–84 of Volume 1.

Quality Review

A process of reviewing the quality of home care services, Commonwealth Home Support Programme services and flexible care services against the Aged Care Quality Standards.

Quality Standards

See *Aged Care Quality Standards*.

Rainbow Tick

National accreditation program for organisations committed to safe and inclusive practice and service delivery for the LGBTI community.

Refundable Accommodation Contribution

A method of payment for residential aged care accommodation that does not accrue daily and is paid as a lump sum. The balance is repaid to the person in residential aged care when they leave that aged care residence. Only partially supported residents can be asked to pay a refundable accommodation contribution.

Refundable Accommodation Deposit

A method of payment for residential aged care accommodation that does not accrue daily and is paid as a lump sum. The balance is repaid to the person in residential aged care when they leave that aged care residence. Only unsupported residents can be asked to pay a refundable accommodation deposit.

Regional Assessment Service

An assessment service which assesses people seeking entry-level support at home provided under the Commonwealth Home Support Programme.

reportable assault

Under the compulsory reporting scheme approved providers of residential care must notify the police and the Aged Care Quality and Safety Commission of reportable assaults. A 'reportable assault' is defined in the *Aged Care Act 1997* (Cth) as unlawful sexual contact, an unreasonable use of force, or an assault specified in the Accountability Principles and constituting an offence against a law of the Commonwealth or a State or Territory that is inflicted on a person receiving aged care services.

reportable incident

National Disability Insurance Scheme providers must notify the NDIS Commission of all reportable incidents. A 'reportable incident' is defined in the *National Disability Insurance Scheme Act 2013* (Cth) as including the death, serious injury, abuse or neglect, of a person with disability.

residential aged care

An Australian Government-funded and regulated service under the *Aged Care Act 1997* (Cth) that provides accommodation and aged care to people requiring ongoing health and nursing care.

Resource Utilisation and Classification Study (RUCS)

A national study undertaken by the Australian Health Services Research Institute at the University of Wollongong (and commissioned by the Australian Department of Health) to: consider the cost of aged care; determine which characteristics of residents and services drive costs; create a new assessment, classification and funding model (see *Australian National Aged Care Classification*); and develop an assessment tool.

respite care

Short-term support and care services for older people and their carers. The services can be provided in the home, in cottages, in residential facilities, or in purpose-built facilities.

Review Audit

An onsite assessment of the quality of care and services provided to people receiving aged care by an accredited service, conducted by the Aged Care Quality and Safety Commissioner.

Serious Incident Response Scheme

An Australian Government scheme intended to commence in 2021 for the reporting of abuse and neglect in residential aged care. It will replace the compulsory reporting scheme.

Short-term Restorative Care Programme

A flexible care service program that provides care and services to a person for up to eight weeks to help improve their physical functioning, wellbeing and independence.

site audit

An unannounced comprehensive performance assessment against the Quality Standards undertaken for the purpose of informing a decision whether to re-accredit a residential aged care service.

Specialist Disability Accommodation

Accommodation for people with disability, generally with extreme functional impairment or high care needs, funded through a separate component of the National Disability Insurance Scheme.

stewardship

Conducting, supervising or managing something: the careful and responsible management of something entrusted to one's care.

Stolen Generations

Aboriginal and Torres Strait Islander people who as children were removed from their families by Australian Government and State Government agencies and church missions.

supported residents

Residents of aged care facilities whose income and assets are assessed as falling below the means testing threshold so they do not have to contribute to their care costs.

System Governor

See explanation on pages 83–84 of Volume 1.

Transition Care Programme

A short-term aged care program to support older people recover after a hospital stay. It can be provided in residential aged care, in a person's home or in the community.

unsupported residents

Residents of aged care facilities who pay the full cost of their accommodation and contribute to their care costs because their income and assets are over the means tested threshold.

Veterans' Supplement

A supplement payable to aged care providers who care for veterans with service-related mental health conditions.

Viability Supplement

An additional payment the Australian Government makes to eligible aged care providers to assist with the additional cost of providing services in remote and some regional areas and to particular disadvantaged groups.

younger person in residential aged care

See Chapter 11 of Volume 3.



Royal Commission
into Aged Care Quality and Safety

Commonwealth of Australia

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ISBN: 978-1-921091-65-0 (print)
ISBN: 978-1-921091-66-7 (online)

Published February 2021