Royal Commission into Aged Care Quality and Safety

Final Report: Care, Dignity and Respect

Volume 1

Summary and recommendations

Royal Commission into Aged Care Quality and Safety

Final Report: Care, Dignity and Respect

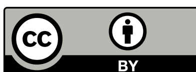
Volume 1

Summary and recommendations

© Commonwealth of Australia 2021

ISBN: 978-1-921091-65-0 (print)
ISBN: 978-1-921091-66-7 (online)

With the exception of the Coat of Arms and where otherwise stated, all material presented in this publication is provided under a Creative Commons Attribution 4.0 International licence. For the avoidance of doubt, this means this licence only applies to material as set out in this document.



The details of the relevant licence conditions are available on the Creative Commons website as is the full legal code for the CC BY 4.0 licence <www.creativecommons.org/licenses>.

The terms under which the Coat of Arms can be used are detailed on the Department of the Prime Minister and Cabinet website <www.pmc.gov.au/government/commonwealth-coat-arms>.

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

Table of Contents

Chair's Preface 1

What is to be Done—an Overview | The Hon GT Pagone QC 7

Context 10

Why is it so? 12

What is to be done? 13

A rights foundation for high quality aged care 14
Duties 14
Independence from Government 15
A secure source of funding 18

Conclusion 20

Care, Dignity and Respect—an Overview | Commissioner Lynelle Briggs AO 23

Background to reform 24

Our approach 30

Care, dignity and respect 31

Transformational reform 32

Clarity of purpose 32
A say and a voice 33
Entitlement to care 35
A new aged care program 35
Love, commitment and service 38
Care standards, the duty of care and integrated care 39
Care workers are properly valued 40
Smarter ways of working 42
A fair share of health care 44
A step up for Government 46
Provider governance 50
Open, accountable and honest 52
Regulation that works 53
Fit-for-purpose funding and financing 55

Thank you 57

Conclusion 58

1. A Summary of the Final Report 61

1.1 Introduction 61

1.2 The current system 61

1.2.1 A look at the aged care system 61
1.2.2 Problems of access 65
1.2.3 Uncovering substandard care 68
1.2.4 Investigating systemic problems 73

1.3	**A new aged care system**	**78**
1.3.1	Foundations of the new aged care system: A new Act, purpose and principles	78
1.3.2	Governing for older Australians	82
1.3.3	Ensuring quality and safety: the imperative	91
1.3.4	An entitlement to care: a new aged care program	96
1.3.5	Giving thanks and giving back: support for informal carers and volunteers	103
1.3.6	Designing accommodation for quality of life	105
1.3.7	Respecting uniqueness: aged care for Aboriginal and Torres Strait Islander people	108
1.3.8	Fairness and flexibility: aged care in regional, rural and remote Australia	111
1.3.9	Securing better access to health care	113
1.3.10	Righting a wrong: services for older people with disability	120
1.3.11	Action for younger people in residential aged care	121
1.3.12	A workforce to deliver quality, safe care	124
1.3.13	Responsibility and accountability: good provider governance	132
1.3.14	Lifting the bar: regulating for quality and safety	136
1.3.15	Improving aged care through data, research and technology	144
1.3.16	Funding for the new aged care system	149
1.3.17	More sustainable capital financing for residential aged care	158
1.3.18	Strengthening prudential regulation and financial oversight	160
1.3.19	Financing aged care: investing in an entitlement to care	164
1.3.20	Getting it done and getting it right: oversight, implementation and monitoring	168
1.4	**Aged care and COVID-19: a special report**	**170**
1.4.1	Recommendations	171

2. Approach to the Inquiry 177

2.1	**Introduction**	**177**
2.2	**Staffing and structure**	**178**
2.3	**Engagement**	**179**
2.3.1	Enquiries and counselling	179
2.4	**Forms of inquiry**	**181**
2.5	**Submissions**	**181**
2.5.1	General submissions	182
2.5.2	Targeted submissions	182
2.5.3	Hearings	183
2.5.4	Notices	185
2.5.5	Community Forums	186
2.6	**Targeted engagement**	**187**
2.6.1	Consultations by Commissioners	187
2.6.2	Consultation by Royal Commission staff	187
2.6.3	Service provider visits	188
2.6.4	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability	188
2.7	**Research and publications**	**188**
2.7.1	International research	188
2.7.2	Internal and commissioned research	189
2.8	**Costing of recommendations**	**189**
2.9	**Out-of-scope themes**	**190**

