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TRANSCRIPT OF PROCEEDINGS

THE HON T. PAGONE QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

IN THE MATTER OF A ROYAL COMMISSION
INTO AGED CARE QUALITY AND SAFETY

SYDNEY

9.30 AM, THURSDAY, 22 OCTOBER 2020

DAY 98

MR P. ROZEN QC appears with MR GRAY QC as counsel assisting

COMMISSIONER PAGONE QC: I would like to commence by acknowledging the traditional custodians of the land on which Commissioner Briggs and I sit today, the Nonawal, and pay our respects to their elders, past present and emerging. Mr Gray?

5 MR GRAY QC: Thank you, Commissioner.

Commissioners, I appear with co-senior counsel assisting Peter Rozen QC and also with the following counsel assisting: Richard Knowles SC, Paul Bolster, Erin Hill, Brooke Hutchins and Eliza Bergin. We also acknowledge the traditional custodians
10 of the land on which we meet and pay our respects to the elders past, present and emerging.

Mr Rozen and I are indebted to our colleagues and our superb instructing solicitors for their assistance in the preparation of the counsel assisting team's final
15 submissions which we will be presenting to you today and tomorrow.

We have prepared a document setting out our submissions in support of a number of recommendations which we, the counsel assisting team, propose that you, Commissioners, should make to the Australian Government in your final report due
20 in February.

The document setting out our submissions will shortly be published on the Royal Commission's website. It is over 500 pages long. In the document, we are submitting 124 proposed recommendations for your consideration and for the
25 consideration of any interested persons who wish to submit a response. The submissions include an outline of supporting reasoning for each of the submissions and recommendations and cover certain other matters.

Commissioners, at the end of the hearing tomorrow, we will ask you to make a
30 direction governing the way in which responses may be made to our submissions and proposed recommendations and the deadline for those responding submissions. Our proposal is as follows: any interested person can respond to the submissions and recommendations and should use the template on the Royal Commission's website to do so. This template will allow responses to all of counsel assisting's
35 recommendations, as well as certain issues referred to in the submissions.

In addition to the template, interested people can submit a document, provided it is formatted in Microsoft Word, of no more than 10 pages in length. In that document a person can address any matters in the submissions they wish, as well as any
40 questions or comments from the Commissioners raised during the hearing.

Commissioners, our work would not have been possible without the dedication and hard work of many other people. Mr Rozen will say more about this in a minute, but I, too, want to pay tribute to the engagement we have seen in particular from
45 witnesses who have appeared in the hearings of the Royal Commission. Not all of the witnesses are mentioned by name in our submissions, but we acknowledge our appreciation to all the witnesses who have given time and effort to assist this Inquiry.

Over the next two days, Mr Rozen and I will give an oral presentation of our submissions and recommendations, drawing particular attention to various aspects of the 500 pages or so of written submissions. We have agreed on a division of topics and will alternate during our presentation.

Mr Rozen will be covering much of the ground we wish to address today and I will be covering much of the ground tomorrow.

I will now hand over to Mr Rozen to commence our oral submissions.

COMMISSIONER PAGONE QC: Yes, Mr Rozen.

CLOSING SUBMISSIONS BY MR ROZEN QC

MR ROZEN QC: Good morning, Commissioners, and thank you Mr Gray.

Commissioners, at the preliminary hearing of this Royal Commission in early 2019, the late Commissioner Tracey observed, and I quote:

> *The Royal Commission is a once in a lifetime opportunity to come together as a nation to consider how we can create a better system of care for elderly Australians that better aligns with the expectations of the Australian people. The hallmark of a civilised society is how it treats the most vulnerable people.*

At the time we, counsel assisting, observed that this inquiry is a unique opportunity to create a better system of care for older Australians and others engaged with the aged care system. We and those instructing us undertook to assist the Royal Commissioners in conducting the inquiry with which they have been entrusted. In so doing, we have assisted in the most in-depth and thorough examination of Australia's aged care system that has ever been undertaken.

The Royal Commission's call for public submissions has been met enthusiastically. Between 24 December 2018 and 9 October of this year, 10,144 submissions were received from people receiving aged care services, their family members, aged care workers, approved providers, aged care and health sector representative bodies, government organisations and others.

The Royal Commissioners conducted community forums in 12 locations nationwide. These were attended by 2,416 people and there were 228 speakers. Those speakers described their experiences of the aged care system. Many of these accounts were difficult to listen to. All were very valuable and we are grateful to the many brave people.

There were public hearings in all eight capital cities; in four regional centres,

Broome, Cairns, Mudgee and Mildura. In total there were 97 days of hearing at which 641 witnesses gave evidence. While many of these witnesses were experts from a wide variety of professional backgrounds both here and overseas, there were also 113 direct experience witnesses, people living in residential aged care, people receiving home care, and their families. Again, we salute the courage of these witnesses for sharing the most intimate details of their lives to inform this inquiry.

Aged care workers, as well as the trade unions that advocate for and represent the workers, gave evidence at a number of hearings and the transcripts and the thousands of documentary exhibits are all on the Royal Commission's website.

In 2019 the Royal Commissioners attended 13 roundtables that examined topics including the aged care workforce, aged care and culturally and linguistically diverse communities, lesbian, gay, bi-sexual, trans-gender and inter-sex communities and Aboriginal and Torres Strait Islander communities. These were held in various capital cities and 132 people with aged care expertise or experience participated.

Together with staff of the Royal Commission, the Commissioners visited 34 aged care services in locations as varied as Bidyadanga and Balaclava. We thank the providers and their staff for being generous hosts. We thank the residents for letting us into their homes.

In early 2020 Commissioners Pagone and Briggs travelled overseas to meet with international officials and experts on aged care and viewed innovative aged care models in several countries. One of the purposes of these meetings and visits was to examine approaches to aged care design and funding in different countries and to consider their applicability in the Australian context.

The Royal Commission's research team has overseen a comprehensive research program which will be an important resource of information for researchers for years to come. It includes 14 research papers on topics including community attitudes to aging and aged care, international and national quality and safety indicators for aged care. The Office of the Royal Commissioners has produced eight background papers on subjects ranging from carers of older Australians to restrictive practices in residential aged care and two consultation papers on aged care program design and financing aged care. Once again, this wealth of material is published on the Commission's website.

The submissions we make today are informed by all of the information that has emerged from this two-year undertaking.

Commissioners, these statistics are impressive but they are so much more than a collection of numbers. The witnesses who have given evidence include:

Ms Shannon Ruddock, who travelled from Sydney to Perth to explain the personal trauma she suffered in wanting her late father to pass away in hospital rather than return to the aged care home where the palliative care he was receiving was

substandard.

Ms Johanna Aalberts-Henderson, who spoke of her ice-cold rage at the terrible state of a leg wound her late mother suffered at a residential aged care facility in suburban Melbourne. A consultant engaged by the provider of that home concluded that registered nursing levels in the home were so low that residents could expect to receive on average only seven minutes of nursing care per day.

Mr James Nutt entered residential aged care when he was 22 years old after he was assaulted at a local footy match which left him with an acquired brain injury and paralysed from the waist down. Mr Nutt gave a heart-breaking account at Melbourne 1 of his time living in a residential aged care facility. On his first evening, he described going back to his room after dinner. He held his head in his hands and he cried and thought to himself, "I'm 22, I've got maybe 65 years left in my life and I am forced to live here for the rest of it with no ability of ever getting out."

Ms Kirby Littley, who was in her late 20s when she had surgery for a brain tumour. As a result of this, Ms Littley had multiple strokes and was severely disabled. Ms Littley and her parents told the Royal Commission that residential aged care was presented as the only option for her. She told the Commission that she felt as though nobody wanted her.

Mrs Rosemary Cameron's husband was in his early 60s when he was diagnosed with Lewy Body Dementia. Based in the Macedon Ranges in Victoria, her experience of caring for her husband left Mrs Cameron completely exhausted.

Ms Veda Menaghetti was 61 when she was diagnosed with a rare variant of young onset frontotemporal dementia. Ms Lynda Henderson gave evidence in the second Adelaide hearing of the immeasurable value of the grassroots support and information after Veda was diagnosed.

In the Broome hearing held in June of last year, Ms Madeline Jadai, an Aboriginal Mangala woman, shared her story of caring for her sister aged 62 in the remote Aboriginal community of Bidyadanga.

Mr Peter Harris gave evidence in Mudgee in November 2019. He cared for his wife at home for five years. He described his experience as a carer as being like a "frog on the cooktop being boiled in cold water".

In the first Sydney hearing, the Royal Commission heard from Mr George Akl, whose late father reverted to his first language, Arabic, as his dementia worsened. Mr Akl reminded us of the importance of an aged care system that respects and is responsive to cultural and linguistic diversity.

Ms Sarah Holland-Batt gave evidence at the Royal Commission's Brisbane hearing. She detailed her experience of her father in residential aged care, told the Commission that she observed neglectful care of her father who has since passed

away. She became concerned that her father was being abused by staff at the facility and raised this with the Aged Care Complaints Commissioner but was dissatisfied with its response.

5 Ms Debra Barnes also gave evidence in the Brisbane hearing. She described her experience of her mother in residential aged care and was also disappointed with the complaints process.

Commissioners, over the course of the public hearings, many aged care workers,
10 including registered nurses and personal care workers who work in home and community care and in residential aged care facilities have given evidence. Some of these workers also work in the disability sector. All spoke with passion and commitment for the work they do and for the older people for whom they care.

15 Ms Kathryn Nobes was one of them, Commissioners. She gave evidence in the first Sydney hearing that the working conditions of care workers had a serious impact on the quality of care that personal care workers are able to provide. She described how she suffered from post-traumatic stress disorder after an incident in the dementia unit at the facility where she worked which involved an assault by a resident that left
20 another resident dead. She spoke with grace of the challenges of caring for those with dementia and that staff working with dementia residents needed more training.

In the more recent COVID-19 hearing in August of this year, Ms Diana Asmar, a union official representing personal care workers who were responding to the
25 pandemic, described her members as feeling like they were "on the bottom of the Titanic ship".

The role of allied health in aged care is fundamental, as is access to oral, dental and mental health treatment and services. In these submissions we will make
30 recommendations about each of these topics.

Mrs Beryl Hawkins, aged 91, gave evidence in the first of several hearings which were conducted this year in a virtual setting. Appearing by telephone, Mrs Hawkins said she had not been able to afford dentures or to use her home care package
35 towards the cost of dentures or other oral and dental treatment.

Ms Merle Mitchell, aged 85, shared with the Royal Commission her experiences of living in a residential aged care facility, firstly in May 2019 and more recently at the COVID-19 hearing. Ms Mitchell explained that she feels that life in a residential
40 aged care facility is not a home; it is an institution, it is where you live, she told us.

To conclude this brief overview, the words of Ms Eileen Kramer are worth recalling. At 105 and a half, Ms Kramer is the oldest witness to have given evidence in this Royal Commission. Like all of the older people and their families who have opened
45 their lives to the work of the Royal Commission, who have shared their experience of their struggles with the aged care system, Mrs Kramer is a remarkable person. She, memorably, urged us at the conclusion of her evidence, and I quote:

Look after the house so the spirit can enjoy life.

With this in mind, Commissioners, we submit it is the responsibility of the aged care
5 system to support and nurture our older people and the recommendations we are
proposing to you today and tomorrow and in the written document that Mr Gray has
referred to are our contribution to that endeavour.

Commissioners, the process of inquiry will conclude when the final report is
10 presented to the Governor-General. This report will represent the culmination of the
Commission's nearly two-and-a-half-year inquiry into Aged Care Quality and Safety.

In the words of Prasser and Tracey, authors of a leading text on Royal Commissions,
the report "will be the basis for judging the quality of the inquiry process and the
15 credibility of the findings". For this reason, the report must substantiate the
recommendations that are made, the conclusions must be justified, and we make
these submissions to assist Commissioners to achieve those goals.

Through these submissions we will set out the recommendations that we say are
20 available for Commissioners to make, based on our analysis and examination of the
evidence.

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

Commissioners, very briefly, if I could outline the structure of these submissions.

Part 2 will summarise the evidence about what is wrong with the existing aged care
30 system and why. It will be seen that there are multiple overlapping causes of
existing problems, many of which have been present for some time. Others have
emerged more recently. Most, if not all, have been identified in previous reviews
and inquiries.

35 We submit that it is important to understand why the various deficiencies have
developed to ensure that the prescriptions for reform will be targeted and effective.

Part 3 of our submissions contains 18 sections, each one of which addresses a
different aspect of the aged care system, broadly following the Terms of Reference
40 addressed to the Royal Commissioners. In each section we set out the
recommendations that we submit the Royal Commissioners should make to meet
these terms of reference. We also draw attention to the evidence that supports the
submissions we make.

45 In the time available, we will not be able to read out the document, nor is that
necessary given that it has been published, as Mr Gray has indicated. We will
address each of the recommendations that we propose and spend time on each,

expanding on why the evidence that has been heard before the Commission justifies the proposal.

While all of the 124 recommendations that we will propose are important, among the more significant are: firstly, a recommendation for a new Act based on human rights principles; secondly, a new planning regime for aged care which provides demand-driven access rather than the current rationed approach; thirdly, a new and independent process for setting aged care quality standards; fourthly, a new and enforceable general duty of care on approved providers of aged care; fifthly, mandated staffing ratios in residential aged care; compulsory registration of personal care workers; an independent pricing authority that will determine aged care prices appropriate to the provision of high-quality and safe aged care services; and, finally, an independent Australian Aged Care Commission that will be responsible for administering and regulating the aged care system.

Finally, Commissioners, Mr Gray will conclude our submissions tomorrow looking to the future and will outline the process by which the current aged care system should transition to the new system.

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

Commissioners, I turn to part 2 of our submissions on page 10 of the written document: The nature, extent and systemic causes of substandard care.

Commissioners, the Terms of Reference require an inquiry into the extent of substandard care being provided to Australians receiving aged care systems, including mistreatment and all forms of abuse.

We submit the evidence before the Royal Commissioners supports a finding that the level of substandard care being delivered in the current aged care system is far too high. "Substandard care" is not a term defined in the legislation governing the aged care system, nor is it defined in the Terms of Reference. In these submissions, the same definition that was adopted in the Royal Commission's Interim Report is used, namely:

> *Care (or complaints about care) which did not meet the relevant quality standards under the Quality of Care Principles and other obligations under the Aged Care Act; and*
>
> *Care (or complaints about care) which, although meeting the relevant quality standards, was not of a standard that would meet the high standards of quality and safety that the Australian community expects of aged care services.*

Types of substandard aged care include instances of mistreatment or abuse and deficiencies in the quality of both routine and complex care.

If I can start by referring to abuse.

Abuse is the most extreme category of substandard care and includes the use of
5 restraints, both physical and chemical, and assaults, physical, sexual and emotional.

Of the in excess of 10,000 public submissions received by the Office of the Royal Commission, a number of themes emerged in which people making submissions raised concerns about neglect, emotional abuse, physical abuse or assault, restrictive
10 practices, financial abuse, and sexual abuse or assault.

The Commissioners received many disturbing accounts raising allegations of abuse of people living in residential aged care at the hands of caregivers and fellow residents. Some of these are detailed in the Interim Report.

15

Commissioners, the Australian Law Reform Commission examined elder abuse as part of its inquiry into protecting the rights of older Australians from abuse. The resultant report released in 2017 highlighted the prevalence of abusive practices within the aged care system and criticised gaps in the regulatory and reporting
20 system that allowed these practices to persist. Despite this, abuse remains rife in residential aged care.

Restrictive practices have been identified as a problem in residential aged care in Australia for more than 20 years. These have been considered in several reviews,
25 many recommendations for reform have been made but not fully implemented.

I will start by referring to substandard routine and complex care.

Commissioners, as people age, simple tasks such as moving, eating, using the toilet,
30 and so on, become more difficult. Assistance with these tasks, often called "routine care" is critical to ensuring older people's basic needs are met and their independence and quality of life are preserved as long as possible. Most commonly complaints before the Royal Commissioners about substandard routine care related to the following areas which we list in paragraph 33 of the document.

35

People in aged care settings also often have complex care needs, particularly those in residential aged care. Meeting these goes beyond assistance with routine care and may need input from a range of healthcare providers including specialists. Complaints about substandard complex care raised before the Royal Commissioners
40 most commonly involve support for dementia and changed behaviours, palliative care and mental health care.

I turn to the extent of substandard care in paragraph 37.

45 Identifying the precise extent of substandard care in Australia's aged care system is a difficult task due to the deficiencies in the data available to measure the quality of care. Commissioners, this should not be the case. It should be a relatively

straightforward task to assess the quality of care provided in our aged care system. That it is difficult says much about the maturity of the sector and the lack of curiosity of the government that funds and regulates it.

5 Until very recently, there has been a surprising absence of any mandated quality indicators for Australia's aged care system. This contrasts with the health sector where there is a long history of measuring quality.

Commissioners, in 2017-18, when participation in an aged care quality indicators 10 program was voluntary, only 8 per cent of approved providers submitted reports. For the 2019-20 reporting year, mandatory reporting was limited to three measures: use of restraints, pressure injuries and unexplained weight loss.

The lack of quality indicators meant that the Office of the Royal Commission had to 15 examine a wide range of data sources to assist Commissioners to reach conclusions about the extent of substandard care. We have set out those data sources at paragraph 41 of our submissions and I won't read those out now.

This has been a complex and resource-intensive task, but it does enable inferences 20 regarding the prevalence of substandard care to be drawn from the facts that are revealed by the data. We set out a number of the inferences that we submit are available in paragraph 42(a) to (d) of our submissions. I refer to paragraph (e) of paragraph 42 and note that almost half of the 10,000-plus online public submissions received during the Inquiry were marked by their submitter as relating to substandard 25 care. This likely understates the total number of submissions which describe issues that the Royal Commission has considered to be substandard care such as abuse or the use of restraint, but were not marked as such by the submitter.

The Terms of Reference make specific reference to abuse as a form of substandard 30 care. The prevalence of abuse of people receiving aged care services is partly revealed by the Australian Government's data regarding reported allegations or suspicions of physical and sexual assault that occur in aged care services. We set out some of the data in paragraph 44 with references, and at paragraph 45 note that we are particularly concerned about the number of allegations of sexual assault revealed 35 by the data.

The Royal Commission itself received 588 submissions mentioning sexual assault. There were 426 allegations of sexual assault in residential aged care facilities reported to the Australian Department of Health in 2014-15 and that number of 426 40 increased to 790 in the year 2018-19. Commissioners, that is more than two reports per day of sexual assault on average, every day of the year.

The increase in the reporting of allegations of assault was far greater than could be accounted for by the increase in the number of permanent residents over the same 45 time period. The rate of alleged assaults, that is the number of assaults per 100 residents, nearly doubled from 1.13 to 2.16 in that four-year period.

As concerning as these figures are, they understate the real extent of the problem in at least two ways. First, as the Australian Law Reform Commission noted in its 2017 report in elder abuse, reportable assaults capture a narrower range of conduct than may be described as elder abuse and there are examples of this in the evidence before the Royal Commissioners. For example, in the Perth Hearing, a senior representative of approved provider Japara explained that Japara did not report cases that were characterised as mere rough handling. This is despite the definition of "reportable assault" in the *Aged Care Act* including any "unreasonable use of force."

Secondly, an assault is not reportable if the alleged perpetrator is a fellow resident with a diagnosed cognitive or mental impairment and the approved provider puts in place arrangements to manage the alleged perpetrated behaviour. Considering that approximately 50 per cent of people receiving residential aged care have a diagnosis of dementia, the effect of this exemption is likely to be significant.

In 2018 the Australian Government engaged KPMG to estimate the number of resident-on-resident assaults and KPMG conducted a survey of 178 residential aged care services. At paragraph 50 we note that based on the data, KPMG made what it described as a conservative estimate that there were 26,960 alleged assaults in 2018-19 that were exempt from reporting.

That figure excluded one particular provider which had a high number of assaults. If that provider was included, then the number jumped to 38,898. That was the figure that KPMG ultimately decided was the best estimate.

Applying the same approach to extrapolation of the figures, KPMG estimated there were 1,730 resident-on-resident incidents involving sexual contact in 2018-19.

When the figures, those estimated figures, are added to the reported figures, then the number of alleged assaults goes from 5,233 to somewhere between 32,193 and 44,131. The estimated number of incidents of unlawful sexual contact is 2,520, or 50 per week.

In percentage terms the incidence of reports increases from 2.16 reports per 100 residents on the official figures to between 13 and 18 incidents per 100 residents. Commissioners, this is a national shame.

Many witnesses have explained they place their loved ones in residential aged care because they felt it would be safer for them or because safety was a concern. It is therefore entirely unacceptable that people in residential aged care face a substantially high risk of assault than people living in the community.

We note at paragraph 53 that an additional concern is the evidence the Royal Commissioners heard about what those who receive the reports that are mandated under the *Aged Care Act* do with them; that is, the Government department, the Department of Health, which receives the reports. Mr Gray will return to this topic tomorrow when he examines quality regulation.

Turning, Commissioners, at paragraph 54 to the patterns that emerge from the data, we have sought to summarise in paragraph 55 some of the evidence sources that have been examined to determine the extent of substandard care in our aged care system. Some of the patterns that emerge through various data sources include that government-run residential aged care services out-perform services operated by both private for-profit and not-for-profit approved providers on many quality measures. That observation is supported by the data which is summarised in paragraph 55, including a University of Queensland study which was commissioned by the Royal Commission in 2019-2020; a residential care survey that was commissioned by the Royal Commission which found that residents with the greatest number of concerns were those living in for-profit residential aged care services; a review of regulatory data which we have summarised in paragraph 55(d) of our submissions; and the sanctions data which we summarise at (e).

It is important to note, as we do at paragraph 56, that the better performance of the government sector on those figures is notable because the evidence reveals that, on average, people living in government-run residential aged care, at least in Victoria, have higher care needs than those generally in the private sector. We point out two aspects of Victorian Government-run residential aged care facilities which are notable: firstly, the compulsory quality indicator program which is operated in Victoria and to which I will return in a moment; and, secondly, that there are prescribed ratios of nurses to residents in Victorian Government-run services and have been since 2000. I will return to that issue shortly as well.

It should be noted that Victorian Government-run facilities receive considerable additional funding from the Victorian Government on top of the funding available that is from the Australian Government and from residents, and this additional funding no doubt enables such providers to provide more staff and especially more nurses to meet the ratios which are mandated.

Commissioners, at paragraph 59 we note that the data also supports a finding that smaller residential aged care services generally outperform larger services on a range of measures of quality, all else being equal, and we set out some of that data.

In conclusion, Commissioners, we submit that the weight of the evidence before the Commission supports a finding that high-quality aged care is not being delivered on a systemic level in our system and the level of substandard care is unacceptable by any measure. At least one in five people receiving residential aged care have experienced substandard care.

Commissioners, the findings that we urge Commissioners to make about the nature and extent of substandard care are important because they are required by the Terms of Reference, but equally they inform many of the recommendations that we submit should be made to address the identified deficiencies in the aged care system to which we shall shortly turn. Many of the proposed recommendations go directly to the matters that I have identified.

Commissioners, the Terms of Reference, in addition to requiring findings about the extent of substandard care, also draw attention to any systemic failures that lead to substandard care. We have addressed what the evidence before the Royal Commission has to say about systemic failures at paragraphs 65 to 89 of the document. I won't read that out at the moment, but I will note that at paragraph 68 we seek to summarise those submissions under two headings: firstly, there are systemic failures relating to access to aged care, including difficulties entering and navigating the system, access to home care and respite care, poor continuums of support, and unequal access to other services.

The evidence reveals that the aged care system presents challenges from a navigation point of view. It reveals that assessment processes are complex. There is a particular lack of pathways for people with a dementia diagnosis. There is a lack of home care packages and a lack of respite services for carers and also a lack of access to the health system, particularly for those in residential aged care.

The second category of systemic failures that we seek to summarise relates to the delivery of aged care; that is, once people are receiving aged care services and have overcome the access challenges, a number of systemic failures appear from the evidence in relation to delivery of aged care services. They are summarised in the submissions starting at paragraph 77 and they include a lack of skilled staff, poor care planning, poor governance and leadership on the part of aged care providers, a lack of transparency within the system generally, inadequate catering for people with diverse backgrounds seeking aged care services and a lack of Aboriginal and Torres Strait Islander focused approved providers.

Commissioners, turning to paragraph 90 of our submissions, as required by the Terms of Reference, we identify what the evidence reveals about the causes of the systemic failures. We do that in some detail from paragraph 90 through to paragraph 111 under the headings identified in paragraph 90: "Attitudes to aged care in the delivery of services", "Funding and financing", "Inadequate governance and regulatory frameworks", and, finally, "Failure to take opportunities for improvement".

In relation to the last topic, the failure to take opportunities for improvement, if I could turn to paragraph 112 of the submissions where we note that there has been absence of leadership by successive governments when it comes to aged care. Even though the aged care system caters for more than 1.2 million older people, governments have treated it as a lower order priority. It has rarely merited a Minister at Cabinet level. The Australian Department of Health should have access to comprehensive data to assess the performance and impact of services provided to older people. It does not.

There is a lack of data collection, poor interoperability between databases and an absence of data analysis. As a result, as we have indicated, no one is in a position to evaluate the performance of the whole of the system over the long term against

appropriately defined goals.

The aged care sector misses considerable opportunities in research and innovation. We outline some of the reasons for that at paragraph 114 and will return to that topic.

At paragraph 116, we note that experts who have given evidence at the Royal Commission have voiced concerns that providers have too much influence over the aged care system and that policy reform processes are not adequately safeguarded from the risk of industry capture. There appears, Commissioners, to be a tendency to hear primarily from the same small group of interested parties on aged care policy and a limited number of consumer groups are repeatedly relied upon to represent older people. The voices of aged care unions are often unheard, a point we will return to.

Finally, Commissioners, as we note at paragraph 117, perhaps most concerningly of all, none of these many problems is revealed for the first time by this Royal Commission. In the last 20 years there have been repeated reviews of aspects of the aged care system, many of which address recurring problems. The Commission's Background Paper No. 8 details those earlier reviews.

While we acknowledge that governments are not obliged to adopt all recommendations of a review, they have tended to respond with piecemeal reforms to aspects of the aged care system which have not resolved the underlying problems. There have also been instances of significant delay in addressing or implementing important and urgent recommendations arising from reviews.

We submit that the above examination reveals not just the nature and extent of substandard care in the current aged care system but also its systemic causes, and in so doing it enables us to lay out a series at reforms aimed at addressing those causes in a sustainable way, which we will do in the remainder of these submissions. If implemented as an entire interconnected package, those reforms should, over time, address those causes and thus improve the quality and safety of aged care in this country for the benefit of older people and ultimately for the benefit of the entire community.

Mr Gray will now commence our submissions on the proposed recommendations.

COMMISSIONER PAGONE QC: Yes, Mr Gray.

CLOSING SUBMISSIONS BY MR GRAY QC

MR GRAY QC: Thank you, Commissioner, thank you Mr Rozen.

Commissioners, I am now at part 3 of our written submissions commencing at paragraph 119. We first address you on principles for the new aged care system. In

this portion of the submissions, we are seeking to crystallise the matters of principle that should be formally recognised in the legislation that grounds the system and these are the guiding principles for all of the submissions that follow.

As a matter of principle, the system should be about supporting people to live well into their old age, whether at home or elsewhere, and it follows that the people receiving aged care services must be at the heart of a new aged care system, whether they are receiving support and care at home and alone or with a spouse, partner, family, carer or in some form of residential setting. As a matter of principle, the system must be about the people it is designed to serve.

It should also actively encourage people who are receiving aged care to continue to enjoy rights of social participation that are accessible to members of society generally and this should all be reflected in legislation which establishes a rights-based approach to aged care marking out clearly defined rights to be enjoyed by those who are applying for or receiving aged care and those rights should include the rights of carers.

Commissioners, research from Roy Morgan obtained by the Royal Commission shows that the vast majority of people who need care will want to receive it in their own home. This is a powerful point and one that we have heard in constructing our proposals for your consideration. It should come as no great surprise. Ageing at home can be central to a person's sense of identify and independence. Home is a place of familiarity, comfort and privacy, providing meaning and security in situations where major life changes need to be confronted and at home older people have more control over their routines with more opportunity to continue performing the roles important to them and their sense of identity, and remaining at home is also important in keeping people socially connected.

There is research showing that people engaged in their community live longer, use fewer health services and have better quality of life.

There are connections between this topic and the accessibility of affordable housing. We address that point in the submissions.

Our framework for what then follows poses a series of questions from paragraph 131. The first question, "How do we want to be looked after in old age?", involves consideration of what should be the content of the aged care that's offered by the system. Without reading what appears from paragraph 131 to 139, an important point that we make here is that aged care should be reorientated towards relationships and interactions between people building trusting, respectful and reciprocal relationships between everyone involved in caring for older people.

The next question we pose is: "Who do we want to deliver the care that we receive?" So after considering what should it be, who should give it? And the deliverers of high-quality care must be adequately funded to do so.

If one thing is clear from the inquiry, it is the connection between staffing levels and the quality of care and safety in residential aged care. Going a step further, higher nurse staffing levels contribute to better care, lower rates of pressure wounds, pressure injuries, pain, infections, weight loss, dehydration, emergency room use,
5 re-hospitalisations and mortality. Higher numbers of nursing staff also correlate with lower uses of anti-psychotic medication.

Our next question: "How should we be viewed as we age?" A very important point reflecting on the perceptions of the people who are seeking care in order to better
10 understand and then impose standards about how it should be provided. Flinders University has conducted research indicating that above all, people value being treated with respect and dignity and this has got to be central to the way the new system approaches the definition of aged care and the calibration to the funding that is going to be required to deliver it through an adequately trained and adequately
15 numerous and abundant workforce.

Research for the Royal Commission found that 90 per cent of those surveyed agreed that older Australians have value to society for a range of reasons, such as work, knowledge and experience, and that society has an obligation to look after older
20 people and care for them. However, older people are frequently associated with descriptions like "vulnerable", "frail and slow", "close-minded", "lonely" and "scared". There is a fundamental issue of ageism in community attitude that has to be addressed here.

25 We submit that negative attitudes about the aged care workforce and working in aged care as a career are by-products of those sorts of attitudes. Ageism may lead to older people being seen as incompetent, when they aren't, and resulting in overly protective responses when they are not called for. While it can be well-meaning, for example, the intention might well be to try to keep a person safe, it can undermine
30 the person's dignity and sense of control over their own lives and this is a theme that has run through a lot of the evidence received by the Royal Commission and it has been referred to as the need to accord dignity of risk.

We submit that one doesn't have to look far to see a culture in which older people are
35 valued, respected and seen as a valuable resource within the community in our own country. The approach of Aboriginal and Torres Strait Islander communities to their elders is instructive for all of us. As observed in the Interim Report, Aboriginal and Torres Strait Islander people see elders as central to the future of their culture, deserving of respect and entitled to be looked after with dignity. We submit that this
40 approach should reset a new bar for aged care in Australia. Looking after our older people should be part of who we are. We should have an innate respect for them and elevate them in our community. All of Australia should value and develop our connection with them.

45 With all this background in mind, the key matters of principle that are developed in the submissions that follow through all the recommendations we set out seek to recognise and give effect to the preference of older Australians to live in their own

homes as they age, to give older people a universal entitlement to high-quality aged care based on assessed need, to define the concept of high-quality aged care using a concept of what it is for the purposes of calibrating the necessary funding that will be required to enable the care workforce to deliver it, and to elevate the role of informal carers.

The current Act is essentially a structure for a funding scheme based on population level rationing of subsidies with incidental mechanisms regulating providers of aged care who receive that funding. A new approach is required. New legislation is needed, repealing the *Aged Care Act 1997* and replacing it with legislation that establishes the rights of older Australians at the heart of the system.

The 1948 Universal Declaration of Human Rights and the 1966 International Covenant on Civil and Political Rights confer important human rights on people, including older people, that legislation should protect. In addition, there is a range of international human rights instruments that contain important provisions relevant to the topic at hand. Those instruments have led, and are continuing to lead, to further development in human rights jurisprudence concerning the rights of older people in aged care systems in European countries.

The 1991 United Nations Principles for Older Persons adopted by the United Nations General Assembly reflects non-binding rules that are expressed in aspirational terms. The principles are focused on five key themes: independence, participation, care, self-fulfilment and dignity. Article 15, for example, states that "Older persons should be able to pursue opportunities for the full development of their potential". The aged care system that we propose is all about such outcomes.

Commissioners, at paragraph 150 we have given you an extract from the principles, picking up a number of important principles which you will see reflected later in Recommendation 1.

We go on to make our submission that the new Act must expressly protect and enhance certain human rights of older people which accord with the themes we have outlined from the UN principles.

Commissioners, I mentioned a minute ago there are elements of the current legislative regime that refer to the rights of people receiving aged care and there is a subordinate instrument, the *User Rights Principles 2014*, that needs to be considered. In our submission, that instrument couches the entitlements of people receiving aged care as consumer rights and it doesn't establish rights that are capable of enforcement either by the individual or the regulator on their behalf. They are largely aspirational and the person's recourse is to make a complaint to the Aged Care Quality and Safety Commissioner. Further and importantly, the rights in the charter attached to the *User Rights Principles* are in subordinated legislation; not in an Act of parliament. They also only apply once someone has obtained a place in the system and has signed an agreement to take up a place. They don't extend to people who are waiting for a place on the various waiting lists that have been referred to in the evidence you have

heard over the Inquiry.

Commissioners, we agree with the criticism of the current approach that is made by the Grattan Institute in a recently published paper concerning human rights and deficiencies in the existing system. Our approach is a rights-based approach to aged care based on a set of principles that will be informative for construction of the regime in the Act.

The guiding principles which we set out in Recommendation 1 should be embedded in every part of the system from overarching aged care policy development through on the ground service delivery.

Recommendation 1 appears under paragraph 158. It proposes the replacement of the current Act with a new Act guided by the objects of providing a system of aged care based on the universal right to high-quality, safe and timely support and care, to assist older people to live an active, self-determined and meaningful life and ensure older people receive high-quality care in a safe and caring environment for dignified living in old age.

It also contains a number of additional objects, rights and principles. I won't read them all out. They appear under paragraph 158. Importantly, as an anchor point they include a definition of 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, physical and mental capacities to function independently" and "supports including respite for informal carers of people who need aged care".

As Mr Rozen has alluded, we later in these submissions are going to be explaining the role of certain new institutions. Those are picked up in the framework for the new Act which we have set out in Recommendation 1. Mr Rozen mentioned a new Australian Aged Care Commission to govern the system and operate and administer it. He also mentioned independent pricing and we have referred there to a body we are calling the Australian Aged Care Pricing Authority. In addition, there is mention here of the office of an Inspector-General of Aged Care who in essence would be a system watchdog or oversight body.

Within Recommendation 1, at paragraph 1.4 there is a list of human rights drawn from existing human rights instruments and adapted to the aged care context. These are to be taken into account, in our submission, in interpreting the Act and any instrument made under the Act. And the list includes, for people seeking aged care, rights that will enhance their ability to access the services they need; and for people receiving aged care, the right to freedom from degrading or inhumane treatment or any form of abuse; the right of liberty, freedom of movement and freedom from restraint; the right of autonomy; the right to the presumption of legal capacity; and in particular the right to make decisions about their care and the quality of their lives; and the right to social participation; the right to fair, equitable and non-discriminatory treatment in receiving care; and, for people receiving end-of-life

care, the right to fair, equitable and non-discriminatory access to palliative and end-of-life care.

Commissioners, as with all such rights where there are scenarios in which there are
5 competing rights, difficult decisions no doubt will have to be made in interpreting the instruments made under the new Act and, in doing so consistently with those rights, decisions might have to be made about the extent to which one right is given precedent in a particular situation over another.

10 Mr Rozen also mentioned the general statutory duty to deliver high-quality care. That is also an important feature of the new legislation.

Recommendation 2 is a recommendation which broadens the perspectives and seeks to engage with other systems of support and services that are available to advance the
15 interests, health and well-being of older people in Australia, and which ought to be better coordinated with the provision of aged care. To this end, there is a proposal in Recommendation 2 for a new National Cabinet Reform Committee on Ageing and Older Australians which we submit should be established between the Australian and state and territory governments and composed of the highest ranking ministers whose
20 primary responsibility is the care, health and wellbeing of older people. And we suggest that one of the important items of business for such a body would be to construct a strategy for, in the long term, an integrated system of support and care for older people covering all aspects of their support and care, welfare support, community services, directed at enhancing social participation, affordable and
25 appropriate housing, healthcare, aged care and disability and there might be other aspects of government that need to be taken into account as well.

In the 20 years since the 2001 *National Strategy for an Ageing Australia* there have been efforts to improve health, wellbeing and social participation of older people
30 across all levels of government. However, there has been limited concerted national effort to bring this work together.

Longer life spans should be seen as a valuable resource for society. Older people contributing to society in a number of ways, including as mentors, entrepreneurs,
35 consumers, caregivers and friends are a valuable resource and need to be incorporated in this strategy. We also submit that there is considerable scope for cross-generational engagement in programs linking older people to their communities.

40 The strategy we submit is necessary should include measurable goals, regular reporting on progress to the newly established National Federation Reform Council and all this recognises that national leadership is required, intergovernmental assistance is required. The Commonwealth's role is clear. However, state and territory service coverage is also critical. All states and territories, other than the
45 Northern Territory, and a number of local governments have developed some form of ageing-related strategy. These need to be brought together. The strategy should initially cover a 10-year period after which time it should be comprehensively

reviewed to inform development of the next strategy.

Commissioners, I will now go to part 3.2 beginning at paragraph 171. Part 3.2 is entitled "Design of the new aged care system". That term "aged care system" ---

5

COMMISSIONER PAGONE QC: Mr Gray, I think Commissioner Briggs wanted to make some observations about the principles section.

MR GRAY QC: Thank you, Commissioner.

10

COMMISSIONER BRIGGS: Thank you, Commissioner. I have been very touched by the thoughtful comments you have made this morning, counsel, and your recommendations. I think a related matter are the policy principles that ought to underpin all of the work that is done on aged care. It has been my experience that
15 clearly defined policy principles can galvanise reform efforts. They are critical for leaders in articulating a future vision and are a key litmus test for the successful implementation of reforms.

There are a number of policy principles that have occurred to me over the course of
20 this Royal Commission. First and most importantly, the aged care system needs to put people first. The preferences and needs of older people really should drive aged care.

Second, the aged care system must be equitable. Older people should have fair and
25 equal access to high-quality aged care.

Third, the aged care system must be effective. It must deliver the best possible outcomes for older people.

30 Fourth, the aged care must be ambitious. Aged care should be the very best it can be, not simply seek minimum requirements.

Fifth, the system must be accountable, by which I mean open, honest and answerable to older people and the wider community for decisions, actions and consequences
35 and, finally, the system must be sustainable. It must be funded to the level necessary to ensure high-quality aged care and both the funding and the design of the system must be resilient and enduring. Australians need to have confidence that the system will be there for them when they need it.

40 As you can see, I think policy principles are critical, counsel, and I welcome the views of counsel later on, and, indeed, those of interested parties about these policy principles for aged care in submissions. Thank you, Commissioner.

COMMISSIONER PAGONE QC: Yes, thank you. Mr Gray?

45

MR GRAY QC: Thank you, Commissioners. We will certainly reflect very carefully on those comments. Thank you, Commissioner Briggs.

Before diving into the detail of what we propose by way of redesign of the aged care system, what is the aged care system? It is a term that we have heard frequently throughout the inquiry, but it seldom has received much attention by way of a definition.

In our submission it is a composite description covering all the entities, structures, people and processes which contribute to how aged care is provided, regulated and funded and one might even take a broader view and say that it includes the formulation of the policies that shape the content of aged care.

Aged care itself is a wide array of services that are both defined by and subsidised by Government. Those services are delivered by approximately 3,000 approved providers, conducting thousands of services throughout the country. Now, services has a particular meaning there. Services can mean outlets and it can mean the activities of those outlets. In the statute, the expression "services" conducted by approved providers means the outlets through which aged care is provided.

The core components of the aged care system consist of entities and actors, in particular falling into these categories: the people who need and receive aged care and their families and friends; those who deliver aged care, the workforce, they are the direct deliverers of aged care; and the approved providers of aged care who engage that workforce, and they are generally companies - not always, but generally companies. One might also include the governing structure through which that system is administered and regulated.

But you can't understand the system without also taking into account its context and the way it interacts in particular with the healthcare system and I could include, as I did before in the previous section, allusions to other services that are available regarding housing, welfare, community services, but include disability as well. You have also got to consider its interactions with the wider community and with the various tiers of government.

Commissioners, at paragraph 177 we have given you a quote from something Mr Michael Lye, the Deputy Secretary for Ageing and Aged Care in the Department of Health, mentioned during the COVID hearing in Sydney in August. Mr Lye made a point that is correct as far it goes about, in effect, the limitation of departmental responsibility for the outcomes of the system. But, as we say later in our submissions, this can be unhelpful if taken too far. It may be true that the primary responsibility for care outcomes lies in the hands of the providers but a broader responsibility rests with an entity which should be actively governing the system and this is a theme we develop as the section progresses.

Drawing on the work of Vincent and Elinor Ostrom, there are statements before you, Commissioners, from Professor Gary Sturgess and Professor Gemma Carey on the nature of systems such as the aged care system which rely heavily on private delivery agents, that is companies who are subsidised and commissioned by government to

provide services. These systems are sometimes referred to as markets but they are not really markets in any traditional sense. At best they are quasi-markets or mixed economies or, as Mr Lye said in his evidence, distributed services.

5 The interesting thing about these sorts of systems is their complexity and the need to be constantly considering their management and design and refining their design in the course of managing such systems.

Commissioners, for more than two decades, the Australian Government has been
10 exercising significant policy and administrative responsibilities in aged care and in 2011, the National Health Reform Agreement between the various governments allocated to the Australian Government responsibility for aged care which was a responsibility that was to become operational in 2012 if we take into account some delay with respect to the transfer of responsibility for community services in Western
15 Australia, that process was only completed in 2018.

Responsibility for understanding and pre-empting problems in the aged care system has lain with the Australian Government for some time and, in particular, with its responsible ministers and departments of state, principally the Australian Department
20 of Health. Those emanations of the Australian Government have had the tools available to them which should have been able to achieve effective leadership of the aged care system. The Department has been the dominant funder of the system, it has been in a position to create mechanisms for collecting data and measuring performance; as Mr Rozen said there have been deficiencies there. And without that
25 information, it is difficult to identify problems, let alone areas for improvement.

Until quite recently, the Department has also been exercising significant regulatory responsibilities and they have now been divested almost entirely to an independent body, the Aged Care Quality and Safety Commission, with the final conferral having
30 taken place on 1 January this year.

The Department has for many years been responsible for funding through either direct grant agreements made between the Department and providers of services or mechanisms that mimic the operation of a market whereby subsidies for services to
35 be provided for the benefit of particular individuals are channelled to providers engaged by those individuals. In both these senses the Australian Government has been the head of the supply chain in the aged care system.

The direction of policy has been to encourage competition between providers of aged
40 care services in the expectation that competitive market forces would lead to innovation and to improvements in quality and outcomes for people who need care. The legislative and regulatory framework under the *Aged Care Act 1997* has encouraged this approach and it has used language reflective of it such as, as I mentioned with respect to the *User Rights Principles*, by describing people in aged
45 care as consumers and emphasising protection of consumer rights.

Consistent with this market-based perspective, the Department has tended not to take

a proactive/active system governance role and instead it has tended to react to adverse developments, often belatedly. In short, in our submission, there has been a vacuum in the area of system leadership and perhaps an unspoken assumption that market forces should generally be left to themselves, subject to the regulation of the quality of the services provided. In our submission, it is clear that one can't rely on market forces to protect the interests of the people who need and receive aged care services. Something has to change.

What sort of approach needs to be taken? This is a very difficult question because effective leadership in a distributed system such as the aged care system or a quasi-market is no simple matter. For reasons which we outline in our submission from paragraph 186, a particular form of governance is called for. The hallmark of effective governance of systems of this kind is that governance needs to be proactive and adaptive and it needs to steer the system towards strategic objectives but not to take a direct command and control approach.

Constant small refinement born of constant attention is far preferable to large changes made in reaction to adverse events. We set out, with reference to some of the academic literature, a number of paragraphs or submissions on these points in paragraphs 186-187, and then, beginning at paragraph 188, Commissioners, we identify some of the aspects of shortfalls in the governance of the aged care system that are evident from the evidence the Royal Commission has received. We are picking up here some of the themes Mr Rozen mentioned in his part of the address a short time ago, we are adding to it in certain other respects.

We single out three topics in particular: "Shortfalls in the area of home care", that begins at paragraph 194. Mr Rozen has already mentioned the topic of the wait lists for home care packages. These wait lists have been, in effect, permitted to remain for far longer than is acceptable and although packages have been brought forward from the Forward Estimates in announcements made over recent times by Government, it is still far from clear that there are adequate measures in place for the wait list or the waiting list, otherwise known as the National Prioritisation System for Home Care Packages, to be eliminated and for all people to receive packages at the level of need for which they have been assessed.

But, in addition, there is a very important question about regulatory visibility of care provided in the home and concerns about how long that has been left as a weakness in the system and whether the capability of the Aged Care Quality and Safety Commission is up to the task of addressing that important topic.

The next matter we address is shortfalls in the area of funding and the structure of the funding arrangements that have applied in the system.

We set out at paragraphs 192 to 204 some submissions on this point and I certainly won't read or even summarise it all, but as we develop here, and then in greater detail in the funding section of our submissions, 3.15, the nature of the funding arrangements that have applied in the aged care system for some time is such that

there has been significant volatility in the funding arrangements, in particular for residential aged care, and this has led to a degree of mistrust and uncertainty between the sector and Government.

5 Mr Callaghan explained the nature of this mistrust and the causes for it in evidence before you in the funding hearing in September, Commissioners. As you will recall, Mr Callaghan proposed that an independent pricing mechanism operating within well-defined functions and limited objectives would assist to dispel that mistrust. The mistrust to which Mr Callaghan referred was stoked by Australian Government 10 claims about the practices of approved providers in making their claims for funding under the instrument that applies for residential aged care, the instrument known as ACFI, Aged Care Funding Instrument, and also generated by Government concerns about its fiscal position and about exceeding forecasted aged care expenditures.

15 These matters led to Government changing its indexation approach to the funding provided to residential aged care providers and changing the funding criteria for residential aged care under that instrument ACFI.

In paragraph 201 we make the submission it is entirely unsurprising that these events 20 occurred or that mistrust developed. I want to ask the operator to now display the document footnoted in paragraph 201 which is a Cabinet Memorandum which is now in the public domain through the National Archives. It is a Cabinet Memorandum prepared by the Departments of Health and Family Services and Finance in March 1997, and we are going to stream an image of this document. The National Archives 25 cover sheet appears now. If we go now to the beginning of the memorandum, which is at page 0006, I believe, we have here at paragraph 4 a reference to the background of this memorandum.

The memorandum is a memorandum advising Government on certain risks presented 30 by the integration of residential aged care which up to that point in time in March 1997 was divided into hostels and nursing homes, and if I could ask the operator to please go back to page 0004, this is the heading of the memorandum and it explains its purpose. There was a request by the Prime Minister in December 1996 leading to the memorandum which discusses "risks to, and appropriate strategies to manage, 35 recurrent outlays under a unified residential care program".

In essence, the memorandum is addressing the possibilities that outlays --- that is, expenditure on aged care --- will be substantially greater as a result of the new arrangements and in light of projections, and when it refers to "risks", it is referring 40 to risks to the fiscal position of the Government.

Operator, if we now please go to page 0008, at paragraph 11, we can see that while in the short term Government or the advisers to Government considered the design would be cost-neutral, there was the possibility of greater outlays over the forward 45 years, but the Departments advising the Government noted that "Government has total control over all of its parameters", that is the systems parameters, "the number of care classifications, the number of residents in each of them and the amount of

funding that attaches to each classification --- and so total control of its theoretical cost".

Next, operator, please go to page 11 at paragraph 33. The memorandum concluded that there were various options available if the Ministers decided at some point that they needed to further reduce the risk of outlays or expenditures above the estimates, and they included "enhancing the management controls on the number of high care or low care (nursing home or hostel) places, applying quotas to numbers of people at various care levels, an efficiency dividend or other adjustment to funding structures, various offsetting savings measures or changes to service provision benchmarks".

Now, Commissioners, as you will see in submissions we develop, the efficiency dividend can be related to a particular method of a calculation of indexation of funding levels. This was a topic we addressed during the funding hearing in September and, in short, an indexation method has been adopted over two decades now which does not track the real increase in costs that are incurred in the provision of aged care and is, in effect, a diluted method of indexation which erodes the value of funding over time. So that efficiency dividend was in fact imposed.

The other options that are mentioned are instructive because they are illustrations of the sorts of things that can be taken into account if the Executive Government of the day is in direct control over the governance of the aged care system. In particular, there is reference here to controls on the numbers of places and quotas on people receiving care. Those elements of the system have, indeed, existed now for many years and they are variously referred to as rationing of subsidies or population based planning controls on subsidies. We submit they should be dispensed with and that the program should move to a demand-driven program, similar to the approach that Australia takes to the provision of public healthcare.

The other reference to the possibility of changes to service provision benchmarks is perhaps a little opaque but it is quite disturbing because that seems to contemplate the possibility of changes in quality requirements and things of that kind.

The memorandum is instructive because it shows that where the governance of a system of essential human services of sensitivity and importance of aged care is placed in the hands of those answerable to the Executive Government of the day and subject to the fiscal constraints and pressures of the day, there are risks that all of these sorts of matters might tend to erode the quality and safety of the care that is ultimately provided.

Commissioners, I will now move through the rest of this section. The third topic we address is slow action to introduce regulatory reform in respect of the use of physical and chemical restraints on people, in particular in residential aged care.

At paragraph 210, we make our submissions about restructuring of the governance arrangements for the system and we identify that there are, broadly speaking, two reasonable options available: a departmental model involving improvement of the

arrangements which currently apply by which the Department remains in charge of system management and is given clearer responsibilities about system governance; or an independent commission model. Under this model, there would be introduction of an independent statutory body, to exercise regulatory system governance, system management, and related administrative responsibilities, together with, under either model, there being independent pricing.

Our submission is that it is the integrated independent commission model which is the best option for the Commissioners to adopt for redesign of the aged care system. For either model, we are submitting that it is an indispensable element of the new system arrangements that there should be independent determination of the level of subsidies to be paid.

At paragraph 213, we set out our reasons supporting our support for the independent commission model. I won't read that all out, but I do commend that to you, Commissioners. We refer to evidence from some of the experts and other witnesses who appeared.

We refer to the point that we have adopted the name Australian Aged Care Commission, which was proposed in 2011 by the Productivity Commission in its report, as the name for a body that would exercise regulatory functions, as well as certain cost- and price-related functions.

We also refer in these submissions to the role of the Inspector-General of Aged Care, the person I mentioned or the office I mentioned earlier in my submissions. We say it should be possible to appoint the Inspector-General under temporary administrative arrangements in the very near future, well before the commencement of the new Act we propose. That would be desirable because one of the key tasks of the Inspector-General would be to monitor and report on progress and implementation of the recommendations that this Royal Commission will make in February.

Recommendation 3 is our detailed recommendation concerning the Australian Aged Care Commission. I certainly won't read it out or even attempt to summarise it. It is a lengthy recommendation. It goes in detail into the proposed structure of the Commission and its governance arrangements and its functions, its staffing, and its reporting obligations.

We also advert to the mechanism that seems most appropriate for appropriation of the revenues, the funding, that will be needed to provide subsidies for aged care services to be provided. As I have mentioned, independent pricing is an indispensable element of the new system redesign. The levels of those subsidies should be priced by an independent body we are calling the Australian Aged Care Pricing Authority.

One important question, Commissioners, would be whether subsidies are to be paid to approved providers through the Australian Aged Care Commission or in some

other manner. Our recommendation is that the subsidies be paid through the Australian Aged Care Commission. We have also made submissions about it being structured as a corporate Commonwealth entity and we are inviting submissions about the implications of all of these institutional recommendations, including the funding administration recommendation.

At Recommendation 4, we refer to our proposal for an Advisory Council to be constituted to assist and advise in the governance of the system by raising or responding to requests for advice on policy issues. We have a schematic diagram under that recommendation about the possible structure of the Aged Care Commission.

One of the advantages of the Aged Care Commission --- we address this topic at 223 and following --- is that the approach we advocate would bring under the same roof a range of very important functions that need to be exercised coherently concerning quality regulation on the one hand and the monitoring of financial risk and the management of issues concerning entry and exit of approved providers into the market on the other.

The Earle Haven case study in Brisbane provides a good illustration of the disconnections that can occur if those two suites of functions are exercised separately. It is most important that there be a coherent approach taken to, in particular, poor-performing approved providers and that there be a clear strategy about whether they are to be supported so that their capabilities can be enhanced, risks monitored, particularly if they are presenting red flags in terms of either their financial performance or their contracting practices, and quality regulation.

I will move quickly past the rest of the submissions on the Aged Care Commission to Recommendation 5, which is our headline recommendation on the establishment of the Australian Aged Care Pricing Authority. That appears just above paragraph 236.

We go in some detail into the functions of that body in the funding section, so I won't do so now. The funding section is much later in the submissions and I will be addressing it tomorrow. It is in section 3.15.

At Recommendation 6, just under paragraph 242, we address the Inspector-General of Aged Care and our proposal for the establishment of that office. The key functions of that office are to monitor and also report on the administration and governance of the aged care system, and that would include monitoring the performance of the Aged Care Commission, we propose, and also the Pricing Authority.

Now, we address the supporting reasoning behind our recommendation for the establishment of the Inspector-General in the passage at paragraph 243 and following, drawing parallels with the role of the Inspector-General of Taxation and I won't attempt to summarise all the points we make, but that passage goes through to paragraph 257, Commissioners.

Then under the next heading we address other important elements, and these remain important elements, of the system architecture. The responsible Minister will remain an important feature of the governance arrangements. That is critical under our Westminster system of parliamentary responsibility, and it is the Minister who would continue to be responsible to Parliament for the Commonwealth's aged care policies and would present to Cabinet any new policy proposals and also the Minister would recommend appointments to the board of the Commission, including appointing the presiding Commissioner, and would also make appointments to the Advisory Board.

The Department would be responsible for supporting its Minister, as it is now, and would be expected to work closely with the Australian Aged Care Commission in the development of aged care policy proposals. The Department and the Minister would also have primary responsibility for support and policy advice to the National Cabinet Reform Committee which we proposed earlier in our submissions.

Finally, Commissioners, another important element of the system is the enhancement of the network of supported advocates to assist older people receiving aged care or people needing aged care, including their families and supporters, to make their voice heard in the system and to ensure that their views are taken into account in a far stronger way to reshape reform in the future.

Commissioners, that is all I will say on the institutional arrangements and redesign of the system. If it is a convenient time, you might wish to take a break now.

COMMISSIONER PAGONE QC: Yes. I think Commissioner Briggs wants to make one or two observations.

COMMISSIONER BRIGGS: Thank you, counsel and Commissioner.

The independent commission that you describe in your submissions is quite an extraordinary proposal and, indeed, some might even call it courageous. I would really like to hear the public's views as to whether taking the core government aged care instrumentality out of the public service and making it independent of the Executive Government and the Minister would be in the best interests of older Australians. In our system of government, counsel, it is important that ministers are accountable to the Parliament for the performance of their responsibilities. Aged care involves complex judgments and trade-offs. It involves the whole community. Aged care needs to be intimately connected with the health system and with other Government services. And at least for the foreseeable future, aged care will continue to be funded primarily through parliamentary appropriations. I would expect that all governments would want clear oversight of over $20 billion in outlays.

I am yet to hear you present arguments, counsel, as to how the Commission model will improve the quality and safety of care for older Australians, or how any such benefits would outweigh the very substantial costs and disruption involved in such a radical transformation of the Government's administrative machinery.

The new Commission would require, as you say, new legislation and a new source of funding. If it is located outside Canberra, as you propose, that complicates things by requiring recruitment of a completely new workforce, creation of new systems and processes and land and building acquisition. This will take many years to set up as we have experienced with the NDIA. It will divert a lot of time and money and lead to massive churn and turnover of experienced and knowledgeable staff and the replacement with private sector people and contractors.

Counsel, all of this will take place at the very time that you are recommending a substantial raft of urgent and important reforms of the aged care sector that will require focus and sustained leadership and direction from the Government, a time when we will need everyone focused on our aged care reform agenda and on delivering it quickly and effectively. We cannot afford to delay that work.

My comments, counsel, are not meant in any way to imply that the Department's performances as the steward and custodian of the aged care system has been without fault. Far from it. You have presented considerable evidence over these last two years that the Department for too long defended the status quo when systemic problems with the aged care system in this country were blatantly obvious to most people who had contact with the system. And the Department was way too slow to act when it was asked to pursue reforms time and time again. There were reasons for that and inadequate resourcing to do its job properly is one of them and leaving the system largely up to the market to self-correct is another.

I have, however, detected over the last year, counsel, a growing determination among officials and in the Government to fix the problems of the aged care system and to pursue a genuine reform agenda. We need to see much more of that through a comprehensive reform of the way the Department goes about its business under more ambitious leadership.

I therefore think it is important that you ask the public to consider another system governor model, that of a radically reformed new Department of Health and Ageing. That Department would be more proactive and more responsive in the way it engages with older people in the sector. It would act more in a sector leadership role, encouraging and nudging improved performance, and it would steward those providing health and aged care services towards an approached care that puts older people first. It would work to the Cabinet Minister for Health and Ageing. Under such a model, the Department would be staffed appropriately and resourced properly so that it has enough qualified staff and money to do its job. The Secretary would drive the necessary changes to implement our reforms and would be supported by high-level staff who would take charge of the major policy reform agenda we recommend and its implementation.

There would be particular focus on working with older people and the aged care sector nationally and at the local level, as well as the states and territories and health and workforce professionals to deliver the changes we envisage.

Aged care is a personal experience. Local approaches to system management are key to achieving lasting change. So the departmental model would also have the local presence you propose to the Commission. A regional network of care finders, assessors and program planners listening to the local community and matching service solutions to local environments, ensuring that services are available and providing personal support to older people on the ground right across Australia. It shouldn't stop there. The reformed Department would have a proactive and ambitious ongoing reform agenda built on research and advice from older people which would be designed to continue to improve the quality and safety of aged care in line with community expectations over time.

The Government has recently made some very sensible changes to bring together a range of regulatory functions and to integrate them in the Aged Care Quality and Safety Commission so that quality regulation is independent of program administration and policy.

Under the alternative model, I put to you, counsel, the regulator would remain a separate government body. It would, nonetheless, be reconstituted and revitalised as an independent aged care safety and quality authority, working to a board with a charter more tightly targeted to it being the tough cop on the beat. It would need to be more risk-based, and more curious and energetic in its pursuit of better aged care performance. It would be resourced to maintain sound regulatory capability. As the authority would serve the public purpose of holding providers to account for the quality and safety of care that they provide, the new authority would be fully publicly funded.

The authority would have the overarching purpose of safeguarding the quality and safety of aged care through monitoring, assessing, enforcing and reporting publicly on compliance with the Act and the standards. It would be the one-stop shop for all complaints about the aged care system and its services, and would engage actively with older people and their families and carers on the outcomes of their work. Please convey this model to the public for their consideration, counsel.

As part of doing so, I would invite public submissions on the two models, and I would also hope the Department of Finance in its submission to us would cost the two models. Thank you, Commissioner.

COMMISSIONER PAGONE QC: Yes, thank you, Commissioner Briggs.

Mr Gray, obviously those remarks are not intended to be a final decision by us. They indicate there are different views about how one may go about the system design and redesign of the kind that we are undertaking and, of course, we would welcome the different views. I suspect that my own view is much closer aligned to that which you put forward and don't think that the description of them as "courageous" is quite the right description.

I must say, whilst we are obviously going to be very keen to see the responses of the public, including those elements of the Government that Commissioner Briggs has indicated, the reference this morning to the internal memorandum of 1997 did show what some might regard a rather cynical approach when you have the combination of the people spending the money with those guiding the money, and we will be very keen to see what responses there are and obviously at the end of the day, we will need to form a view or possibly different views about the model going forward. I think we will now adjourn for 10 minutes.

ADJOURNED [11.18 AM]

RESUMED [11.30 AM]

COMMISSIONER PAGONE QC: Yes, Mr Gray.

MR GRAY QC: Thank you, Commissioner.

In the last period just before the break, I referred at some length to a Cabinet Memorandum of March 1997. I now seek to tender that document. Its document code is RCD.9999.0539.0001 and it is entitled "Residential aged care - long term outlays and issues for funding structures", Department of National Archives of Australia A14370 JH1997/158.

COMMISSIONER PAGONE QC: Yes. We might need to find what our exhibit numbers are up to.

MR GRAY QC: 22-1.

COMMISSIONER PAGONE QC: Yes, 22-1, thank you, Mr Gray.

EXHIBIT 22-1 - DOCUMENT RCD.9999.0539.0001, "RESIDENTIAL AGED CARE - LONG TERM OUTLAYS AND ISSUES FOR FUNDING STRUCTURES"

MR GRAY QC: Commissioners, I will now move to part 3.3 of our submissions beginning at paragraph 289. This section of our submissions is entitled "Program design" and it commences with a discussion of "Guiding principles for proposed new services, administrative arrangements, and funding arrangements". Those topics of the services, administrative arrangements and funding arrangements are what we mean by "the program".

We have conducted a consultation, as you will recall, Commissioners, commencing

in December 2019 on the topic of program redesign and it consisted, as well as involving consultations outside hearings, it consisted of a number of workshops, including transcribed and web-streamed workshops in February 2020 and written submissions by Counsel Assisting on 4 March 2020 and program design issues were also covered in aspects of two hearings held in Sydney, the one commencing at the end of August, and the one that ran from 14 to 22 September.

The key elements of our proposals for program redesign remain as they were in our submissions of 4 March 2020 and we set out the key principles that have guided our proposals about redesign of the program at paragraph 292 of the written submissions you now have before you, Commissioners.

At 293, we make a point I wish to emphasise now. There is a need to strike an appropriate balance between two very important objects. The object of empowering people seeking aged care with greater self-determination and direction of the services they receive, and the object of minimising administrative burden both on them and on the system more generally.

The dilemma between those competing objectives is particularly acute in the context of home and community care. Some of the witnesses before you, Commissioners, and many of the submissions, have suggested that assessment and funding arrangements that lead to the assignment of consumer-directed packages of entitlements are more conducive to the empowerment of individual self-determination. Other witnesses and submissions have placed emphasis on the administrative burden of such packages or certain iterations or approaches to assessment and construction of such packages.

People who have made submissions about administrative burden of individualised packages have tended to emphasise the advantages of grant-funded service arrangements, so it is said, that they are administratively less burdensome and have other advantages such as according flexibility to providers to scale services up and down, irrespective of any need to acquit the services that are provided to individuals.

It has also been suggested those grant-funded arrangements encourage establishment and retention of sufficient scale of services to make service provision viable in areas and in service lines where services might otherwise not be viable.

The key challenge here, Commissioners, in the area of services in the community and in the home is to integrate the two major existing programs that currently exist: the Commonwealth Home Support Programme and the Home Care Package program and to do so in a way that strikes an appropriate balance between those competing considerations I have just outlined.

In 2018-19, there were over 660,000 people who received Commonwealth Home Support Programme services in the nature of living supports or care in their own homes. Of these, over 260,000 received living supports alone. So if those people are excluded, there were about 400,000 people who received care at home, funded

through the Commonwealth Home Support Programme, that is, care in the nature of personal nursing and allied healthcare. These figures illustrate the magnitude of the task of integrating these two programs into a single suite of service arrangements, particularly if it is proposed that there is going to be some form of comprehensive
5 assessment of need and construction of a package of entitlements for all of these people tailored to their need for care at home. In essence, doing that would involve migrating a very large number of people, something in the order of at least 400,000 people, to arrangements for assessment and funding service delivery that are administratively more complex than the current arrangements that apply under the
10 Commonwealth Home Support Programme.

There are other things that need to be done in order for a successful integration to occur, particularly if, as we are suggesting and submitting, the system should be reformed along the lines of a demand-driven system, not one that is based on
15 population-based limits in the availability of subsidies. It would be necessary before moving to a fully demand-driven system that a sufficient supply of well-trained and skilled nurses and personal care workers are available to provide the care that will be required and it is also going to be necessary to ensure that the capabilities are in place to ensure high standards of quality and safety.
20

We will submit in more detail towards the end of these submissions that factors of this kind necessitate a cautious phased and flexible approach to implementation. We are going to submit, as you will see tomorrow in more detail, that an administrative unit should be set up under temporary arrangements pending the statutory reforms
25 that are needed to establish the independent Australian Aged Care Commission and this administrative unit we are calling an "implementation unit". That body should commence on the implementation of the recommendations to be made by the Royal Commissioners forthwith, and then responsibility would move to the Australian Aged Care Commission, on our submission, and the entire process would be
30 monitored by the Inspector-General of Aged Care.

In the remainder of the section on program redesign, from paragraph 298 onwards, we set out a number of formal recommendations, each of them accompanied by a proposal about the timing of implementation of the relevant reform. If the public
35 wishes to see a chronological account of all of the reforms that are proposed, that will soon be available on the website as an addendum to the submission. We are hoping to be able to publish that on the website very shortly.

At the conclusion of all of those transitional steps, at paragraph 299 we set out
40 Recommendation 8 which is the new aged program as it should exist once those steps are taken. Based on our analysis of the tasks involved in the necessary steps, we're recommending to you, Commissioners, that you suggest a deadline of 1 July 2024 for the commencement of the new aged care program. We have set that out in Recommendation 8 by reference to its key features and I won't read them out now.
45

In the interim, Commissioners, much has to be done. It shouldn't be simply a state of preparation of things to be done by 2024. Over the next three or more years there are

interim measures that should be taken to ameliorate the situation which currently exists and to address some of the flaws with interim measures in the short term.

We have, in particular, addressed the need to improve access to Home Care Packages in Recommendation 9 and in the submissions that begin at paragraph 300 and go right through to paragraph 306. These submissions will be familiar to you, Commissioners, from the Home Care hearing which we held some weeks ago in Sydney, and they are recommendations for immediate measures to ensure that all the people who have been assessed as eligible to receive a particular level of Home Care Package should receive that and the relevant national prioritisation system waiting list should be kept to no more than a one-month wait from here until, from this point on until 1 July 2024. When I say "this point on", there is a short period of grace to achieve that outcome and then the list must be kept clear on the basis of this proposed recommendation.

Next, I will address you, Commissioners, on a point Commissioner Briggs referred to a short time ago before the break, when you referred to the establishment of care finders to assist people to access aged care services by providing locally based face-to-face services. This, again, is a matter with which you are familiar, Commissioners, from our submissions on 4 March. I won't repeat what was said then.

The recommendation on the establishment of this capability, care finders to support people seeking aged care and to support them through the assessment process and to provide case management for those who need it in order to move from assessment to the provision of services, that's all addressed in a passage at paragraphs 307 through to 311, and our recommendation in this respect is Recommendation 10.

The next heading, beginning at paragraph 312, is on accessible and usable information on aged care.

There are submissions made about ongoing refinement of the My Aged Care call centre and website information service. There are suggestions in the submissions there at paragraph 313 about further refinements that should be made and the continuous improvement of My Aged Care or, if it is to be rebranded, whatever other name is chosen for that very important information service and data holding capability.

We also, at paragraph 314 --- and this is also in line with our submissions of 4 March --- make a recommendation, Recommendation 11, about other ways in which information concerning the availability of resources that can assist people to plan for ageing and aged care needs should be made, and this involves making the best use out of existing resources in the community and existing relationships with health professionals. Again, this is a topic that has been addressed in submissions in March; I won't spend any more time on it now.

The next topic --- again it is something very consistent with what we said back in

March --- is the proposal for the integration of the existing fragmented assessment processes that are available under Regional Assessment Services and Aged Care Assessment Teams into one assessment avenue. That assessment avenue should be scalable; that is, a person with relatively basic or simple needs shouldn't go through the kind of very detailed and lengthy assessment that a person with more complex needs might have. In that sense, the relevant assessment teams that should be conducting the single avenue of assessment will need to take into account the individual concern and to scale up the resources needed for the assessment accordingly.

I think all of those points that we made in the recommendation on this are quite uncontroversial and there wasn't a single witness that I can recall who took issue with any of the principles we have set out in Recommendation 12.

We have also submitted that there needs to be specific attention given to informal carers, identification of their needs, and the construction of a plan of supports tailored to their needs, including for respite.

Respite is an area that requires urgent attention and expansion in scope and the variety of offerings that are available and scale. The current offerings in respite are somewhat fragmented, are difficult to navigate and, with respect to the category known as "residential respite", the evidence before you, Commissioners, has been for some time, and this has been a matter investigated by the Aged Care Financing Authority, for some time there have been distorted incentives that apply under the financial arrangements or the funding arrangements for residential respite, such that residential aged care providers are not sufficiently incentivised to provide short-term regular respite and residential respite has been used more as a mechanism, leading straight to permanent admission to a residential aged care facility. This has been referred to in the evidence as a "try before you buy" approach.

Furthermore, residential respite has been used for quite lengthy blocks of time and it has tended not to be available for short regular amounts of time. All of these things militate against the purposes of respite. Respite is intended to sustain in the long term, to sustain the caring relationship between the informal carer and the person receiving care, and that suggests that a greater variety of short-term and more regular forms of respite are needed and incentives are needed to support them.

This supports our reasoning around Recommendation 13, that there should be a grant-funded program specifically constructed to encourage the development of a greater variety and a greater scale of respite offerings. The beauty of that being a grant-funded program is that a very local approach can be taken and the future Australian Aged Care Commission, and in the interim the Implementation Unit, should do all it can to acquire local knowledge and use local resources under that regional approach that we have referred to in our earlier section, that regional and local approach to understanding local needs and providing services that meet them.

There might need to be price differentiation between different localities. So be it.

Whatever is needed should be done to ensure that there are abundant respite services available to meet the needs of informal carers. There also needs to be far better coordination between respite, on the one hand, and the other kinds of services that are available for informal carers through the carers' gateway that is operated by the Department of Social Services.

At paragraph 323, we then turn to aged care in the home and community and we introduce some important building blocks to the recommendations that follow.

In Recommendation 14, we address the approved provider's responsibilities for care management. Care management is an important concept that isn't restricted to home and community care by any means; it is something that has to be done as a matter of course and done well in residential care as well. It is in home and community care where it is liable to be misunderstood and perhaps undervalued and we have set out detailed recommendations, in Recommendation 14, about how care management should be approached in the future system and on a transitional basis as the future system is built.

At Recommendation 15, we have recommended another grant funded category of supports that will be available to people, particularly in home and community care, but also tailored to what their needs may be, to people who are living in residential aged care facilities. People living in such facilities should also be supported by services provided under this social supports category. Of course, if the social support in question is Meals on Wheels, then a person in a residential aged care facility won't be requiring that because they will be fed and looked after in terms of their nutritional needs by the residential aged care service. But there may be other aspects of the grant-funded services provided under this category, such as transport to activities, that should be available to people irrespective of the care setting in which they live and that is Recommendation 15, Commissioners.

The next recommendation is another grant-funded category of support. It is called "Assistive technology and home modifications". Assistive technology again might be available to a person irrespective of the setting in which they live. Home modifications obviously is something available to a person living in their own home or living in the community and needing help with their built environment which might very well make the difference between them being able to stay at home or not. This also should be grant funded, in our submission, and that is Recommendation 16.

We then turn to a category of services which we are calling "Care at home." In addition to the three grant-funded categories of services --- respite, assistive technology and home modifications, and social supports --- in addition to those, during the Home Care and the Funding hearings we conducted recently in Sydney, we proposed a care at home category of services to be provided upon assessment and assignment of either a personalised budget reflecting the individual's assessed needs or else a standard amount based on a particular casemix classification.

Commissioners, there is then a discussion from paragraph 334 of the conclusions we

draw from the evidence that you heard in those submissions on this topic. Professor Eagar's evidence and Dr Hartland's evidence feature in that passage.

Our conclusions so far on this topic are tentatively reached and they are that before you, Commissioners, settle the details of the administrative and funding arrangements for the care at home category, it would be necessary to consider a range of matters that are still under consideration and analysis by the Australian Government. And it may be that it won't be possible for you, Commissioners, to reach final conclusions on these matters before that work is concluded.

In our submission, before finalising the scope of the category of care at home and settling on particular assessment classification and funding arrangements, either the Implementation Unit or the future Australian Aged Care Commission should complete the work that is being done by the Australian Government at present on the optimal design for integration of the CHSP and HCP programs and should continue the study ascertaining need characteristics, service usage patterns and resource requirements of people who are accessing care at home and who need to access care at home. We have addressed that in paragraph 337 and at paragraph 339.

We have said that you, Commissioners, should recommend to Government that there be a deadline for the conclusion of this work and the implementation of the new design by 1 July 2024. We have submitted at 339 that the study and the consultations on these matters should start with the propositions that have developed from the Royal Commission's work. Those are enumerated in the subparagraphs under paragraph 339.

We have said there what the starting point for the consultation development and refinement process of the care at home category should be, and then we outline the conclusions we have drawn from the work of the Royal Commission so far. But those matters are not yet sufficiently firm in our minds that we can make a submission to you, Commissioners, that this should be the final form of the service arrangements for this category of services.

A key theme that has emerged from the evidence before the Royal Commission is the need for the aged care system to support the delivery of allied health care and to do so in a way that is person-centred and focuses on the goals of the individuals. So we can also say that that continuing work on the appropriate arrangements for care at home should include that there is a level of allied health care provided under this category appropriate to each person's needs, and we have at 345 set out the approach that should be taken by the Implementation Unit and the future Australian Aged Care Commission, in our submission, in ensuring that allied care has a prominent role to play in the enabling objectives of the care at home category.

At 346 and following, we set out principles that should guide the approach to developing a casemix-based classification and funding mechanism, at least for the more complex and intense needs of people who are seeking care at home. We have said in all this --- and this echoes something you said a minute ago, or at least before

the break, Commissioner Briggs --- throughout all these steps it will be critical to ensure no interruption occurs in the continuity of services provided by either directly contracted providers who are providing services under the Commonwealth Home Support Programme or by Home Care Package providers and that a smooth transition occurs from the currently separate programs to the new service arrangements and the people seeking support and care in the community and home are met with a seamless process of assessment/assignment of entitlement and of service delivery and that they can be supported, if they choose, by a care finder in those endeavours.

We then turn to residential care and we address our submissions in support of Recommendation 17 at paragraphs 352 to 355.

As we said in our submission on 4 March, we have come down in favour of separate service categories between residential care and people who are receiving care at home, and it is appropriate that residential care continue to be provided on a bundled basis, that is that a number of services are provided together to assist in providing a well integrated holistic suite of care services to meet all the needs of the person who is living in a particular residential aged care facility.

We have also submitted that, in line with the current work being done under the auspices of the Department of Health, a casemix-based funding approach to residential care will be appropriate and there is significant work being done on the Australian National Aged Care Classification Model and the trialling of that model and that should continue, and that candidate should be considered very seriously as the appropriate model to bring casemix-based funding, supported by independent pricing by the Aged Care Pricing Authority, to the residential aged care segment.

It may be that that model has to be varied in some way. It may have to be refined. It may be that, in time, it will need overhaul. It needs to take into account the importance of quality of life, social connection and other matters that have been emphasised as inherent in high-quality aged care in evidence before the Royal Commission, and that will presumably require trials and iterative testing and refinement of that model over time. All of that can take place in the future and they will be critical inputs into the future work of the independent pricing body, the Aged Care Pricing Authority.

Now, we have also made a recommendation at Recommendation 18 about far better integration of allied health provision in residential aged care. At paragraph 365 we have addressed the important topic of "Designing for diversity" and we have set out our reasoning in the paragraphs that follow, 366 through to 369, in support of Recommendation 19.

Recommendation 19 sets a series of deadlines, firstly in mid-2022 and secondly by the important deadline for the commencement of full transition to the new program on 1 July 2024, of a number of steps intended to integrate measures to provide proper support and care for people who have needs that arise from diverse experiences, diverse cultural background. There are a number of matters concerning training

requirements, including training about cultural safety and trauma informed service delivery, which we set out there in Recommendation 19. I won't try to outline everything we have submitted there, but there is also a heavy emphasis on improving data collection and analytics and conducting a national audit about the extent to
5 which diverse needs are currently being met, where the gaps are and what commissioning arrangements need to be done to meet those gaps and remediate those problems.

Finally, at the end of this section, we have Recommendation 20 which is, again,
10 triggered by this important deadline of 1 July 2024, the proposal for the removal of population-based rationing.

Commissioners, that's the end of the "Program design" section.

15 Commissioner Briggs, I understand, wishes to address ---

COMMISSIONER PAGONE QC: Not on this section, Mr Gray, I think the next section ---

20 COMMISSIONER BRIGGS: No, it is on this section that I wish to make a few very short comments.

Thank you, counsel, for your survey of what I think are very impressive recommendations for program design.

25

Reflecting on what you are saying, we have an indication of unmet need for the home care packages, but no indication of unmet demand for home support.

Moving to the entitlement system you are proposing, counsel, where older people are
30 guaranteed the services that they are assessed as needing, it will require the Commission or the Department to have a way of knowing and responding to those needs in a timely way. A comprehensive planning regime is going to be essential to ensure that there are home care and support services available to meet that entitlement.

35

The first step towards this planning regime would be a process for identifying the current unmet need in the Commonwealth Home Support Programme and reporting on it. That intelligence would inform how the CHSP growth funding is best allocated in the lead-up to the demand-driven system that you propose, counsel.

40

Changes to care at home, while not a specific recommendation in your counsel's submissions, are fundamental to bringing about better aged care. Reforms to create a single system for care at home have been flagged by the Australian Government since at least 2012, but the sector has been left waiting.

45

The current home care programs provide care and support for over 1 million older people each year. They overlap in some ways and leave gaps in others. They lack a

coherent set of objectives and present a complex and confusing picture for people seeking to access the care. We have completed a lot of significant design work for care at home and it is absolutely critical that we get the design of the new care at home system right.

I think it is important to present to the Government a clear and convincing design for care at home that can be delivered for the aged care sector, and I think it is equally important that we provide certainty to older people that care at home will meet their needs.

In the same vein, counsel, I note you have not made recommendations about allied health in the home and community. This is a pity because allied health is critical to restoring older people's physical and mental health to the highest level possible, to maximise their independence and autonomy and improve their quality of life. It is clear that allied health and care at home must increase from its current miniscule level and become a central part of the care at home service offering.

I very much look forward, counsel, to hearing what interested parties say in response to your request for views around the design of care at home and allied health, as part of that care in the home. I also would encourage feedback on the level of unmet demand in the home support program.

Thank you, Commissioner.

COMMISSIONER PAGONE QC: Thank you, Commissioner Briggs.

MR GRAY QC: Thank you. Mr Rozen will now carry on.

COMMISSIONER PAGONE QC: Yes, thank you, Mr Rozen.

CLOSING SUBMISSIONS BY MR ROZEN QC

MR ROZEN QC: Thank you, Commissioners. The next topic I will address is topic 3.4, "Quality and safety". That can be found on page 126 of the written submissions.

Commissioners, quality and safety of the aged care system is clearly at the heart of this Royal Commission. The Commission was established and in fact its name indicates that that is the case.

The Commission is tasked with inquiring into what the Australian Government aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe. We draw particular attention to the expression "high quality." The submissions we make today are directed to establishing an aged care system that will consistently deliver high-quality aged care to older Australians. That is what the

Terms of Reference require.

In this part of our submissions, we address quality and safety under five headings. We make some general observations about the notion of high quality and refer briefly to the new general duty that we submit ought to be included in the aged care legislation.

The second topic we address is quality and safety standards. Thirdly, we deal with the topic of dementia.
The fourth topic is restrictive practices and, finally, we make some submissions about quality indicators.

There is a lot of ground to cover and our submissions do that in writing, and I obviously don't have time to read them out, but we will draw your attention, Commissioners, to the key features.

Starting with some introductory observations, we draw attention at paragraph 373 to one of the more important pieces of research that was commissioned by the Royal Commission. It is a study by the University of Queensland entitled "The cost of care." The authors of that study examined both quality and efficiency in the residential aged care sector and we referred briefly in passing to some of the findings of the study in our discussion of substandard care earlier. We note the theoretical and conceptual background to the work in paragraph 374 by reference to a well-known --- an author that is well known in the area of health and aged care quality, Avedis Donabedian, and we note at 375 that that theoretical background provides the context in which the Queensland study took place.

The study built on that theoretical framework and assessed quality in aged care by reference to a set of quality indicators or measures that were chosen by the authors of the study. They considered clinical health outcomes of residents, process accreditation standards and service experience indicators. We seek to summarise the findings at paragraph 376 by reference to the three levels of quality that were identified or categories of quality: Q1, the highest level; Q2, medium level quality; and Q3, lowest quality. We note that the study concluded that only 11 per cent of facilities were in the highest quality category.

Importantly, to get into the highest quality, a facility need only have met all the accreditation standards, had no complaints, a higher than average customer rating and lower utilisation of high risk medicines. There are also 11 per cent of the facilities in the lowest category, that is ones that had lower customer experience ratings, higher failure of meeting accreditation standards and a higher number of complaints. The overwhelming majority were in the middle, 78 per cent provided what was referred to as average quality aged care.

But average quality aged care, Q2, meant those facilities still at times failed accreditation standards, albeit less frequently than the ones in Q3, the lowest category, and the vision that we have for high-quality aged care is more than merely

meeting accreditation standards and similarly, we would submit that average quality care can't be provided in a facility that is failing to meet such standards, even if only sometimes.

5 It is important to note, as we do at 377, that there are some limitations associated with the study because of the incompleteness and unevenness of the data, a theme that runs through our submissions as a whole.

However, it is possible to conclude from the study that there is a lot of aged care in
10 Australia which is, at best, of average quality. Having said that, there are some examples in the evidence that you have heard over the last two years of high-quality aged care. We refer to them as shining examples that are being achieved within the same funding and other constraints that apply to all providers in the current system. The hallmarks of these high-quality aged care providers are that they value their staff
15 and they attract loyalty of those staff in return and that, in turn, enables consistent staffing that promotes high-quality, relationship-based care, a theme that we will return to later in these submissions.

Such providers are also well governed. They value feedback from the people who
20 live in their facilities, their families and their employees. Professor Kathy Eagar from the University of Wollongong, to whom reference has already been made by my learned colleague Mr Gray, stated at the recent hearing about funding and financing that the current aged care system contains what she described as "pockets of excellent practice", but she went on to say that average practice is a long way from
25 uniformly good practice

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

What do we mean when we refer to high-quality aged care? Another study that has been carried out under the auspices of the Royal Commission was the Caring Futures Institute study from Flinders University. It was a large-scale study assessing the
35 views and preferences of the general public about quality of aged care and the future funding of quality aged care. In excess of 15,000 people participated and of those 65 per cent completed the survey and passed all the specified quality control criteria. Importantly, the study found what is referred to as "high levels of agreement amongst members of the general public about what constitutes quality in aged care".
40
The study concluded that the salient characteristics consistently rated as highly important in encapsulating quality in aged care service delivery are largely reflective of the fundamentals of care, including older people being treated with respect and dignity, aged care staff having the skills and training needed to provide appropriate
45 care and support, the provision of services and supports for daily living that assist older people's health and wellbeing and older people feeling safe and comfortable. The basics, in other words, Commissioners.

Respondents to the survey feel very strongly that an older person has a right to be treated with respect and dignity by a skilled and trained workforce should they need access to care. Interestingly, being supported in making your own decisions about care and services was "among the less influential characteristics" identified.

The authors of the study noted that the findings concurred with another study referred to in 2018 by COTA and more recently, Commissioners, as we note at paragraph 384, in fact just this week, a study by the National Ageing Research Institute surveyed 391 residents or their proxies about how they felt about their lives and the care they received and a significant share of those surveyed indicated that some aspect of the quality of their care and services was failing them. The study concluded that that share could be at least a third of residents depending on one's perspective.

Notably the study also concluded that about 41 per cent of residents were rarely or sometimes satisfied with the amount of time staff spent with them. These are residents in residential aged care facilities.

Commissioners, we submit at 387 high-quality care puts older people first. It assists older people to live a self-determined and meaningful life through expert clinical and personal care services and other support provided in a safe and caring environment. High-quality aged care is respectful, timely, and responsive to older people's preferences and needs and assists them to live a dignified life. It is provided by caring and compassionate people who are skilled in the care they provide. High-quality care enables older people to maintain their capability for as long as possible while supporting them when they experience functional decline or need end-of-life care. High-quality care delivers a high quality of life.

We submit a measurable definition of high-quality care needs to be formulated over time. It should be measurable in terms of the amounts of care time per recipient per day that a person within a particular casemix classification should receive from the different identified skill categories of care staff. This will enable the costs of high-quality care to be estimated and that estimate may be iteratively reviewed and refined over time by the Australian Aged Care Pricing Authority, to which Mr Gray has referred. We will return to the pricing implications of this later in these submissions.

Commissioners, this is an example of the linkages between different aspects of our submissions, the linkages between quality of care, workforce requirements and pricing and funding of care and it highlights a point that we will emphasise that what we are placing before you is a package of reforms which needs, for it to be successful, to be implemented as a package.

The first recommendation in this section is at Recommendation 21. We submit that the *Aged Care Act* should be amended to provide that the Australian Commission on safety and quality in health and aged care, a body I will refer to in a moment, in

setting and amending safety and quality standards for aged care give effect to the following characteristics of high-quality aged care and I have touched on a number of those already.

5 The second recommendation that we propose in this part of our submissions is that approved providers must have a statutory duty of care to care recipients. We see this as being among the more important of the recommendations that we propose and we note at 391 that the Act, perhaps surprisingly, does not set out a clear statement of the approved providers' basic responsibility to ensure that the care provided to
10 residents is safe and of high quality.

We do note, of course, that section 54(1)(a) of the Act imposes a responsibility on a provider to provide such care and services as are specified in the quality of care principles, but we note that it is not an offence for a provider to fail to meet that
15 standard; nor can a civil penalty be imposed as is commonly the case in relation to duties under Commonwealth legislation in particular.

We submit at 392 there needs to be a general duty on an approved provider to ensure, so far as is reasonable, the quality and safety of its aged care services. We submit
20 that such a reform would send a clear message to providers, the community and the regulator about the primary duty of an approved provider to protect the health, wellbeing and safety of its residents. The amendment should be made in the existing Act and should be transferred to the new Act when the current Act is replaced.

25 The duty we propose is based in part on the well understood employer duty under occupational health and safety law and the significance of that is that all providers --- well, most, probably all providers --- are employers and already have that duty and that duty extends to their employees and their contractors, but also to third parties such as residents and we have included a number of references to the
30 applicable law.

Importantly, the way the duty has been interpreted in workplace health and safety jurisprudence is that it requires employers to take an active, imaginative and flexible approach to potential dangers and requires employers, together with their experts, to
35 be proactive and not reactive in meeting the duty. It requires employers to ensure their staff are instructed, informed, trained and supervised, so they can work safely.

We note the similarities between the duty we propose and the existing common law duty that providers have to accord residents with a reasonable level of care.

40

We note in particular that the experience of jurisdictions such as workplace safety but also environmental law that have introduced such a general duty into the statutory regime is that it has guided the work of the regulator once the new duty is included, and we would expect a similar pattern to be followed in relation to the aged
45 care area.

At paragraph 399, we make particular reference to the increasing frequency that

exists, particularly in the disability care area of brokerage arrangements and platforms, what is sometimes referred to as "uberisation" of personal care, and we note the evidence that was given by representatives of two such organisations, albeit with different business models, Mable and Hireup, evidence that was given in the recent home care hearing, and we note that in such arrangements there is often no direct relationship between the provider and the care worker. We will return to this topic after lunch when we examine the aged care workforce.

The question at the moment is how can the law ensure that care provided in such circumstances is of high quality and safe?

Where the provider directly employs the care worker, the provider can direct the care worker as to the model of care and other aspects of the work, and thereby ensure compliance with the duty, but where the person doing the work is not an employee and may in fact have no relationship at all with the provider, then that raises difficult questions as to how the law can ensure that the quality standards are met in such arrangements.

We have noted that there are at least two options available to address this situation. One would be to deem the facilitator of labour, if I can use that generic expression, to be an approved provider of aged care services. We discuss, but ultimately reject that, at paragraph 401, on the basis that there is a degree of arbitrariness associated with it and a degree of artificiality as well because, in truth, such a facilitator would not be an approved provider in many respects under the statute.

What we have focused on is the particular area where we think it is most important that there be regulation and that is in relation to the training and experience of workers and we propose a more limited duty that we submit is proportionate to the risk; that is, that a facilitator of labour, such as the online platforms I have referred to, should have a duty to ensure that any worker who they make available to perform care work has the experience, qualifications, skills and training to perform the particular care work that they are being asked to perform and we note that the implications of such a duty ought to be to encourage such facilitators of labour or platforms to actively investigate the work and ensure that the worker provided is matched to the work. Not unlike the way the law addresses labour hire arrangements and there are certain similarities between this scenarios and labour hire arrangements

It would not be enough under such a scenario for the brokerage firm to say, well, we have a portal that the workers can access for training purposes. There would be a positive obligation to ensure that the workers avail themselves of such training before they are made available on the platform and, once again, as with so much in aged care, this notion of a general duty has been addressed in a previous inquiry, a Senate inquiry into aged care quality in 2019. We submit that the time for this important reform is now and we set out in Recommendation 22 the detail of the duty that we have in mind and the secondary duty that would be imposed, as I have previously referred.

The second topic that I wish to discuss briefly is aged care quality standards which is addressed at paragraph 404 onwards.

There are two questions here. Firstly, how should standards be set or, rather, who should do it; who should set the standards? And the second question is what should happen to the existing standards. I will deal with the first question briefly.

We submit at Recommendation 23, which is on page 138, that a new approach should be taken to aged care standard setting. We submit that the existing body, the Australian Commission On Safety and Quality in Health which sets quality and safety standards for the health sector, ought to be renamed the Australian Commission on Safety and Quality in Health and Aged Care and its remit ought to be broadened to cover the aged care sector. We explain our reasoning for preferring that approach to, for example, conferring on the proposed Aged Care Commission that Mr Gray has already referred to, the role of being the standard setter. We think as we submit in the document, the advantages of the existing body taking on this additional role exceed any disadvantages that might flow from, for example, it not being an aged care specialist body but rather one operating primarily in the health area.

We are particularly attracted to the form of the standards that the Australian Commission on Safety and Quality in Health has promulgated and we have chosen as an example of that the standard that it has for clinical governance and we have contrasted that with the standard that exists under the existing aged care quality standards for clinical governance. We think the detail in the standards that are prepared by the Australian Commission on Safety and Quality in Health presents a compelling case for it to have this broader responsibility.

We note that the then Chief Executive Officer Professor Picone gave evidence in the Brisbane hearing. This possibility was flagged with her and we have summarised her evidence to the effect that there are sound reasons for ensuring consistency or even uniformity in standards as between the aged care and the health sector. So, on that basis, we make the submission you ought recommend the recommendations set out at number 23.

What should happen to the existing standards is a question that we have given considerable thought to. The evidence, as we indicate at paragraph 423 about the existing standards, is, to some extent, mixed. On the one hand, there has been evidence of witnesses who have supported the increased consumer focus as it is referred to in the new standards, which, of course, came into operation only a little more than a year ago on 1 July 2019. But, at the same time, there are other witnesses, particularly experts, and we have drawn your attention to Dr Iluiano, who gave evidence in the Darwin hearing about the food and nutrition standard, in particular, where the lack of detail is bemoaned by those witnesses and we share those concerns, as I have already indicated, in relation to the governance standards. We note that it is not just the food and nutrition experts that have given that evidence, it is also experts in the fields of dementia care, continence care, palliative

care and oral health, have all expressed similar concerns and the references are at footnote 415.

This lack of objective measurement is a general concern and we point out standard 7 of the existing standards which requires a provider to have a workforce that is "sufficient and is skilled and qualified to provide safe, respectful and quality care and services". We submit that such a standard exemplifies the difficulty. What does "sufficient" mean in that context? Against what objective standard is compliance to be judged? And we make the observation that that uncertainty is in no one's interests. It is not in the interests of the regulated, the providers, it is not in the interests of the regulator, and it is certainly not in the interests of the important party and that is the recipients of care. There needs to be certainty in relation to such standards and something that can be objectively measured.

We note at 428 that, on balance, despite these concerns, we're conscious that the new standards have only been in operation for a little over a year; that a great deal of work has been done by the Department, the regulator, the sector, and recipients of care to get used to the new standards and to some extent they are still being bedded down. The evidence before you was that the process of the development of those standards was highly consultative and took quite a period of time. Throwing them out now and replacing them immediately would be a big step, a courageous step to quote you, Commissioner Briggs, not one that we would submit ought to be taken, but we do submit that it is important that the new standard setter for aged care, which we submit should have the ongoing responsibility for maintaining the standards, ought to be asked by the Minister responsible to review as a matter of urgency certain standards which, on the evidence before you, are requiring some urgent attention.

We have set out in Recommendation 24 the standards that we submit ought to be the subject of an urgent ad hoc review. We have in mind some urgent amendment to the legislation to broaden the remit of the Australian Commission for Safety and Quality in Health, so that it can be not only renamed but its remit broadened so that there would be no doubt about its statutory power to engage in such an urgent review, and we are recommending that by 15 July next year, the Minister make the reference to the newly named body and that it complete its review into the matters we have identified by the end of 2022.

We note at recommendations 25 and 26 that in addition to what we are referring to as that urgent ad hoc review of the identified standards, that the Australian Commission on Safety and Quality in Health ought to complete a comprehensive review of the standards within three years of being given the statutory responsibility for doing that, and then on a five-yearly cycle that ought to happen over time. One of the difficulties that emerged from the evidence is that whilst the quality standards have, of course, been replaced recently, there is nothing in place to require that ongoing assessment of the standards and we submit that is a very important component of a system that will ensure high-quality care is provided through the aged care system on a sustainable basis, to pick up on a term you used earlier, Commissioner Briggs. So

recommendations 25 and 26 do that.

There are three areas which we have identified in the submissions we make on quality and safety for particular attention. They are food and nutrition, on the one hand; secondly, we have made some particular submissions about dementia care and we have also made some reference to restraints. I will briefly refer to each of those.

Firstly, in relation to food and nutrition, we are struck by the amount of evidence that has been given by care recipients, by family members, and by aged care workers in relation to the quality of food, particularly in residential aged care. We have made reference to the evidence in the Cairns hearing, where there was a particular focus on food and nutrition, and we have highlighted the evidence of one particular witness who described some of the evening meals that she saw her mother being offered as terrible, and that is at paragraph 443. I won't go through the evidence. It is there in the submissions.

At paragraph 446, Commissioners, we make the observation that there is nothing more basic than food. People living in residential aged care have no choice but to eat the food they are served, and there are real questions, we submit, about the nutritional standards of the food in our aged care homes, despite the evidence you have heard of the need of older people to have nutritious meals and particularly ones that are high in protein.

Why shouldn't people living in residential aged care be able to smell their food being cooked? We submit that's one of the joys of life. And also why shouldn't they be able to cook their own meals or at least participate in the preparation of their meals? They are practical, simple aspects of quality of life and they are also relevant to the maintenance of physical and cognitive capacity.

We note that the current standards in relation to food and nutrition are perhaps an improvement on the previous standard, and we also note that the food and nutrition standard is one of the ones that we submit ought to be urgently reviewed, but that process of review will take some time. We submit that this is an area where there is a need for some urgent action so that this time next year people in residential aged care can say, "Well, it is now six months since the Royal Commission reported and I can see a demonstrable improvement in the quality of my life in relation to food", and so we propose a recommendation which Mr Gray will take you to in more detail tomorrow. It is Recommendation 82, which will see an immediate offer of an increase in the basic daily fee of $10 per resident per day, with additional funds to be spent on daily living needs, including nutrition.

If I can turn to dementia care at paragraph 451 of our submissions. We make the point that the Terms of Reference specifically direct the Royal Commissioners to consider how best to deliver aged care services to the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged care services. At paragraph 454, we note that over half of the people permanently living in residential aged care in 2019 had a diagnosis of one of

the forms of dementia. We also note evidence that was given, I think in the first Sydney hearing by Associate Professor Macfarlane, that those figures might understate the actual incidence of dementia in residential aged care. It could be as high as 70 per cent, he said, given the prevalence of undetected dementia.

Despite this, Commissioners, the Inquiry has revealed the quality of aged care that people living with dementia receive is at times abysmal. This is particularly so for people with more complex needs. The Commissioners have heard in evidence time and again that staff do not have the time or the skills to deliver the care that is needed and the response, sadly, is for the staff often to rely on restrictive practices which restrict a person's freedom and diminish their quality of life. We submit the quality of dementia care in the aged care system needs significant improvement.

We make two recommendations which we propose will result in significant improvement to this aspect of the aged care system. The first is a dedicated dementia support pathway in Recommendation 27 which you will find under paragraph 466 on page 149. We note the evidence about the importance of the development of such a pathway.

The second aspect of our dementia-related recommendations is at Recommendation 28 which concerns specialist dementia care services. We note that a specialist dementia care program has been introduced as the inquiry has been conducted. It is one of the reforms which has occurred during the life of the Inquiry. There has been no evidence before the Royal Commission about its effectiveness, and we submit that the appropriate course is for the Commissioners to review and publicly report on the matters set out in Recommendation 28, whether the number of specialist dementia care units established or planned is sufficient to meet need, and the other matters that are set out.

A moment ago, I made reference to eliminating or reducing restrictive practices and the approach that the evidence has revealed can be taken by aged care providers and their staff in addressing the behaviours that are often accompanied, particularly high level dementia in residential aged care recipients.

Recommendation 29 addresses the regulation of restraints. This is an area a little bit like the submissions that Mr Gray made, not long ago, about the reforms to the home care sector. This is an area that we have given considerable thought to, and our submissions are quite detailed on why we think that the relatively limited recommendation that we propose in Recommendation 29 is the appropriate and cautious approach that we submit ought to be taken in relation to this important area.

In summary, there are existing requirements in the quality of care principles relating to physical and chemical restraints, and, in part, as a result of a human rights report that was prepared by the Human Rights Committee of the Australian Parliament, there is a time limit on those rules so that they will expire and have to be replaced by 1 July 2021.

We note that they are being reviewed presently and the review is not due to report to the Minister until 31 December 2020, and these submissions are at paragraph 485 and the review is being conducted under section 15H of the Quality of Care Principles.

In those circumstances, we submit that it would be premature for this Royal Commission to recommend a detailed set of requirements to replace those that are presently in the Quality of Care Principles, without having the benefit of the findings of that review. The Government response to the Joint Committee on Human Rights Report that I referred to is extracted at paragraph 487 of the submissions, and you will see that in the response the Government made, it referred to the extensive consultation that was required of the review. It is anticipated the review will make recommendations about replacement requirements for part 4A of the *Quality of Care Principles*.

In those circumstances, the recommendation that we make, recommendation number 29, is that the Government should introduce new requirements regulating the use of chemical and physical restraints by 1 July 2021 when the existing rules will be revoked and that the new requirements should comprehensively regulate the use of chemical and physical restraints in residential aged care and should be informed by the matters that we set out at 29.2, including the operation of the National Disability Insurance Scheme (Restrictive Practices and Behaviours Support) Rules which have, themselves, been introduced quite recently and, we submit in the written document, contains some features that could well be adapted for the aged care sector.

In addition at 29.3, we recommend that any replacement requirements should enable a person receiving aged care, who is the subject of a restraint, to be able to seek an independent review of the lawfulness of the conduct, and, further, any breach by an approved provider of the new requirement should expose the provider to a civil penalty.

Each of those features are not there in the present requirements and we submit are important requirements in any rules that replace those that are presently there.

Commissioner Briggs, I am conscious that you wish to make a statement about the restrictive practices area. I could either invite you to do that now or perhaps when I conclude this topic, which will be in about five minutes, if that's all right? Thank you.

The final matter that I wish to make submissions briefly about concerns quality indicators. You will find these submissions immediately after paragraph 505 of the document on page 160.

Quality indicators, in some respects, are the flip side of the coin of quality standards. As we observe at paragraph 506, if the standards set the rules for aged care quality, then quality indicators enable that quality to be measured, and there needs to be an alignment between the two.

We note at paragraph 507 some evidence that was given very recently by the Secretary of the Department of Health, Dr Murphy, who was asked by my learned friend, Mr Gray, about funding shortfalls in the aged care system at Sydney Hearing 5, the funding and finance hearing.

While Dr Murphy acknowledged that there had been a significant reduction in government funding for approved providers in real terms in recent years --- and you will recall that evidence --- he baulked at any suggestion that the funding shortfalls may have caused deficiencies in the quality of the care delivered by those providers. He said:

> *We don't have any evidence at the moment that there is an impact on quality and safety from financial performance.*

We submit at 508 that at first blush one might derive some reassurance from that statement that the reductions in funding haven't impacted deleteriously on quality, but that assumes that there is in place a robust process by which the Department measures aged care quality, and there is no robust process. Quality is not adequately measured in our aged care system. In fact, until last year, there were no mandatory quality indicators, and whilst there are now some quality indicators, there are only three.

We noted earlier in these submissions how difficult it had been for the staff of the Royal Commission to assess the extent of substandard care in our aged care system, and that's in no small part because of the lack of quality indicated data.

We note that the health sector is different, that there are requirements on hospitals to report publicly on key quality metrics such as hospital acquired infections, wait lists, costs and time of admissions.

We submit that the same body that we have identified as taking on the role of standard setting in relation to aged care, the Australian Commission on Safety and Quality and Healthcare should be tasked with developing a more comprehensive suite of quality indicators for residential aged care and, in due course, for aged care in the home. We submit that, in that work, that Commission ought be guided by the three matters that we set out at paragraphs 520 to 522 of the written document.

And finally, in relation to quality indicator data, we note at paragraph 523 and onwards the role that quality indicated data can play in driving improvements in quality. We draw attention to the experience once again in the Victorian public sector where there have been mandatory quality indicators in place since 2006, and we note some of the evidence that has been given about the impact of that ongoing quarterly reporting that is required under those quality indicators to drive improvements in quality.

We also note evidence that has been given about the role that such indicators can

play in informing consumer choice, both by people looking for a residential aged care service and also, perhaps, by people who are presently receiving services in one, and might want to move to another.

5 Recommendation 31 is directed to the implementation of a benchmarking process to enable providers to judge themselves against some standards for particular quality indicators, and we think that is an important role for the Australian Government to take by 1 July 2022, and we also see that as being an important ongoing responsibility for the Australian Aged Care Commission that, we submit, ought to be
10 establish from 1 July '23 onwards.

That concludes the part of our submissions that deal with quality and safety. Thank you, Commissioners.

15 COMMISSIONER PAGONE QC: Thank you, Mr Rozen. Commissioner Briggs?

COMMISSIONER BRIGGS: Thank you, Commissioner. Thanks, counsel, for those pretty strong recommendations on ways to improve quality and safety. They are food for thought for us.
20

As you correctly said, the issue of restraints is what I would like to raise, and you will remember that in our Interim Report, we said that significant change was needed in order to address this unsafe and substandard care regime and that we would come back in our final report on that.
25

We also said that there had been numerous reviews of the aged care system and most had delivered very little.

We need to be careful that we don't fall into that same trap of waiting for another
30 review to recommend a change to restraint arrangements that might never eventuate. There are some stronger options that I would hope you would consider, counsel, and they build on really what you have been saying.

Firstly, it is clear that the aged care sector hasn't kept pace with the disability sector's
35 national framework and strict rules around the use of restraint practice.

I think there is an important consideration there as to whether we should be harmonising aged care restraint arrangements with the tougher disability restraint restrictions. That NDIS approach to the use of restrictive practices includes a
40 requirement that they be used only where there is an emergency and there is a need to avoid harm; or, if a behaviour support practitioner, approved by the Regulator, has prepared a Behaviour Support Plan which is lodged by the Regulator and there is monthly reporting against the plan to regulate, so that the Regulator can have independent security.
45

Secondly, and building on this, restrictive practices only being used, one, as a last resort to prevent serious harm after the provider has explored all other approaches to

mitigate risk; two, to the extent necessary and proportionate to the risk of harm; three, for the shortest possible time, and I could go on, but I think it is important to say that in the case of chemical restraints, if provided by a doctor who has documented the purpose of the prescription. And, finally, I think making use of
5 unauthorised restraint, a reportable incident under the Serious Incident Response Scheme and ensuring that any breach of the statutory requirements would leave directors of a provider personally liable to a civil penalty at the suite of the Quality Regulator with possible compensation options for older people affected.

10 I would appreciate, counsel, hearing the public's views on those issues, and I would also appreciate receiving submissions addressing the performance of this NDIS regime and whether or not its key features could be applied to the aged care system.

Thank you counsel and Commissioner.

15

COMMISSIONER PAGONE QC: Yes, thank you, Commissioner Briggs. Adjourn to 2 o'clock?

MR ROZEN QC: Thank you, Commissioner.

20

ADJOURNED **[12.53 PM]**

25 **RESUMED** **[2.00 PM]**

COMMISSIONER PAGONE: Yes, Mr Rozen?

30 MR ROZEN QC: Thank you, Commissioner. The first topic this afternoon that I seek to address you on is part 3.5 of the written document. It's at page 166 and the topic is "Aged Care for Aboriginal and Torres Strait Islander people".

Commissioners, in the Royal Commission's Interim Report it was concluded that
35 Aboriginal and Torres Strait Islander people were not being well served by the current aged care system. Although it's well understood that the aged care needs of some Aboriginal and Torres Strait Islander people go unmet, the extent of the problem remains unclear.

40 In these submissions we describe a new approach to the aged care of the First Australians. We do so from the starting point that although Aboriginal and Torres Strait Islander people have particular cultural needs and requirements that may parallel other culturally and linguistically diverse sectors, they are ultimately unique.

45 We note in the submissions, as was the case in the Interim Report, it is important not to assume homogeneity within the Aboriginal and Torres Strait Islander population. There is diversity both in terms of lifestyle, geographic location and attachment to

culture, and that complexity is important to recognise in the design of any aged care system that is seeking to cater for Aboriginal and Torres Strait Islander people.

Presently, as is detailed at paragraph 540 of our submissions, there is a special program, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, rejoicing in the acronym of NATSIFACP, which sits outside the *Aged Care Act*. It's the principal program that is relied upon to target culturally appropriate aged care close to home and community for Aboriginal and Torres Strait Islander people and deliver the mix of high care residential, low care residential and home care places on a block or grant-funded process. Importantly, because it sits outside of the *Aged Care Act*, providers do not have to be approved providers.

In the submissions, and I won't go through it in detail, we note a number of demographic facts about Aboriginal and Torres Strait Islander Australians and we ultimately conclude at paragraph 552, that the life expectancy gap, which is notorious in Australia between Aboriginal and Torres Strait Islander people on the one hand and non-Aboriginal and Torres Strait Islander people on the other, is closing and the Australian Bureau of Statistics forecast that to 2031, I'm reading from 552 of the submissions, the Aboriginal and Torres Strait Islander populations will grow at a rate faster than the total Australian population with the highest projected growth in major cities. And further, substantial growth is projected amongst the 65 and over population which is likely to increase as a proportion of the Aboriginal and Torres Strait Islander population from 4.3 per cent in 2016 to in excess of 8 per cent by 2031, an increase of some 150 per cent, meaning that today's population of 34,000 could grow to as many as 89,000. These are very significant forecasts and, in our submission, they necessitate a changed approach to Aboriginal and Torres Strait Islander aged care and we note this at paragraph 560.

We submit that the projected growth in the number of Aboriginal and Torres Strait Islander Australians needing care in the future means that NATSIFACP is not the answer. Were NATSIFACP to be expanded to meet the needs of all Aboriginal and Torres Strait Islander Australians, there would be, in effect, over time, be two aged care systems in this country and we submit that is not a desirable outcome.

Rather, we submit the aged care system must be ready to accommodate the needs of the growing cohort of Aboriginal and Torres Strait Islander Australians and we make a suite of proposed recommendations that are aimed at ensuring that the special features of the Aboriginal and Torres Strait Islander populations are catered for within what I might describe as the mainstream aged care system.

To that end, we propose seven recommendations, which I will take you through one at a time.

The first appears at paragraph 557, page 173 of the written submissions, and it recommends that the Australian Government should ensure the new aged care system makes specific and adequate provision for the changing and diverse needs of Aboriginal and Torres Strait Islander people and it identifies six particular features

that should be present to achieve that overall aim.

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

The second is that priority be given to existing and new Aboriginal and Torres Strait Islander organisations including health, disability and social service providers to cooperate and become providers of integrated aged care services.

Commissioner Briggs, in particular, you will recall the evidence from Broome and Darwin where the Royal Commission heard from community-controlled health organisations, and I'm thinking particularly the evidence in Darwin, which are well placed to expand into the provision of aged care services and in some cases are already doing that, albeit on a less formal basis than perhaps is anticipated.

Thirdly, that there be regional service delivery models that promote integrated care and they're deployed wherever possible; fourthly, that there be a focus on providing services within or close to Aboriginal and Torres Strait Islander populations while maximising opportunities for people to remain on and maintain connection with their country and communities.

Fifthly, that aged care is available and providers engage at the local aged care planning regional level on the basis of objectively established need that is determined in consultation with Aboriginal and Torres Strait Islander populations and communities.

Finally, (f), that Aboriginal and Torres Strait Islander people are given access to interpreters on at least the same basis as members of culturally and linguistically diverse communities when seeking or obtaining aged care. And once again, Commissioner Briggs, you will recall the evidence in Darwin that that is certainly not uniformly the case, strikingly so the evidence was.

We submit at paragraph 558 that the new comprehensive inclusive and responsive national system of aged care must incorporate particular service arrangements to meet the particular aged care needs of Aboriginal and Torres Strait Islander people now and in the future.

An important feature of the new aged care institutional framework that we submit ought to be instituted as part of the aged care commission, Australian Aged Care Commission, which my learned friend Mr Gray made reference to earlier, is that there be one commissioner with specific oversight of Aboriginal and Torres Strait Islander aged care. This is Recommendation 33, which you can find on page 176, immediately under paragraph 569.

We submit that there should be a statutory role within the Aged Care Commission that involves the ongoing fostering, promotion and development of culturally safe,

tailored and flexible aged care services for Aboriginal and Torres Strait Islander people and we submit the person appointed to this role should themselves be an Aboriginal or Torres Strait Islander person.

5 In advance of the formal establishment of the commission, which we submit ought to occur on 1 July 2023, there should be a person appointed under the interim administrative arrangements by 31 December 2021 to perform the same functions.

We note at paragraphs 570 through to 576 a range of functions, important functions
10 which we consider should be performed by the Aboriginal and Torres Strait Islander Commissioner that is appointed within the Aged Care Commission. I won't go through each of those now. But you can see, for example, in paragraph 574 that we submit a principal focus of the role is to be identifying unmet need, and identifying strategies to meet that need and providing direction to the Commission in resource
15 allocation and program delivery. We would see the role as being a very collaborative and cooperative one with Aboriginal and Torres Strait Islander populations, communities and community health organisations about the types of aged services that they require and that can be provided. As we say, consultation and co-design are crucial to the success of this work.
20
We also submit that the role should be responsible for gathering data and providing information to the independent Aged Care Pricing Authority about the real cost of delivering aged care to Aboriginal and Torres Strait Islander people around Australia and referring there to the real cost, we would anticipate there being appropriate
25 regard in costing for cultural requirements such as returning to country in appropriate circumstances.

We accept, of course, that there can be a considerable cost associated with such aspects of cultural requirements and expectations but they're costs that need to be
30 borne as part of the search for high-quality aged care. High-quality aged care has got to mean something for each diverse group for whom it is provided otherwise it becomes meaningless.

We list in paragraph 576 a range of other responsibilities which we envisage the
35 Commission being responsible for including the very important role of facilitating the transitioning of providers who are currently outside the *Aged Care Act* to become registered and approved under the new national system. Encouraging more Aboriginal and Torres Strait Islander organisations to become approved providers, developing cultural safety training and assessment, a topic which I will return to in a
40 moment, and providing assistance to Aboriginal and Torres Strait Islander providers about technical, clinical, and clinical governance in particular, a topic that I will return to in a moment, as well as developing workforce programs, which I will also return to.

45 Recommendation 34 is the next recommendation that I want to make reference to, which you will find on page 179, immediately under paragraph 579 and we note there that from 1 July 2022 the Government, and from 1 July 2023, the Aged Care

Commission, should require all of its employees who are involved in the aged care system and any care finders who are not its employees to undertake regular training about cultural safety and trauma-informed service delivery care. We think that is a very important part of addressing the needs that we have identified in a practical
5 sense on a day-to-day basis.

We also submit that the Government and, in due course, the Commission, should require all aged care providers which promote their services to Aboriginal and Torres Strait Islander people to train their own staff in cultural safety and trauma-informed
10 care and to demonstrate to the Commission that they have reached an advanced stage of implementation of the Aboriginal and Torres Strait Islander Action Plan under the Diversity Framework to which Mr Gray made reference earlier.

In addition, the care finder workforce that reference has been made to that is serving
15 Aboriginal and Torres Strait Islander communities should be made up of local Aboriginal and Torres Strait Islander people who are culturally trained and familiar with existing Aboriginal and Torres Strait Islander service providers and importantly, who are trusted by the communities that they are serving.

20 We make references in (b) and (c) to the importance of ensuring all people associated with the aged care system who are coming into contact with Aboriginal and Torres Strait Islander people to be informed and appropriately trained and knowledgeable.

We note at paragraph 580 the references in the Interim Report to the importance of
25 cultural safety and we note the submission received from the National Aboriginal Community Control Health Organisation that cultural safety must be both the starting point and central to any aged care offerings to our people.

I made reference earlier to the transition from the NATSIFACP program into the,
30 what I might call the mainstream aged care service delivery program, and we address that in a number of ways. Firstly, Recommendation 35, which is on page 181 of the submissions. The recommendation is concerned with prioritising Aboriginal and Torres Strait Islander organisations as aged care providers and recommends that the Government should assist Aboriginal and Torres Strait Islander organisations to
35 expand into aged care service delivery and in so doing, at 35.2, we accept that a degree of flexibility in the approval and perhaps the regulation process of aged care providers may be necessary to ensure that existing providers are not disadvantaged but also to ensure that high quality and safe aged care is still being provided whilst that assistance is rendered. There's a balance to be struck there between flexibility
40 necessary to provide that assistance and the strictness, if you like, of ensuring that standards are maintained.

We would submit that that's another area that the Aboriginal and Torres Strait Islander Commissioner would be well placed to ascertain where the balance is to be
45 struck in a cooperative way.

The sort of flexible mechanisms we have in mind, or examples listed in 35.3, such as

additional time to meet new requirements, alternative means of demonstrating the necessary capability and possibly, in very limited cases, exemptions. Assistance ought to be practical as well. It ought to involve financial assistance for capacity building in appropriate cases.

Some of the additional requirements particularly in the area of governance will be the subject of submissions later this afternoon and they're the sorts of additional obligations that we have in mind.

I've made reference already to the role the Aboriginal and Torres Strait Islander Commissioner could be expected to play in relation to workforce development. This is a very important area of the evidence that's emerged, particularly the evidence that we heard in Broome, but also the evidence from the hearings in Darwin which we've sought to summarise at paragraph 596 of our submissions. The evidence that we heard, which was to the effect that best practice provision of Aboriginal and Torres Strait Islander aged care involves a preponderance of Aboriginal and Torres Strait Islander care workers delivering that care and we've referred to some of the evidence there which included that 80 per cent of the staff at Star of the Sea on Thursday Island are recruited locally including the service manager. 95 per cent of staff, as we've referred to delivering Aboriginal community care in South Australia are local and the third is the evidence from the Kimberly where 90 per cent of workers and coordinators in remote locations are Aboriginal people from the communities where they work, and the fourth example was also from Darwin of the remarkable work that is done by the Purple House organisation in the Northern Territory where, once again, 80 per cent of the staff are Aboriginal and Torres Strait Islander people.

Having said that, it's acknowledged that there are significant barriers that work against greater Aboriginal and Torres Strait Islander employment in the sector. We've identified some of those at paragraph 597 of our submissions and it's accepted that this is a particularly challenging area that requires practical assistance from government. We've made reference to the report by the Aged Care Workforce Taskforce which I will refer to in a bit more detail in the context of the workforce submissions, but there were some references in that report to this particular issue in the context of a government workforce, particularly the assessing workforce and the My Aged Care workforce consisting of more Aboriginal and Torres Strait Islander people. What we're primarily referring to in the submissions at this point, though, is the direct care workforce and what can be done to promote opportunities in the direct care, aged care workforce for Aboriginal people.

Commissioner Briggs and Commissioner Pagone have heard me refer to the evidence of Sharai Johnson before in Darwin who spoke to us in such glowing terms about her --- the joy, the passion that she had for the aged care work that she was able to do and one couldn't help but be struck by the references she made to serving the community and how that was so important to her. If there was a way of bottling that passion, then that's something that one would like to see expanded as much as possible. But there are, one would think, great opportunities to do this with some assistance and we have suggested in Recommendation 36, if I can take you back to

that on page 183, that there be a comprehensive national Aboriginal and Torres Strait Islander workforce plan developed. We see this as being a compellingly important bit of work that needs to be done in consultation with the National Advisory Group for Aboriginal and Torres Strait Islander aged care. We identify some practical ways in which such a workforce plan could assist to promote aged care work as a desirable career opportunity particularly for younger people in the Aboriginal and Torres Strait Islander community.

We address the question of funding in relation to Aboriginal and Torres Strait Islander aged care at Recommendation 37 which is on page 187 of the written document, and we submit that a recommendation for block funding of providers on a three to seven-year rolling assessment basis be in place. We note at paragraph 605 that establishing the infrastructure and the operation of an aged care facility in a remote location is something that is very challenging. We note some of the evidence that has been given in the Royal Commission to that effect. We submit that one of the ways in which the sorts of challenges that arise can be tackled is to fund operations on the rolling basis that we submit in Recommendation 37.

We submit at paragraph 608 that a more direct way to tackle the issue is through block funding that covers the actual cost to provide culturally safe and high-quality aged care services and submit that the Aged Care Pricing Authority should set prices for the provision of care in such circumstances following advice from the Aged Care Commissioner that we've referred to earlier. And that's noted at paragraph 610.

Finally, Commissioners, I refer to Recommendation 38 which you will find on page 188, and here we refer to the evidence that has been given about the difficulties, particularly smaller providers experience, this is at paragraph 609 of our submissions, and the importance of funding being provided at an adequate level to overcome the challenges that are there identified.

Recommendation 38 is that under the Aboriginal and Torres Strait Islander aged care services arrangements that we've referred to, the Government and subsequently the Commission, should provide flexible grant funding streams that are able to be pulled for home and community care and for residential and respite care including transition and in addition, should establish funding streams that allow Aboriginal and Torres Strait Islander aged care service arrangements to apply for funding for capital development and provider development.

We propose five particular funding streams at paragraph 611, and we - I won't go through each of those in detail but each of them is an aspect that we consider is important and is supported by the evidence that we summarise at paragraph 613.

We make particular reference to the importance of the retaining connection to country stream that is one of the funding streams that we have identified.

Commissioners, they're the submissions that I would seek to put before you in relation to part 3.5 of our submissions and I will now go onto address you in relation

to the aged care workforce which is set out at part 3.6 of the document, which commences at page 190.

Commissioners, in the Interim Report, there were a number of conclusions, in fact a whole section devoted to the aged care workforce and more recently, in the special report that you published in relation to the COVID-19 experience of the aged care sector, you noted that the workforce which had been described as being under strain in your Interim Report is now also traumatised, was the word that you used in the COVID-19 Report, and that was clearly reflected in the evidence that was heard during that hearing, both from aged care workers and particular from unions who were representing those aged care workers.

That is no doubt the case, but as I've emphasised both in the submissions I made after the Melbourne 3 Hearing and also in the submissions I made earlier this year on behalf of the Counsel Assisting team in February about the workforce, I think we may have lost Commissioner Briggs.

Can you hear me, Commissioner Briggs? Yes, sorry, it's just this screen.

As I've sought to emphasise, for every story the Royal Commission has heard about the challenges faced by the workforce and the difficulties associated with attracting workers to the aged care sector, it's been balanced by some remarkable stories of the dedication and commitment of aged care workers and we refer to two of them in the submissions that we make which I would just like to refer to briefly, both arising from the terrible challenge that the aged care sector has faced in responding to the pandemic this year. These are dealt with at paragraph 621 and onwards in the submissions.

We note there that whilst the COVID outbreak has revealed the structural weaknesses in the aged care workforce, it's also thrown up a number of inspirational stories of the dedication of aged care workers. There are many such stories but two seem worthy of brief mention.

The first was evidence that was given in the COVID Hearing by Dr Judd, the former Chief Executive Officer of Hammond Care, and he told of a home care staff worker working for Hammond Care whose car had broken down whilst driving to see a home care client who was palliative, and he explained that the worker concerned knew the roster was very tight and therefore walked the 7 or 8 kilometres which meant she was able to provide the care to that client. He described that as being one of the remarkable stories that had emerged and that had been used to maintain the enthusiasm and the commitment of the care workers during that period.

The other story was one that received some media attention just in September of this year, and it was a story of a Perth-based nurse who volunteered to come to Melbourne at the height of the crisis in aged care homes in this city in early September and contracted the virus herself whilst working at an aged care home and had to be repatriated back to Perth.

There are, of course, many other stories but they illustrate the remarkable resource that the aged care sector has in its workforce and for all the challenges and all the difficulties associated with it, nurturing that resource, making the aged care sector one that not only attracts workers but retains them remains one of the greatest challenges, not just for the sector, but for the entire system, and also for this Royal Commission.

Paragraph (j) of the Terms of Reference makes specific reference to what is called the critical role of the aged care workforce in delivering high-quality person-centred care and we note at paragraph 617 that we have made detailed submissions on this topic to you earlier this year, submissions that included 11 proposed recommendations about improving both the size and the quality of the workforce.

We note at 618 that in response to the request for responding submissions to those, the Royal Commission received 22 submissions in reply from bodies as varied as the Aged Care Workforce Industry Council, the Australian Physiotherapy Association and South-West TAFE. As has been the case with all the submissions received by the Royal Commission in response to calls, they have been thought provoking and they have caused the Counsel Assisting team and those assisting us to reflect on some of the proposed recommendations that were contained in our February submissions.

In addition, at the Adelaide Hearing 3 where we made those submissions, we identified a few areas where more work needed to be done internally before we were in a position to make concrete suggestions about recommendations that the Commissioners should make, and particularly we noted the need for more work on the home care workforce, and more work to examine ways in which remuneration levels could be improved. And we are able to report that a great deal of further work has been done in those areas. That work has included, and we list this at paragraph 619, a very helpful round table with a group of industrial relations experts, which was held in February, some further one-on-one consultations that have taken place with experts such as Professor Andrew Stewart of the University of Adelaide and Professor Kathy Eagar and her team at the University of Wollongong and of course a public hearing that examined home care in general with particular reference to the home care workforce, in September.

We also note that the COVID-19 Hearing in Sydney in August raised a number of issues about the aged care workforce and we have drawn on that evidence in preparing these submissions.

Commissioners, we make the submission at paragraph 625 that the sort of dedication and commitment that is exemplified by the two stories that I related a moment ago, by aged care workers to those for whom they provide care, must be properly recognised and rewarded. We note that the vast majority of the aged care workforce are women and the low pay they receive we submit is nothing less than the aged care system exploiting the goodness of their hearts.

As we said in February, aged care workers don't need to be told they're heroes. What they need is a practical recognition of the value of their work. They need better wages and conditions and they need to have enough colleagues so that they can complete their work safely and to the standard that they consider appropriate.

We submit that that's how their work can be properly respected and acknowledged.

Unless we indicate in these submissions that we want to depart from something we submitted to you in February, we maintain the submissions that we made then.

We note that international research, which we refer to at paragraph 627, identifies four drivers of aged care quality. These are not intended to be exclusive of other matters, but they do arise again and again in the research. That is the number of staff, the mix of staff including the number of nurses and allied health workers, staff continuity, and clinical governance are features of the drivers of quality in aged care.

We submit, as we did in February, that the Australian Government must exercise a leadership role in planning for the future needs of the aged care workforce. There's one of those areas that my learned friend Mr Gray referred to earlier where there is a need for more direct involvement in the administration of the aged care system. We submit that the sector, despite the best of intentions through organisations like the Aged Care Workforce Industry Council has not been able to play that planning role for the future needs of the aged care workforce. We note that there was a time frame of one to three years that was proposed for completion of the strategic actions in the Aged Care Workforce Strategy Taskforce report and whilst progress has been made in a number of areas, particularly in the question of remuneration levels, which I will come to presently, there is a great deal more that is needed and that can be done.

The submissions I want to make on behalf of the Counsel Assisting team in relation to the workforce can be divide under five headings. The first topic I will address you on is institutional arrangements and the changes that we propose there. Secondly, we make some submissions about increasing wages and improving conditions and what can be done in a practical sense to address those concerns. The third topic concerns improving skills and training requirements, and we have a suite of recommendations that we make in relation to that topic. The fourth topic concerns minimum staff time in residential aged care, a matter that we made some submissions about back in February and that we have refined and I want to draw your attention to the refinements that we would seek to make in that regard. And finally, we make some submissions about the home care workforce and particularly the question of the registration of personal care workers, where there are aspects of that that had not been addressed in the February submissions.

If I can start with the institutional arrangements question, we think that there is the need for some important changes to be made to the institutional arrangements that are particularly concerned with the workforce. There's two parts to this, in Recommendations 39 and 40.

If I can start with the existing body, the Aged Care Workforce Industry Council. I've already referred to that and you heard evidence from Mr McCoy, who was the Acting Chair of that Council, at Melbourne 3 Hearing, and you also heard from another
5 member of the Council who gave evidence in Melbourne 3.

We note at paragraph 628 that the Council should, in our submission, be reconstituted and properly resourced. Commissioner Briggs, you earlier noted that the years ahead are going to be years of change for the aged care sector through the
10 implementation of this Royal Commission's reports, and we consider this as one area where a modification of an existing body is preferable to throwing it out, starting again.

The principal changes that we submit ought to be made to the Aged Care Workforce
15 Council are, firstly, there needs to be Government representation on the Council. You will recall the evidence you heard in Melbourne 3 about the difficulties that the Council seemed to be experiencing even getting a member of the Government to attend the meetings. We think that that's a most unfortunate state of affairs when there should be shared interest between the Government and a body like that
20 representing the sector and so we submit that not only should there be Government representation on the Council, but as we say in Recommendation 40, on page 194, the Government representative should assume the role of chair.

That shouldn't be imposed on the Council, it should be the subject of discussions, but
25 we submit the other way in which the make-up of the council ought to be changed is that there ought to be greater representation of the workforce and representatives of the workforce. At the moment there is one member out of 10 who represents the workforce. That person is the strategic stakeholder management coordinator of the United Workers Union which represents personal care workers. There's no
30 representations of the thousands of nurses who work in aged care nor are allied health professionals represented on the council.

Having said that, one union representative on that council is an improvement on the situation with the Taskforce that led to the Council where of the 13 members, not one
35 was a representative of a trade union or any worker organisation, professional organisation. We submit that it's counter-productive to exclude worker representatives, or not to include, rather, worker representatives on bodies like this that are concerned to improve terms and conditions and the working life of the people that are represented by the people of those unions.
40
So that's the first institutional change that we recommend in Recommendation 40.

Recommendation 39 concerns a new body devoted to aged care workforce planning. This is page 193 of the document. We submit that the Government should establish
45 an aged care workforce planning division by 1 January 2022 and when the Aged Care Commission is established, that division should transfer into the Aged Care Commission answering to one of the Assistant Commissioners who should have

responsibility for workforce development.

We recommend that the body should be responsible for developing workforce strategies for the aged care sector through the four matters that we identify in Recommendation 39: long-term workforce modelling; consultation with the providers of education and training for health professionals and personal care workers; ensuring an appropriate distribution of health professionals and care workers to meet the needs of populations across the aged care sector, particularly in regional, rural and remote Australia; and workforce planning through modelling and shaping the role of immigration and changes to visa arrangements as a workforce strategy to address aged care workforce needs.

Commissioners, for all the problems that have been thrown up by this year's experience of COVID-19, there are also opportunities, one of which is that is the challenge of matching high rates of unemployment which now exist in particular areas of Australia with the need to increase the size of the aged care workforce. It ought not be beyond us as a country to be able to match those two and it would be a very tangible way of giving effect to the Australian Government's commitments to rebuilding the Australian economy and creating workforce opportunities and particularly creating workforce opportunities for people to work in that caring workforce.

We see the two bodies as working together, one as a sector representative body, the other as a government body. We identified a number of areas, which I will come to presently, where we think cooperative work between those two organisations can achieve tangible improvements for the aged care workforce and the sector generally.

The second topic I'd like to come to, Commissioners, is at paragraph 633. This is: how can wages for aged care workers be increased and working conditions improved? We readily accept that this is a very challenging topic. There is a high degree of unanimity that aged care workers are underpaid, both in terms of the value of the work that they do to the community, and also relative to other comparable sectors like the acute health sector. Once again, this Royal Commission is not the first time that those observations have been made. Numerous inquiries both that have looked specifically at the aged care workforce and have considered the aged care sector generally have recognised this as one of the major challenges to attracting the greater numbers of workers that are needed to meet future demand for aged care.

We note in paragraph 633 that there have been several failed attempts that are referred to in the evidence before the Royal Commission where governments have provided additional funds to providers in the hope that they would be passed onto aged care workers by way of increased wages and you will recall the evidence of Mr Gilbert from the ANMF who detailed, from recollection, three occasions in his working life where that had occurred.

We've also, of course, seen something in the order of $1.5 billion provided just this year of additional funds to the aged care sector, as recorded in your COVID-19

special report. But without a great deal of accountability as to exactly how that money is to be spent and whilst no doubt some of it has found its way to the workforce, there is really no way of knowing that for certain. We think that's a most unfortunate state of affairs and it just leaves open the criticism that this is untagged money and there's a lack of accountability.

Ultimately, Commissioners, we've concluded that merely increasing subsidies without more is unlikely to translate to higher wages and unless aged care workers have a legal right to be paid more, then they won't be.

We note that the Aged Care Taskforce report saw this as being principally a role for industry to develop a strategy to support the transition of personal care workers and nurses to pay rates that better reflect their value and contribution to delivering care outcomes, I am reading from paragraph 634 of the submissions, and that strategy was to be achieved or executed within one to three years.

We note at 635 that apart from wage increases that have flowed from some annual award reviews by the Fair Work Commission and some other minor improvements to penalty rates that have resulted from the work of the Fair Work Commission, there has been no discernible increase in aged care wages in the 2.5 years since the Taskforce report was published.

We've concluded, therefore, that the proposal that an industry-led process would lead to substantial increases in aged care workforce wage rates has failed and we submit that it's unlikely to succeed in the foreseeable future.

We submit at 636 that a new approach is needed, an approach that will only succeed if all parties, providers, unions and government work together. There are three parts to our proposed recommendations, and I will summarise those and draw your attention to where you can find more detail in the submissions.

The first is a work value case by the Fair Work Commission which will examine terms and conditions in the relevant awards and if the case succeeds, then that will increase the wages of personal care workers and nurses in both residential and home care.

The second limb of the recommendations we make relates to the aged care funding system which Mr Gray will detail in submissions that we make tomorrow, we submit that there needs to be an explicit policy objective associated with ascertaining the actual cost of the provision of high-quality aged care that factors in the need over time to increase wages as an explicit policy.

And the third aspect of the prescription is a more short-term proposal, that is that as part of the annual wage review under the relevant awards, which takes place by an expert committee at the Fair Work Commission, that both the Government and provider representative bodies should support increases to award rates pending the finalisation of the work value case that we propose.

The work value case is under the *Fair Work Act*. We deal with it in Recommendation 41 on page 197 of our submissions. We note that the Fair Work Commission is empowered to make a determination varying modern award minimum wages where it's satisfied the variation is justified by work value reasons and such a determination outside of the system of annual wage reviews is necessary to achieve the modern award's objective. The key phrase there is "work value reasons" which is defined in the Act, I'm reading from paragraph 639 of the document:

> *work value reasons are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:*
> *(a) the nature of the work;*
> *(b) the level of skill or responsibility involved in doing the work;*
> *(c) the conditions under which work is done.*

And we make some references to some other cases that touch upon this issue in the Fair Work Commission in our submissions, and we note the evidence before the Royal Commission from Professor Stewart, that I referred to earlier, who is, if not the pre-eminent labour law expert in Australia, he's certainly in the upper echelons, he provided to us a detailed witness statement but he also gave evidence at the Home Care Hearing in which he analyses the history of work value cases and he notes that under present law, undervaluation of the work itself rather than the need to demonstrate some particular change in the nature of the work, may suffice for this purpose, and we submit at paragraph 643 that this is a matter that should be tested.

We note at 644 that a work value case can be initiated by the Fair Work Commission itself of its own initiative, or alternatively, it can be the subject of an application by a union representing workers in a particular industry, or for that matter, an employer. We submit that because, ultimately, the Fair Work Commission has to be convinced on the evidence that it's necessary to increase award wages, that the aged care unions ought to be the drivers of any such application.

We submit, though, in line with the evidence of Professor Stewart and the other evidence before the Royal Commission, that the best chance of success for such an application will be if it is supported by the employers, the providers, and also by the Government and so we submit there ought to be a collaborative approach as set out in Recommendation 41.

We note in paragraph 646 that success will not necessarily be easy. If this was easy we wouldn't be making submissions about the way in which it can be achieved. There is evidence before the Royal Commission from at least one union official, Ms Smith, of United Voice that it is extremely difficult to make substantial changes to awards. But as we submit, at paragraph 647, the case has to be well argued and has to be convincing and we note that there have been significant improvements achieved in wages of workers in the social and community services area under an

equal remuneration case. We made some lengthy submissions about this in the submissions we made earlier this year and that could point the way to possible success.

5 Many of the workers, particularly nurses, who work in the aged care sector, have their wages governed by enterprise agreements, they're not award reliant, as the expression is used. Nonetheless, we submit that because of a mechanism in the *Fair Work Act* which states that if an award wage is higher than a wage in an enterprise agreement, then the wage in the award automatically applies. Many of the enterprise
10 agreements in the aged care sector provide workers with wages that are marginally higher than the award and therefore if there was to be even a marginal increase in the award rates it could mean that the award rate would effectively leapfrog the enterprise agreements. So in our submission, it's an avenue that is potentially available to increase wages.
15
Having said all that, obviously it will be a discretionary decision ultimately for the Fair Work Commission. But the evidence that is before this Royal Commission is certainly supportive of the proposition that aged care work is undervalued and the award rates are too low.
20
We would see the reconstituted Aged Care Workforce Council as potentially playing an important role in this.

The second limb of our proposals to improve remuneration for aged care
25 workers --- and sorry, just before I go onto that, this is one area where we would welcome any submissions, particularly from aged care unions and employers and the Government, about the proposal that we are making.

If I go onto the second limb, it's in Recommendation 42 and it's about linkages
30 between the determination of appropriate prices for the subsidies that flow to providers to deliver high-quality aged care and a policy of increasing wages and improving conditions. And we note the evidence of Mr Downey, the Chief Executive Officer of the Independent Hospital Pricing Authority at paragraph 656, which was, and I quote, "If there was a clear policy initiative to increase aged care
35 wages by a defined quantum, then a case-mix funding model could be adjusted prospectively to ensure wage increases are accounted for in the price paid by the Government for aged care services".

So we think that's an important aspect of this, it may be of particular importance for
40 the home care workforce where, for example, the evidence is that home care workers are regularly not paid appropriately for their travel time and, in our submission, that is a matter that ought to be factored in appropriately into any future pricing of the provision of high-quality home care. And I don't need to say any more about the third proposal which we deal with at paragraph 658.
45
The third topic I want to address you on concerns skills gaps and this appears above paragraph 659 of our submissions. We look back to the submissions we made in

February. We noted the challenges of attracting people to work in aged care and we noted that the Royal Commissioners have the opportunity to set the policy parameters to ensure that aged care workers get the training and support they need to have a fulfilling career. We see all of these topics as being related, wages, skills development and minimum numbers which I will come to presently.

We make a number of proposals for recommendations in relation to the improvement of skills of the aged care workforce. They are all found on page 205 of the written document. I will take you through those briefly.

The first calls for a recently constituted body as part of the reform of the VET sector, the human services skills organisation, to conduct a review of the specialist aged care certificate III and IV courses and also to commence an annual cycle of review of the content of the certificate III and IV courses and to consider if any additional units of competency should be included. And we have recorded at paragraph 668 of the submissions, a range of areas which could be considered by that organisation in its review of the certificates, including trauma-informed care, mental health, wound care, oral health, physical health status, palliative care, falls prevention and so on. I won't read all of them but there are --- the evidence has thrown up a number of important areas where there is a need for skills development in relation to the qualifications particularly for personal care workers.

The second recommendation, number 44, on the same page, concerns two areas that have featured again and again in the evidence, that is dementia and palliative care training. We have ultimately concluded that the two areas, and we make this point elsewhere in the submissions, ought to be both core business, particularly the residential aged care sector, and to that end, we submit the Government should implement, by 1 July 2022, as a condition of approval or continued approval of aged care providers that all staff engaged by providers who are involved in direct contact with people seeking or receiving services in the aged care system, undertake regular approved training in those two areas. We think they're important enough areas to require mandatory ongoing quality training to be provided to that category of aged care workers and to make that a condition of ongoing approval for providers.

The third of that suite of recommendations concerned with skills gaps is Recommendation 45 and this recommendation picks up the evidence that we've heard in the Royal Commission about health professionals and the need for improvement in skills of a range of health professions, not just nursing and medicine but audiology, optometry, physiotherapy, psychology and so on. Once again, I won't read them all out but they're in Recommendation 45.1. And what we are proposing is that the National Boards, professional associations or accreditation bodies for each of those professions should review the existing course accreditation standards to ensure that professional entry qualifications for each of those professions appropriately addresses age-related conditions and illnesses including dementia and the evidence that Associate Professor Macfarlane gave, once again comes to mind at the Sydney 1 Hearing where he made the point that there's a lack of dementia awareness and knowledge all the way from personal care workers right through to

the medical profession and in between, and that's one of the areas that we are seeking to address in Recommendation 45.

Commissioners, at paragraph 670, we note that each of the recommendations that I've just identified, 43 to 45, will take some time to be implemented. However, the evidence suggests that there is an urgent need for skills acquisition amongst aged care workers and as for food and nutrition that I referred to earlier, we're proposing an immediate injection of funds into the sector for education and training. It's in Recommendation 84, which I won't take you to now because Mr Gray will address it as part of the funding recommendations tomorrow. But what is intended is that there be a scheme under which providers will be reimbursed for the cost of education and training of their direct care employed workforce for a two-year period in the lead up to the implementation of the Aged Care Pricing Authority's work.

We see that as being an important way in which the sector can contribute to skills development of aged care workers knowing that there will be reimbursement for both the direct and indirect costs associated with doing that and what's envisaged is an application process for access to those funds.

Commissioners, the last aspect of this skills development recommendations that I draw your attention to starts at paragraph 671 of the submissions and builds on the evidence in the workshop that was held in Adelaide earlier this year, back in March, where you may recall you heard from a number of people from the Wicking Centre in Hobart and also Dr Barnett who had been involved in a program called TRACS, which stands for Teaching and Aged Care Services which ran in Australia from 2012 to 2016.

The evidence that Dr Gilbert in particular gave was that the TRACS program was based on the teaching nursing home model which operates in some Scandinavian countries as well as the United States and Canada. The teaching nursing home program is in turn based on the concept of a teaching hospital and is predicated on the idea that particular residential aged care or home care providers can become centres of excellence for placements by students, nurses and allied health workers, and personal care workers, who, through having a positive placement experience, might then become enthusiastic about the idea of pursuing a career in the aged care sector.

I'm probably overdoing the references to Associate Professor Macfarlane but one more comes to mind and we deal with it at paragraph 673 where he memorably explained how he came to be working in aged care and his evidence was that he didn't enter medical school with any burning ambition to become a geriatric psychiatrist and had no interest in it until he did a rotation in aged psychiatry during his training. As he said it, he fell in love with it as a result of that experience and he made the point that if there were more opportunities for exposure to aged care for trainee nurses, then that would have a flow-on effect for recruiting passionate, qualified nurses into the sector. And we submit at paragraph 673 that that evidence was inspiring and it shows how important quality placements are to encourage

interest in aged care on the part of students.

We detail in our submissions from 675 through to 677 the evaluation of the TRACS program, which is a detailed report, that is in evidence before the Royal Commission, and we submit that in accordance with the evidence you heard from Dr Barnett, that a reinvigorated TRACS program or program based on the TRACS idea, could be a very valuable contributor and we submit that the Government should commit to recurrent funding of such a program. It's one of the areas, like so many things in aged care, there was a pilot, that was evaluated, was seen to be doing well and then no further funding and that was the end of it. The impression one got from Dr Gilbert's evidence was that was all rather a shame.

Her evidence was that what she described as a hub and spokes model would be a good model to use, drawing, I think, on what they have in Norway, from memory. At paragraph 681 we explain the idea being that there are teaching aged care services on a regional basis, they're the hubs, and the hubs, in turn, mentor and support other services within the designated catchment area which are known as the spokes.

Engagement with universities and registered training organisations are vital for the reasons we set out in our submissions through to paragraph 687, and Recommendation 46 follows that and that's the recommendation about those matters.

The fourth topic I would seek to address you on in relation to the aged care workforce. I don't need to spend too much time on because, as you will recall, we made comprehensive submissions about mandated staffing ratios in our submissions in February of this year. I do need to indicate, though, that this is an area where the responding submissions made a number of observations about the proposal that had been put up which have led us to do quite a bit of work fine-tuning the proposal. We maintain a recommendation for minimum staff time in residential aged care. We submit that it ought to be a standard, the content of which should follow Recommendation 47 which you will find on page 211.

In summary, the modifications that we have made to the proposal that we included in our submissions in February will see staffing levels increase in a two-step process. So you will recall the evidence about the CMS star rating system for staffing levels, that remains the basis for our recommendation, and we recommend that from 1 July 2022 that staffing based on a three-star level ought to be the minimum standard for residential aged care providers, which would require there to be at least 215 minutes of care per resident per day, that's up from the current average which is 180 minutes, and of that, at least 36 minutes of time would be required to be provided by a registered nurse.

We also submit that there would be a mandatory requirement from 1 July 2022 for at least one registered nurse to be on-site in each residential aged care facility for the morning and afternoon shifts. That would be the requirement from 1 July 2022. And then two years later, on 1 July 2024, a staff standard based on a four-star requirement would be imposed which would see either 215 minutes of care per resident per day

with at least 44 minutes of that staff time provided by a registered nurse, or alternatively, 264 minutes of care per resident per day on average with at least 36 provided by a registered nurse. And in addition, from 1 July 2024, the standard would require at least one registered nurse on-site per residential aged care facility at
5 all times for all shifts.

We set out in further detail the linkages that are needed to the case mix adjusted activity based funding about which you will hear more in the submissions tomorrow.

10 And finally, in response to submissions made, including submissions made by the Australian Government in relation to the proposal that was included in our February submissions, we have included four categories of exemption that will be available to providers that either can't meet the staffing requirements or whose case mix means that, for example, a requirement to have a registered nurse on-site 24/7 is
15 unnecessary and in the second category we're thinking of the specialist providers like Wintringham, for example, with its homeless cohort where it might be more desirable to have more social workers, for example, than registered nurses. So we've provided that level of flexibility in exemption category A.

20 Exemption category B would be where the facility is co-located with a multi-purpose service where registered nurses are present at the co-located health service. And the third category is where regional, rural and remote facilities can demonstrate they've been unable to recruit sufficient number of staff with requisite skills.

25 We add the rider that any exemption granted from this standard ought to be time limited and there ought to be transparency associated with a provider having received an exemption. So someone ought to be able to ascertain that.

We've summarised the changes that we've made to the February proposal in our
30 submissions from paragraph 695 through to 699 and I should also draw your attention to paragraph 702. You will recall the two-step process, a three-star staffing by 1 July 2022 and four-star staffing by 1 July 2024. The principal beneficiaries of the first step will be residents in the more than half of facilities that currently have staffing levels that are below three stars. You will recall the evidence in the
35 University of Wollongong study which describes staffing levels of one and two stars as being unacceptable and residents in those facilities will see an increase in staffing on average of 37.3 per cent in that first, the first step of the recommendation. And the sector as a whole will see a staffing increase of 20 per cent across the board on 1 July 2022.
40

And at paragraph 703 we include similar figures based on the report from the University of Wollongong about the implications of moving to the four-star staffing level in 2024.

45 Those increases are obviously significant. They should have a significant impact on the ability of workers in facilities to provide high-quality aged care in line with the research that we referred to both in our submissions earlier this year and in these

submissions.

Finally, Commissioners, if I could refer briefly to the home care workforce, which you will see in the submissions starting at paragraph 705, and you will recall that in the submissions we made in February of this year, we noted that the home care workforce raises particular challenges, particularly because home care workers are often working alone without the support that might be available to them in a residential aged care setting. They work in a setting over which the providers that send them to work often have far less control than is the case in a residential aged care setting and, in addition, as you will hear in the submissions tomorrow about quality regulation, that the regulator itself often has limited visibility of the work that is being done by home care workers.

We include in our submissions some data about the home care workforce at paragraph 707 through to 710 and we address an issue that arose in the evidence in the Home Care Hearing in September of this year and that is this question of whether aged care workers that are directly employed rather than contractors or working through brokerage arrangements, such as those I described earlier today, whether there is an association between the mode of engagement, whether or not an aged care worker is an employee and the quality of care that they're able to provide. The submissions we made on this topic survey the evidence that was given both by Mr Scutt from Mable Technology and Ms Timmins, the head of service at Hireup, two organisations that provide workers, particularly in the disability area, but in the case of Mable also in the aged care setting, and we note particularly at paragraph 718, the evidence that was given by Ms Timmins from Hireup that the business model they have, under which they employ the workers rather than the Mable model where there's no employment relationship, Ms Timmins said, and I quote, that "That was a significant business decision because the duty of care that's created when you are an employment model can lead to higher quality support outcomes for people with disability." She said that Hireup wanted support workers to "feel part of our team and committed to those same quality outcomes", that's at paragraph 718.

That was supported by other evidence both from providers and also by an academic researcher, Dr Stanford, the director of the Centre of Future Work.

One of the propositions that was tested in the hearing was whether or not providers should be required to deliver a set percentage of their care hours through care workers that they employ directly and, in summary, there wasn't a lot of support for that proposal, for example, Professor Stewart referred to it as too arbitrary. However, he and other witnesses were generally supportive of the proposition that high-quality care is more likely to be delivered by aged care workers who are employed, all else being equal, than aged care workers who are not, because of the ability of the employer to give directions as to how the work is to be done which is, of course, at the heart of the employment relationship.

At paragraph 724, we submit, as the Counsel Assisting team, that we agree with that general proposition. That's what the evidence shows and we submit that it is, with

respect, correct, but we submit that a rule, even a general rule, trying to set an arbitrary percentage would be too difficult to enforce and too uncertain in practice. We submit that the best way to encourage approved providers and contractors engaged by approved providers to employ care workers rather than engage them through platforms is by means of the statutory general duty which we proposed earlier today in our submissions. Because providers will be required to comply with this duty, whether they directly employ care workers or not, we consider it's likely that over time providers will find it easier to comply with their obligations to provide high quality and safe care if they're legally able to direct the way in which the care work is performed. It will be easier to deliver a model of care through employed care workers than otherwise.

The final topic under workforce that I will briefly refer to concerns our proposal for a registration of personal care workers. You will recall we made those submissions back in February. There was overwhelming support for the proposition that personal care workers should be registered as part of a push to professionalise the personal care workforce and everything that that entails.

One topic that we were not in a position to make concrete submissions about at that time was who should administer any such registration scheme. You will recall we floated the proposition that the Australian Health Care Practitioner Regulation Agency, AHPRA, could be the body to do that but we indicated that further work needed to be done. That further work has been done by the staff of the Royal Commission and we are now in a position to submit to you that AHPRA is the right body to oversee the registration of personal care workers and we have set out in our submissions from paragraph 727 through to 741 how we consider the national law that AHPRA is constituted under is a suitable mechanism for a registration scheme for personal care workers.

We consider that there is some urgency associated with this initiative, and so we have indicated in Recommendation 48 that AHPRA should establish a National Board and registration scheme for personal care workers by 1 July 2022, that the practicality of that is something that we would welcome submissions on, including in particular from AHPRA.

And finally, Commissioners, Recommendation 49 repeats a recommendation we made in our February submissions that there should be a mandatory minimum qualification for personal care workers of a Certificate III and the National Board that we referred to a moment ago operating under the AHPRA scheme should, we submit, consider whether personal care workers working in home care unsupervised as they often are and perhaps with greater responsibilities than an equivalent care worker in a residential care setting should be required to have some higher certification, a Certificate IV, for example. We don't make that recommendation at this time, there isn't evidentiary basis that would justify it but it is a matter that we think should be considered and examined as part of the registration roll out that we've referred to.

Commissioners, they are the recommendations and submissions that we seek to make to you in relation to the aged care workforce and the next topic is informal carers on page 226 of the submissions.

5 Part 3.7, which if I can deal with fairly briefly, Commissioners. We note at paragraph 742 that the future aged care program should ensure that family and friends who provide care to older people are supported to look after their own health and wellbeing and the submissions we make in this part of the document are aimed at that.

10

The Terms of Reference the Royal Commission mandate inquiry into what can be done to strengthen the system of aged care services by the Australian Government, the aged care industry, families and the wider community as well as ensuring there's improved engagement with families and carers on care-related matters and the need 15 for close partnership with carers.

Commissioners, we note at paragraph 747 that the value of informal carers to the sustainability of the aged care system is difficult to overstate and yet their work is largely invisible. Whilst there are other ways to measure the value in economic 20 terms, the contribution of those providing unpaid care in Australia is enormous. The replacement value of unpaid care across the total carer population this year has been estimated at nearly $80 billion and whilst not all of that care is care that's provided to older Australians, we note the data at paragraph 748 that of the 861,000 primary carers from Australian Bureau of Statistics in 2018, nearly 50 per cent of them 25 provided care to people over the age of 65 and even those figures may understate the numbers because not everyone would identify themselves as a carer.

At paragraph 750, Commissioners, we note evidence that the current aged care system provides reactive, inadequate and piecemeal support to family and friends 30 and it only does so when the strain on a caring relationship reaches crisis point, that's often the case.

We ask what can be done to support informal carers and submit at paragraph 752 that a preventative approach which identified and values the role of informal carers is 35 required. An approach which having identified an informal carer then equips carers with skills at an early stage in their caring role. We submit this must be supported by access to regular and flexible high-quality respite services.

We note the evidence about the role played by, for example, the Mildura Carers’ Hub 40 and the HAC centre at Bidyandanga north of Broome and the evidence you heard about the support provided to carers through those facilities.

At paragraph 757, we submit that carers should be identified and appropriate supports put in place as part of the assessment process for an older person for access 45 to aged care services. We note the needs of a person receiving aged care will evolve as will the role of their family and friends. Not all informal care relationships may be readily apparent at the stage of initial investment but it's important that care

finders, to whom Mr Gray made reference to earlier today, have an ongoing role in relation to the identification of informal carers.

The first recommendation we make in this part of our submission is Recommendation 50, which will you find on page 229, informal carers and assisting them to receive support. And the recommendation is that the Australian Government, and from 1 July 2023 the Aged Care Commission, should improve services and support for informal carers by taking the steps identified in the recommendation on the dates. Firstly, linking the My Aged Care and Carer Gateway by 1 July 2022 to enable sharing of information. Secondly, on and from 1 July 2022 enabling direct referral and information sharing for informal carers between My Aged Care, care finders, assessment services and the carer gateway and providing accurate and up-to-date information on My Aged Care about supports. And then on 1 July 2023, requiring My Aged Care, care finders and assessment services to identify informal carers when assessing a person for aged care, and the other steps that we have identified.

Commissioners, the other part of this recommendation concerns volunteers, which we deal with at paragraph 758 of our submissions and we note that along with informal carers, volunteers are an integral part of the aged care system. Data reveals the majority of volunteers in residential facilities and in home care undertake social activity support assistance as well as planned group activity assistance and companionship, and we list other types of assistance provided by volunteers. One of the tragic consequences of the pandemic this year, as you recorded in your special report, has been the reduced access that volunteers have had to aged care facilities as part of the lockdown and the impact that has had on the quality of life for the overwhelming majority of residents that don't have the virus and may not necessarily be exposed to any high risk of it.

We note the census data from 2016, the National Aged Care Workforce Census, this is paragraph 759, that 83 per cent of residential facilities and 51 per cent of home care outlets utilise volunteer staff and the numbers which we set out in 760 that I won't take you to indicate the very significant contribution made by volunteers through organisations like Meals on Wheels Australia to the aged care system and its sustainability.

We submit that more needs to be done to encourage and support volunteers and to that end, we submit that Recommendation 51 ought to be made by you, which you will find on page 230 of the submissions, that the Government, and from 1 July 2023, the Aged Care Commission should promote volunteers and volunteering in aged care to support older people to live a meaningful and dignified life and supplement the support and care provided to them through the aged care system by taking the three steps that are identified there. Firstly, increasing funding to the volunteer grant under the families and communities program to support organisations and community groups to recruit, train and support volunteers. Secondly, requiring as a condition for approval of providers that there be a designated volunteer coordination role, and that there be induction training provided to volunteers. It's, of

course, highly likely that many providers are already doing that, perhaps not with that degree of formality but that will formalise that process and make it part of the mandatory requirements for approval.

And finally, governments should provide additional funding and expand the Community Visitor Scheme so that it be an Aged Care Volunteer Visitors Scheme to provide extended support for older people who are at risk of social isolation. And the submissions that we make in support of that recommendation are set out at paragraph 758 through to 766.

I should briefly make reference to the question of carers leave, which we address at paragraph 767 of our submissions, where we note that the National Employment Standards which set out minimum requirements for annual leave and other forms of leave do not enable an employee to take extended unpaid leave for the purpose of caring for an elderly family member or friend. There is evidence that that type of flexibility in work arrangements can relieve the impact of carer burden that we have referred to in our submissions.

There was evidence about this at Sydney Hearing 4. Ultimately we consider that the evidence before the Royal Commission doesn't support anything like a proposal for the *Fair Work Act* to be amended in a way to introduce even unpaid carers leave in the absence of any investigation of the consequences that that may have across the economy, and what we submit is that there ought to be an investigation. We don't put this as highly as a recommendation but we do raise it as a matter worthy of consideration and investigation into an amendment to part 2.2 of the *Fair Work Act* to provide for unpaid carers leave for an employee to care for an elderly family member or friend and we submit that any such investigation should examine the social and economic impacts of such an amendment and in particular the matters that we've set out at paragraph 770.

Commissioners, they're the submissions that we put before you in relation to the aged care workforce and, Commissioner Briggs, I see you have your hand up, I will pause, take a breath.

COMMISSIONER BRIGGS: Not to make it an interjection, counsel, but I'm wondering, Commissioner, that we've got a bit of trouble with the system at this end, is it possible to have a 5-minute break?

COMMISSIONER PAGONE: Sure, we'll adjourn for five minutes.

ADJOURNED **[3.33 PM]**

RESUMED **[3.39 PM]**

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN QC: Thank you, Commissioners.

5 Commissioners, the next and second-last topic for the day is provider governance which is part 3.8 of our submissions which you will find on page 235 of the document. As we say in the first paragraph, without good governance aged care providers are less likely to deliver high-quality care. Evidence before the Commission has shown that the level of substandard care is unacceptably high in the 10 aged care sector and it's improbable that if all aged care providers had good governance arrangements this level of substandard care would exist. Put that more positively, better governance will increase the prospect of more high quality care.

The evidence emphasises the need for aged care providers to have robust governance 15 arrangements focused on delivering safe and high-quality care.

We make proposals for three recommendations in this part of our submissions. Each of them has a number of subparagraphs within the recommendation that I will briefly take you to.

20

The first proposed recommendation is number 52, which you will find on page 237 of the submissions, and this is a proposal for the *Aged Care Act* to be amended to stipulate a number of governance requirements. Firstly, that the governing body of an approved provider providing personal care services must have a majority of 25 independent nonexecutive members, unless the provider is exempted from that requirement by the quality regulator. You will recall the evidence in the Hobart Hearing which supported the proposition that having a majority of independent non-executive members on a governing body of an approved provider was consistent with good governance principles.

30

Secondly, a requirement that the constitution of an approved provider must not authorise a member of the governing body to act other than in the best interests of the provider and this is relevant to the submissions we make about, at paragraph 786 of the submissions, about the application of the *Corporations Act* which under certain 35 circumstances a director may discharge their duty to act in the best interests of a wholly owned subsidiary by acting in the best interests of its holding company and we submit in the aged care setting that's an inappropriate provision because it could lead to a situation where a wholly owned subsidiary that is a provider, a board member of such a subsidiary could meet their obligations by acting in the best 40 interests of the holding company which may not have any responsibilities under aged care legislation itself.

The third aspect of Recommendation 52.1 would call for applicants for approval to provide aged care services to notify the quality regulator of their key personnel and 45 to notify any changes in their key personnel within ten business days of such change.

The submissions we make in support of that proposal are at paragraph 788 where we

submit that for the sake of transparency and accountability, the people responsible for governance and management of approved providers should be clearly identifiable. They should be identified to the regulator on an ongoing basis and as a matter of course. Presently, that is not a requirement.

5

We note there, and I won't go into detail about this now, the definition of key personnel in existing aged care legislation and prior to 2016 there was an obligation along the lines of the one we are proposing but it was removed by what was referred to as a "red tape reduction" measure at that time and we rely on the other submissions
10 that we make in relation to that part of the document.

The fifth requirement that we submit ought to be imposed is a fit and proper person test, that is a positive obligation to be a fit and proper person to be a member of the key personnel of an approved provider, rather than the negative disqualified
15 individual test which presently applies under which a person that fits certain categories is disqualified from being part of the key personnel. Those categories are set out at paragraph 798 of our submissions. We consider that to be a somewhat arbitrary test and we submit that a less rigid approach is needed under which key personnel would need to satisfy a test which is commonly found in legislation
20 dealing with eligibility into professions, for example, that hold positions of responsibility, and we note at paragraph 801 that the words have been construed as referring to honesty, knowledge and ability and that the words give the wider scope for judgment and, indeed, for rejection.

25 We don't see it as being necessary for the aged care regulator to consider these suitability matters for every member of the key personnel of every provider, rather, at paragraph 805, we submit the legislation should require a provider to exercise due diligence in gathering information about the existence or otherwise of suitability matters for each of its key personnel.

30

The other aspect in Recommendation 52.1 would see an obligation on a provider to provide an annual report to the Secretary of the Department of Health containing information which is to be made publicly available through My Aged Care and we detail in our submissions, in further detail at paragraphs 812 through 815, the types
35 of information that are anticipated would be included.

The next recommendation in this area is number 53, which appears on page 249 of the submissions. And this recommendation calls for a new governance standard to be developed. I made reference earlier, Commissioners, to the existing governance
40 standard which imposes minimal requirements on an aged care provider at present. We detail our submissions in support of the new governance standard starting at paragraph 824, and we make the point that ultimately this is really a matter for the specialist body that's been identified as having oversight under the new aged care system of aged care standards, that is the Australian Commission on Safety and
45 Quality in Health to be rename the Commission on Safety and Quality in Health and Aged Care and we note that one of the matters in the list, the urgent review list that was referred to earlier in the submissions that we made about quality and safety, is

for there to be a new governance standard.

As we note at paragraph 824, whether the Commission ultimately conducts a review and how it does so are ultimately matters for it to determine, but we do submit that based on the evidence that is before you, and I'm referring particularly to the evidence you heard in Hobart about provider governance and also the evidence about provider governance in the Darwin and Cairns Hearings, that any review that the Commission conducts should involve consideration of the matters that we've set out starting at paragraph 825 of our submissions. And I won't go through that. There's quite a bit of detail there in the submissions about the matters that any such governance standard should address.

One that is probably worthy of particular attention, because the new requirement is an attestation, annual attestation requirement, this is dealt with at paragraph 840 of our submissions. We submit that a new governance standard should include a requirement that a nominated member of a governing body of a provider attest annually on behalf of the members of the governing body that they have satisfied themselves that the provider has in place the structures, systems and processes to deliver safe and high-quality care and if such an attestation cannot be given, explain the inability to do so.

We note, based on the case study evidence, especially in Darwin and Cairns, that members of governing bodies are too often unaware or unresponsive to emerging and significant risks to the safety and wellbeing of older people receiving care from the provider and governing bodies should direct at least equal attention to their role and responsibilities in that regard as to the financial performance of the provider, for example, and we submit that an obligation to attest in the way that we have described is an important way of focusing the minds of those who are responsible for the operation of approved providers.

Finally, Commissioners, in this area we draw your attention to Recommendation 54 on page 255. We recognise at paragraph 846 that there is a very wide range of approved providers of aged care services. They range in size, expertise, resources, provider type. There are large approved providers, including for-profits. There are small providers operated by charities and some, particularly smaller providers, will struggle to implement good governance arrangements, in particular in regional and remote areas providers may face challenges in recruiting members for their governing bodies who have the right skills and experience to deliver effective governance.

We note at paragraph 847 that there is government funding available to providers to improve their operations, including governance arrangements. These initiatives play a valuable role and are welcome but they are limited either by the range of providers they target or the forms of assistance they fund. We submit the government should establish an ongoing program to provide assistance to approved providers to improve all aspects of their governance arrangements and that ongoing program ought to commence in the 2021/22 financial year and could have a particular focus on care

governance arrangements.

We make the submissions at paragraphs 846 to 852 in support of that. We note at paragraph 852 that there should be tailoring of assistance to particular circumstances.
5 We provide the example that the assistance could take the form of funding for an approved provider to engage an adviser for a certain period who would attend the service in person and offer practical guidance on the provider's governance processes. Such an adviser could be a person with equivalent skills to an eligible adviser appointed under the *Aged Care Quality and Safety Commission Act*.
10
Too often, as you've heard in the evidence, providers don't get access to such expertise until after a crisis. That's what prompts, and you've heard this time and again, that --- I'm thinking of the evidence in Hobart but also elsewhere --- where it is a crisis that precipitates the appointment of an adviser. We saw it recently with
15 Newmarch House in the COVID hearing. It shouldn't take that. It shouldn't take a crisis for the expertise to be available and provided. We would support a proactive approach to the provision of that sort of assistance and expertise knowing that it's out there, it's a matter of making it available and providing perhaps some funding assistance to get access to it.
20
Commissioners, the last topic that I will address today is ---

COMMISSIONER PAGONE: Mr Rozen, I think Commission Briggs ---

25 MR ROZEN QC: My apologies, Commissioner Briggs.

COMMISSIONER BRIGGS: That's fine. Thank you, counsel and Commissioner. These provider governance issues are extremely important and that's because one of the great challenges of the aged care system is that the Government doesn't run the
30 system nor deliver the services itself. That means that it doesn't have the same levers that direct service provision has to direct and control service delivery and care so that high-quality care is delivered.

This makes it much harder to deliver procedural change and bring about cultural
35 change in aged care.

The Government can regulate, it can set standards and it can change institutional arrangements but only those delivering the services can change the day-to-day approach to the delivery of care. That means providers and their employees doing
40 the right thing by older people and making sure that they receive high-quality care with a good quality of life.

As you say, counsel, the real value add comes from leadership and culture on the ground in every service. It's therefore important that in changing the aged care
45 system to one that puts people first, will also need to focus on provider leadership and provider culture. We will need to see providers championing the reforms we propose and will need each and every service to be discussing the changes and

working out what it can do to implement them successfully so that older people really are put first. I have no doubt that many staff in many services will want to do just that, counsel, but they need permission and support to do so from their leaders and managers.

I heard earlier on, counsel, that Senior Counsel Gray intends to recommend extra funding for training to assist this transformation. That's terrific. I'd like to see these changes embedded in workforce practice. So we need to see whether two years is sufficient to achieve that kind of outcome.

I also think we need to nudge providers along to take their leadership responsibilities more seriously and make them accountable for doing just that. I therefore suggest, counsel, that the Australian Government should, as part of its approval and certification of aged care services establish that boards have in place executive leadership arrangements that transform the culture and delivery of aged care services consistent with the objects and principles of the new Act, that they ensure employment arrangements for the executive and other senior managers include performance appraisal against the areas of leadership, team development and support for organisational culture, that they have in place professional leadership and management expertise, qualifications and capabilities consistent with the objects and principles of the Act, and that they have in place a staff enablement framework to support and manage staff training, professional development, continuous learning, career and educational pathways, staff engagement, feedback, and communications and, of course, team building. Thank you, counsel.

MR ROZEN QC: Thank you, Commissioner.

The final topic, Commissioners, that we would seek to address you on today is part 3.9 of the submissions on page 256, and it concerns the important and related areas of research and aged care data.

Commissioners, paragraph F of the Terms of Reference requires and authorises the Royal Commissioners to inquire into how best to deliver aged care services in a sustainable way including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure.

Throughout the Royal Commission, witnesses have given evidence about aspects of innovation and technology in aged care, most notably in Adelaide Workshop 2. The Commissioners have also commissioned and published research about innovation in aged care and we make reference to, for example, the work of Flinders University review of innovative models of aged care, a research paper published by the Royal Commission this year.

Research innovation and technology are interrelated but separate concepts. Research can provide an evidence base or highlight a need that might prompt innovation or the development of technology. Applied research can demonstrate the benefits or otherwise of innovation or technology. Research, innovation and technology require

further attention to ensure the continuous improvement of aged care into the future. Technology may address an identified problem but innovation may involve re-conceptualising the problem entirely and adopting new approaches.

5 In this part of our submissions, we address the role of research in delivering high quality and safe aged care services and the importance of quality data for aged care research. We also make submissions about the innovative role data and data collection technology should play in aged care delivery and regulation, building on the submissions we made to you during Adelaide Hearing 4.

10

I will deal with research first and then data. The attention that aged care research received by national research institutions is disproportionately low compared to the number of people accessing aged care services and the multitude of challenges facing the sector. There are structural limits in the way of researchers examining ageing

15 and there's a lack of funding for aged care research.

Having said that, Commissioners, it's apparent from the work of the Royal Commission and particularly the research that's been commissioned by the Royal Commission, that we're blessed with a number of academic and applied research and

20 development bodies that focus on aged care. I'm thinking of NARI and ROSA and the Caring Futures Institute and so on. We see scope for their efforts to be better coordinated and funded to build the capacity of researchers and their aged care sector partners and to provide the best outcomes for people who access aged care services. It's a cliche, but there's an opportunity to value add for the many organisations that

25 are already existing.

We submit that without significant investment in research and the development of a coherent and comprehensive evidence base, aged care policy will continue to be knee-jerk responses to try to solve problems when they become critical, and that's a

30 quote from a witness, Ms Kitson in the Adelaide Workshop earlier this year, but it's also a theme that flows through a lot of the evidence that problems in aged care get addressed when they become critical, rather than there being a more sort of coherent, proactive approach to management of the Sector and oversight of the Sector.

35 To contribute to a sustainable high quality and safe aged care system, we propose that a new aged care research council be established and that is our first recommendation that we make, Recommendation 55, which you will find on page 262 under paragraph 883. We submit the Government should establish and fund a dedicated aged care research council which should be responsible for the seven

40 functions that we identify as part of Recommendation 55.

Firstly, the Council should set the strategy and agenda for research and development into aged care and ageing-related health conditions. It should administer an aged care and ageing-related health conditions research fund with a significant annual

45 budget, funded by a special appropriation and set, we submit, at 1.8 per cent of the total government expenditure on aged care. It should conduct peer review of projects to determine funding allocations and, consistent with the evidence you heard in the

Adelaide workshop, prioritise research that involves co-design with older people, with their families and with the aged care workforce. We heard some examples of successful co-design in innovative research from Bolton Clark and from other providers.

It should facilitate networks between research bodies, academics, industry and government for research, technology pilots and innovation projects and assist with the translation of research into practice to improve aged care in Australia. It should work with existing bodies such as the Australian Research Council, the National Health and Medical Research Council and Health and Research networks to facilitate the sharing and application of research outcomes. And it should ensure research into ageing-related health conditions is high on the national research agenda to lift the profile of aged care research.

We refer in our submissions to a number of the specific areas. We deal with the importance of applied research from paragraph 870 through to 876. At 875, sorry, 874 and 875, we note the proposal that came out of the Aged Care Workforce Task force, sometimes referred to as the Pollaers Taskforce, for the establishment of a centre for growth and translational aged care research and we note the progress and that there are some pleasing commitments, both financial and by way of dates when certain things are to occur that have emerged in the three years since that recommendation was made, but as we say at paragraph 875, like so much in aged care, the progress of the establishment of this centre has been too slow.

We submit that an aged care research council with a broader focus as described in these submissions is needed to contribute to the delivery of high quality and safe care and if it's established in other recommendations we propose are adopted, then it will be unnecessary to proceed with a separate centre for growth and translational research.

Once again, we would welcome any submissions that interested parties wish to make about that and about whether there is a place for two such bodies or whether they are essentially doing much the same job of providing this coordination service and funding that we anticipate.

And we note, and are pleased to see, the Australian Government has recently indicated its support for the establishment of a body with responsibility for aged care research, that's as detailed in paragraph 876 of the submissions.

We make reference to the importance of co-design, which I've already referred to, and particularly to the importance of evaluation. This is at paragraph 881 of our submissions. We know that a large-scale review about innovative aged care models has revealed little work is done to evaluate this safety and effectiveness. This is the Flinders University work that I referred to earlier. The review identified a number of approaches to providing aged care for people in the community and in residential care both in Australia and overseas, and noted that most innovative models of care have not been rigorously evaluated and evidence of their effectiveness of improving

care recipient outcomes is limited.

You will recall, Commissioners, that one of the categories for which we submitted an exemption could be granted from the minimum staffing requirements in residential
5 aged care would be for innovative models of care. There is research which would suggest that some small home models that are focused on people with diagnoses of dementia can achieve better outcomes for those residents by having high numbers of personal care workers than necessarily having registered nurses in place.

10 The important point here is that any such innovative model of care needs to be evaluated if it is to be the subject of an evaluating of the ratios. There's a link there between the need to innovate, which we support, and we wouldn't want any of the standards that we propose to get in the way of innovation, but innovation has to be genuine and it has to be evaluated for it to be valuable and to make a contribution.
15
Turning to the other aspect of this topic, that is aged care data, we deal with that at paragraph 884 of our submissions and we note that in the submissions that Counsel Assisting made at the conclusion of Adelaide Hearing 4 in March this year, the Australian Government should implement a standardised data collection program
20 designed on the principle of "collect once, use many times". We submitted that care outcomes data, quality of life data and data on needs were required and we note the development and maintenance of the new quality standards and quality indicators, which I referred to earlier, will assist in this process. There were 27 submissions received by the Royal Commission in response and those which address the topic of
25 data collection and analysis were strongly supportive of the implementation of standardised data collection and the "collect once, use many times" principle.

The Australian Government acknowledged that improved data analysis may help improve understanding of older Australians' access to healthcare and that there are
30 opportunities to collect more information and conduct more analysis across data sets, agencies and jurisdictions.

At paragraph 888 of our submissions, we propose that centralising and harmonising the functions of aged care in the new Australian Aged Care Commission will go
35 some way to achieving this goal. Ensuring information and communications technology, connectivity and interoperability of the Australian Aged Care Commission's data and data system with those of organisations such as the Department of Health and the Australian Commission on Quality and Safety in Health and Aged Care will be vital and we submit that the principle should be
40 actively pursued by the Aged Care Commission as part of its system governance role.

We detail some of the evidence, including the evidence of Ms York from the Australian Institute of Health and Welfare, Professor Inacio from the Registry of
45 Senior Australians, and Dr Grenfell from the CSIRO in our submissions. We note in particular the evidence of Dr Grenfell at paragraph 899, that while the Australian Institute of Health and Welfare, a well-known body in the field of data analysis,

should be responsible for data curation, data governance needed to sit with an independent entity. It's on that basis, and the remainder of our submissions, that we submit that the new Commission should have the primary responsibility for governing and delivering quality and comprehensive aged care data and the control of such data means the Commission can maintain control of the aged care system which we see as being at the heart of its role. To use a colloquial nautical metaphor, it would provide the Commission with a firm hand on the tiller to be able to steer the system in the way that we consider is necessary.

At paragraph 902, we note that the development of an aged care national minimum data set will serve purposes beyond the immediate needs of the Australian Aged Care Commission. Other national minimum data sets established by national agreement are governed by management groups, a technical term referred to in our submissions at paragraph 902. We propose that a similar management group chaired by the Australian Aged Care Commission should establish an aged care national minimum data set. The group should be comprised at a minimum of some of the relevant custodians of aged care data, the Australian Bureau of Statistics, the National Health and Medical Research Council, the Aged Care Research Council, the Quality Standards and Quality Indicator setting body, as set out at paragraph 902.

It is not to say there isn't a role for the Australian Institute of Health and Welfare, there clearly is. We submit at paragraph 905 that the Institute should be given responsibility for the technical role of curation and publication of the aged care national minimum data set consistent with its expertise and curation and publication of other national minimum data sets.

Commissioners, we, for those reasons, make the Recommendation 56, which you will find on page 269 of the submissions which sets out in some detail our proposal for the establishment of a minimum aged care data set and its control by the Australian Aged Care Commission and also acknowledges the complementary role to be played by the Australian Institute of Health and Welfare.

Commissioners, they're the submissions that we seek to make in relation to aged care research and data and it may be an appropriate time to call it a day. Commissioner.

COMMISSIONER PAGONE: Thank you, Mr Rozen. I think Commissioner Briggs wanted to say something.

MR ROZEN QC: I'd forgotten, yes. My apologies.

COMMISSIONER BRIGGS: Thank you, Commissioner. These are very important recommendations, counsel. The idea of a dedicated research council, I think, should be definitely explored further. I would like to hear specific feedback on whether or not the dedicated research council should cover both aged care and ageing-related healthcare or be more tightly targeted on aged care only, avoiding health research yet again swamping aged care research. I'd also like to hear whether a Council might usefully operate virtually.

It also seems to me that there are other options that might be considered, counsel, on data governance and the mandatory minimum data set in addition to the one you've mentioned. A couple that spring to mind are either having the Australian Institute of
5 Health and Welfare pick up these functions in their entirety. The AIHW is already an accredited data integration authority and manages a range of health data sets and the disability minimum data set. It has sophisticated IT systems and strong technical capabilities along with a deep understanding of health and welfare databases or having a split arrangement where the Commission or Department takes governance
10 responsibility for the minimum data set, data sharing, and provide a software accreditation with data standards while the Australian Institute of Health and Welfare would become the data custodian and assume responsibility for the aged care data hub along with its associated data collection integration and data sharing and release functions.
15
I'm interested in submissions from parties on these two options as well as the one you mentioned, counsel. This is quite a difficult area and we need all the input we can get to get it right. Thank you very much, counsel.

20 MR ROZEN QC: Thank you, Commissioner Briggs.

COMMISSIONER PAGONE: We'll adjourn until 9:30 tomorrow.

25 **ADJOURNED AT 4.16 PM UNTIL THE FOLLOWING DAY AT 9.30 AM**

Index of Witness Events

CLOSING SUBMISSIONS BY MR ROZEN QC P-9674

CLOSING SUBMISSIONS BY MR GRAY QC P-9685

CLOSING SUBMISSIONS BY MR ROZEN QC P-9711

Index of Exhibits and MFIs

EXHIBIT 22-1 - DOCUMENT RCD.9999.0539.0001, "RESIDENTIAL AGED CARE - LONG TERM OUTLAYS AND ISSUES FOR FUNDING STRUCTURES" P-9702