1. A Summary of the Final Report

1.1 Introduction

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

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

1.2 The current system

1.2.1 A look at the aged care system

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

Changing demographics

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

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

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

Aged care services

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

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

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

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

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

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

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

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

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

Funding

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

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

Workforce and providers

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

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

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

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

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

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

Regulation of aged care

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

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

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

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

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

1.2.2 Problems of access

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

Entering and navigating the system

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

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

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

Accessing care

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

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

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

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

Access for groups already at a disadvantage

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

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

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

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

Access to health care and disability services

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

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

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

1.2.3 Uncovering substandard care

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

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

What we learned about substandard care

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

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

Abuse

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

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

Complex care

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

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

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

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

Routine care

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

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

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

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

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

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

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

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

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

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

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

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

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

Extent of substandard care

Discovering the extent of substandard care in any human service should be quite straightforward. In Australia's aged care system, it is exceedingly difficult. Those who run the aged care system do not seem to know about the nature and extent of substandard care, and have made limited attempts to find out. There has been a reluctance to measure quality.

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

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

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

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

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

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

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

We consider that the extent of substandard care in Australia's aged care system is deeply concerning and unacceptable by any measure. We also consider that it is very difficult to measure precisely the extent of substandard care, and that this must change. Australians have a right to know how their aged care system is performing; their government has a responsibility to design and operate a system that tells them; and aged care providers have a responsibility to monitor, improve and be transparent about the care they provide.

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

1.2.4 Investigating systemic problems

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

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

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

Systemic problems in aged care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion to systematic problems

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

should regularly collect and publish data, for each State and Territory, on the number, ages, length of stay and admissions and discharges of younger people living in residential aged care.

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

Endnotes

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