3. Recommendations 205

Chapter 1: Foundations of the New Aged Care System 205
Chapter 2: Governance of the New Aged Care System 209
Chapter 3: Quality and Safety 218
Chapter 4: Program Design 226
Chapter 5: Informal Carers and Volunteers 237
Chapter 6: Aged Care Accommodation 239
Chapter 7: Aged Care for Aboriginal and Torres Strait Islander People 240
Chapter 8: Aged Care in Regional, Rural and Remote Areas 245
Chapter 9: Better Access to Health Care 246
Chapter 10: Aged Care for Older People with Disability 255
Chapter 11: Younger People in Residential Aged Care 256
Chapter 12: The Aged Care Workforce 258
Chapter 13: Provider Governance 265
Chapter 14: Quality Regulation and Advocacy 268
Chapter 15: Research and Development and Aged Care Data | Commissioner Pagone 277
Chapter 16: Data, Research, Innovation and Technology | Commissioner Briggs 282
Chapter 17: Funding the Aged Care System | Commissioner Pagone 284
Chapter 19: Prudential Regulation and Financial Oversight | Commissioner Pagone 298
Chapter 20: Financing the New Aged Care System | Commissioner Pagone 301
Chapter 21: Funding the Aged Care System | Commissioner Briggs 302
Chapter 22: Personal Contributions and Means Testing | Commissioner Briggs 304
Chapter 23 Capital Financing for Residential Aged Care | Commissioner Briggs 307
Chapter 24: Financial Oversight and Prudential Regulation | Commissioner Briggs 307
Chapter 25: Financing the New Aged Care System | Commissioner Briggs 309
Chapter 26: Oversight, Implementation and Monitoring 309

4. Glossary 313

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 inquires 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 Minster (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 certainly. 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 though 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 inexpert 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 inquires 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.

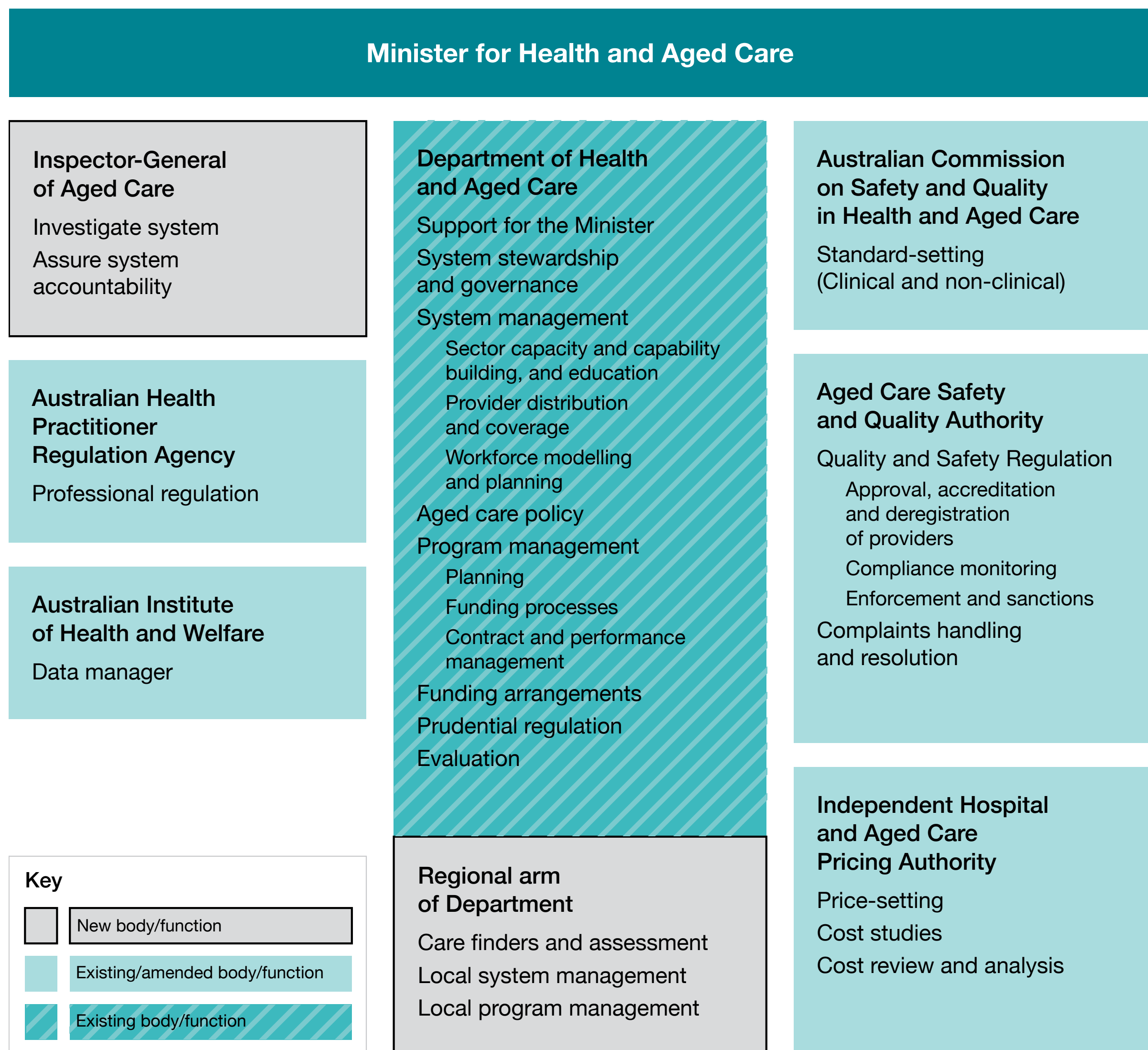
The Government must step up and embrace its responsibilities for aged care. Aged care is a social service, not a commodity that can be outsourced so that it can be bought or sold at the lowest price. The Australian Government has a responsibility to lead and manage the delivery of this important service, 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 age 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 is 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!

Endnotes

1 Transcript, Darwin Hearing, Lisa Backhouse, 11 July 2019 at T3205.35–40.
2 Royal Commission into Aged Care Quality and Safety, *Medium- and long-term pressures on the system: the changing demographics and dynamics of aged care*, Background Paper 2, 2019, pp 2–3.
3 Royal Commission into Aged Care Quality and Safety, *Medium- and long-term pressures on the system: the changing demographics and dynamics of aged care*, Background Paper 2, 2019, p 3.
4 Royal Commission into Aged Care Quality and Safety, Background Paper 2, *Medium- and long-term pressures on the system: the changing demographics and dynamics of aged care*, pp 10–11.
5 Australian Department of Health, *Home Care Packages Program: Data Report 4th Quarter 2019–20*, 2020, p 11.
6 StewartBrown, *Home Care Provider Survey Analysis of Data Collected*, 2020, p 43 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 4, RCD.9999.0444.0001).
7 Australian Institute of Health and Welfare, *Interfaces between the aged care and health systems in Australia—first results*, 2019, p 6 (Exhibit 14-1, Canberra Hearing, general tender bundle, tab 66, RCD.9999.0280.0003).
8 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 251, AWF.001.02142 at 0005.
9 Exhibit 13-2, Hobart Hearing, Southern Cross Care Tasmania tender bundle, tab 251, AWF.001.02142 at 0003.
10 Exhibit 1-23, Adelaide Hearing 1, Statement of Glenys Beauchamp, 4 February 2019, WIT.0022.0001.0001 at 0037 [163].
11 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, 2019, p 7.
12 Exhibit 6-48, Darwin and Cairns Hearing, Statement of Robert Hunt and Sharon Lawrence on behalf of the Dieticians Association of Australia, 20 June 2019, WIT.0205.0001.0001 at 0011[53]; Exhibit 6-1, Darwin and Cairns Hearing, general tender bundle, tab 82, DAA.0001.0001.0079 at 0080–0082.
13 PD Hibbert et al., 'CareTrack Aged: the appropriateness of care delivered to Australians living in residential aged care facilities: a study protocol', *BMJ Open*, 2019, Vol 4, Appendix 1, p 2.
14 Exhibit 6-1, Darwin and Cairns Hearing, general tender bundle, tab 51, CSH.0001.0001.0032 at 0041.
15 Exhibit 3-61, Sydney Hearing 1, Statement of Juanita Westbury, 29 April 2019, WIT.0117.0001.0001 at 0008 [13]; J Westbury et al., 'More action needed: Psychotropic prescribing in Australian RACFs', *Australian and New Zealand Journal of Psychiatry*, 2019, Vol 53, 2, p 139 (Exhibit 3-2, Sydney Hearing, general tender bundle, tab 49, RCD.9999.0032.0128).
16 National Ageing Research Institute, *Inside the system: aged care residents' perspectives*, A report for the Royal Commission into Aged Care Quality and Safety, Research Paper 13, 2020, p 51.
17 National Ageing Research Institute, *Inside the system: aged care residents' perspectives*, A report for the Royal Commission into Aged Care Quality and Safety, Research Paper 13, 2020, pp 39–40.
18 Aged Care Quality and Safety Commission, *Sector Performance Report July – December* 2018, 2018, p 2 (Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 34, CTH.0001.4000.8890); Aged Care Quality and Safety Commission, *Sector Performance Report January – March 2019*, 2019, p 2 (Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 35, CTH.0001.4000.8900); Aged Care Quality and Safety Commission, *Sector Performance Report April – June 2019*, 2019, p 2 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 55, RCD.9999.0473.0051).
19 See Aged Care Quality and Safety Commission, *Sector Performance Report July – December* 2018, 2018, p 5 (Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 34, CTH.0001.4000.8890); Aged Care Quality and Safety Commission, *Sector Performance Report January – March 2019*, 2019, p 5 (Exhibit 8-27, Brisbane Hearing, general tender bundle, tab 35, CTH.0001.4000.8900); Aged Care Quality and Safety Commission, *Sector Performance Report April – June 2019*, 2019, p 5 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 55, RCD.9999.0473.0051).
20 Aged Care Quality and Safety Commission, *Sector Performance Report July – September 2019*, 2019, pp 2, 3, 8 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 56, RCD.9999.0473.0027); Aged Care Quality and Safety Commission, *Sector Performance Report October – December 2019*, 2019, pp 2, 3, 9 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 57, RCD.9999.0473.0011); Aged Care Quality and Safety Commission, *Sector Performance Report January – March 2020*, 2020, pp 3, 10 (Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 2, RCD.9999.0361.0014); Aged Care Quality and Safety Commission, *Sector Performance report April – June 2020,* 2020, pp 4, 10.
21 Australian Health Services Research Institute at the University of Wollongong, *How Australian residential aged care staffing levels compare with international and national benchmarks*, A research study commissioned by the Royal Commission into Aged Care Quality and Safety, Research Paper 1, 2019, p 34 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001).
22 KPMG, *Prevalence study for a Serious Incident Response Scheme (SIRS)*, 2019, p 37; Australian Department of Health, *2018-19 Report on the Operation of the Aged Care Act 1997*, 2019, p 84.
23 Australian Institute of Health and Welfare, *Residential Aged Care Quality Indicators – April to June 2020*, 2020, p 2.
24 Exhibit 23-4, final tender bundle, Office of the Royal Commission, *Pressure Injury and weight loss reported by residential aged care providers as part of the National Aged Care Mandatory Quality Indicator Program*, RCD.9999.0499.0016 at 0017.
25 Exhibit 23-4, final tender bundle, Office of the Royal Commission, *Pressure Injury and weight loss reported by residential aged care providers as part of the National Aged Care Mandatory Quality Indicator Program*, RCD.9999.0499.0016 at 0017.
26 Exhibit 13-3, Hobart Hearing, Statement of Helen Valier, Hobart Hearing, WIT.0599.0001.0001 at 0016 [139].
27 Transcript, Perth Hearing, Noleen Hausler, 24 June 2019 at T2259.6–10.
28 Transcript, Brisbane Hearing, Gwenda Darling, 7 August 2019 at T4472.15–19.
29 The University of Queensland, *The cost of residential aged care*, A research paper prepared for the Royal Commission into Aged Care Quality and Safety, Research Paper 9, 2020, p 3 (Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 14, RCD.9999.0388.0550).

30 Australian Health Services Research Institute, University of Wollongong, *How Australian residential aged care staffing levels compare with international and national benchmarks*, A research study commissioned by the Royal Commission into Aged Care Quality and Safety, Research Paper 1, 2019, p 22 (Exhibit 11-1, Melbourne Hearing 3, general tender bundle, tab 148, AHS.0001.0001.0001).

31 Australian Department of Health, *Home Care Provider Survey Analysis of Data Collected*, 2020, p 16, https://www.health.gov.au/sites/default/files/documents/2020/06/home-care-provider-survey-analysis-of-data-collected.pdf, viewed 11 November 2020.

32 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, Vol 1, 2019, p 98.

33 Transcript, Canberra Hearing, Antony Bartone, 9 December 2019 at T27270.24–27; T7270.34–38.

34 Exhibit 8-29, Brisbane Hearing, Precis of evidence prepared by Professor Ron Paterson ONZM, RCD.9999.0143.0001 at 0002 [17].

35 Transcript, Melbourne Hearing 1, Ben Gauntlett, 11 September 2019 at T5152.38–44.

36 Transcript, Brisbane Hearing, Debora Picone, 9 August 2019, T4769.7–10.

37 See Transcript, Brisbane Hearing, John Braithwaite, 9 August 2019 at T4794.44–4795.2.

38 Transcript, Brisbane Hearing, John Braithwaite, 9 August 2019 at T4794.44–45.

39 Australian Institute of Health and Welfare, *Extended Aged Care at Home Census 2002*, 2004, p 12.

40 COTA Australia, Public submission, AWF.680.00058.0001 at 0002.

41 Exhibit 21-1, Sydney Hearing 5, general tender bundle, tab 84, WIT.0764.0001.0001 at 0022 [74].

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

43 Exhibit 20-1, Sydney Hearing 4, general tender bundle, tab 92, RCD.9999.0483.0002 at 0016.

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 Departmental 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: