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

Relationships Australia welcomes the opportunity to make a further submission to the Royal Commission into Aged Care Quality and Safety. This submission is made on behalf of the eight State/Territory Relationships Australia organisations. It is informed by the observations made by the Royal Commission in its Interim Report, and other publications of the Royal Commission, including Consultation Paper 1. The central premise of this submission is that ageism, permeating all sectors of our community, is at the root of:

- systems and services built on bio-medical models and values, that fail to support the full and continued moral and legal personhood of older people, their choices and actions[1]
- systems and services that are segregated from other relevant services, and that are confusing, opaque and inaccessible
- systems and services that segregate and 'other' older people, and that stigmatise both users of those systems and services, and people who work in those systems and services
- chronic under-funding and under-staffing, and under-valuing the contribution and needs of unpaid carers
- reactive *ad hoc* and 'scandal driven' reviews and reforms,[2] and
- failure to engage with peer-led co-design of systems, services and supporting regulation.[3]

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[1] For research reporting on older people's life goals, see Kendig, Browning et al, 'Health, Lifestyle, and Gender Influences on Aging [sic] Well: An Australian Longitudinal Analysis to Guide Health Promotion,' (2014) doi: 10.3389/fpubh.2014.00070; Bowers et al, 'Older People's vision for long term care' (2009) https://www.jrf.org.uk/report/older-peoples-vision-long-term-care (a study from the United Kingdom).

[2] Acknowledging the Royal Commission's observations on these matters in its Interim Report, pp 66-69.

[3] We agree with the observations, made in the 2019 submission to the Royal Commission from the EveryAGE Counts campaign, about the features and effects of ageism, noting also the distinction between benevolent and malevolent ageism, and the harms that can accrue from both (see EveryAGE Counts 2019 submission, 5). We note, too, observations that peer support is hard to find, and under-utilised: see, eg, Health Design Lab, *Dementia in the community report*, 2019, 16.

This submission advocates a human rights-centred transformation of the status of older people in Australia, and explores how that would be progressed and reflected through:

- Australian advocacy for an international convention on the rights of older people, to support legislation and programmes that are human rights-centred and that move away from arrangements which segregate and 'other' older people, reinforcing the stigma that currently attaches to older people and those who work with them[4]
- service delivery that is person-centred and integrated, so that the onus of system navigation does not rest on users, and
- user co-designed regulation that emphasises transparency, accountability and outcomes valued by users, supported by a compliance framework based on principles of responsive and credible regulation.[5]

The work of Relationships Australia

Relationships Australia is a federation of community-based, not-for-profit organisations with no religious affiliations. Our services are for all members of the community, regardless of religious belief, age, gender, sexual orientation, lifestyle choice, living arrangements, cultural background or economic circumstances.

Relationships Australia has, for over 70 years, provided a range of relationship services to Australian families, including individual, couple and family group counselling, dispute resolution, services to older people, children's services, services for victims and perpetrators of family violence, and relationship and professional education. We aim to support all people in Australia to live with positive and respectful relationships, and believe that people of all ages have the capacity to change how they relate to others and develop better health and wellbeing.

From 2016, Relationships Australia has provided targeted services to individuals and families with age-related issues and who are experiencing difficulties coping with life course transitions, conflict, family violence and abuse of older people, grief and loss, poor mental health, intergenerational trauma, or who need professional support to have difficult conversations with family members. In addition, services include:

- capacity building within families, mental health and transition support, family counselling and mediation
- supported referral to appropriate specialist services

[4] See, eg, Aya Ben-Harush et al, 'Ageism among physicians, nurses and social workers: findings from a qualitative study', *European Journal of Ageing*, 14(1) 2017 39-48; Debra Dobbs et al, 'An ethnographic study of stigma and ageism in residential care or assisted living' *Gerontologist* 48(4) (August 2008) 517-526. The stigma attaching to age is often compounded by stigmas attaching to impairment, as well as gendered caring roles, as well as other intersectionalities around culture, language, gender and sexuality and religion. See also submission to the Royal Commission from EveryAGE Counts, 2019, 2, 8.

[5] See, eg, J Braithwaite (2011) 'The essence of responsive regulation' *UBC Law Review* 44(3), 475-520.

- family meetings co-facilitated with a counsellor and a mediator, and
- training and clinical supervision for service providers and their staff.

Relationships Australia State and Territory organisations, along with our consortium partners, operate around one third of the 66 Family Relationship Centres across the country. In addition, Relationships Australia Queensland operates the national Family Relationships Advice Line and the Telephone Dispute Resolution Service.

The core of our work is relationships – through our programs we work with people to enhance and improve relationships in the family (whether or not the family is together), with friends and colleagues, and within communities. Relationships Australia believes that violence, coercion, control and inequality are unacceptable, and we respect the rights of all people, in all their diversity, to live life fully and meaningfully within their families and communities with dignity and safety, and to enjoy healthy relationships. A commitment to fundamental human rights, to be recognised universally and without discrimination, underpins our work.

Relationships Australia is committed to:

- Working in regional, rural and remote areas, recognising that there are fewer resources available to people in these areas, and that they live with pressures, complexities and uncertainties not experienced by those living in cities and regional centres.
- Collaboration. We work collectively with local and peak body organisations to deliver a spectrum of prevention, early and tertiary intervention programs with older people, men, women, young people and children. We recognise that some families need a complex suite of supports (for example, family support programs, mental health services, gambling services, drug and alcohol services, and housing).
- Enriching family relationships, and encouraging clear and respectful communication.
- Ensuring that social and financial disadvantage is no barrier to accessing services.
- Contributing our practice evidence and skills to research projects and the development of public policy.

This submission draws upon our experience in delivering, and continually refining, evidence-based programs in a range of family and community settings, including:

- younger and older people
- people who come from culturally and linguistically diverse backgrounds
- Aboriginal and Torres Strait Islander people
- people adversely affected by adoption practices, including post-adoption and forced adoption support services
- people who have suffered from abuse within institutions, out of home care, and under wardship arrangements

- people who identify as members of LGBTIQ communities
- people affected by intergenerational trauma, and
- people affected by intersecting disadvantage and polyvictimisation.

Notes on language

Relationships Australia uses:

- 'abuse of older people' rather than 'elder abuse' because of the implications of 'elder' for Aboriginal and Torres Strait Islander people
- 'changed behaviours' – consistent with guidelines developed for describing the behavioural and psychological symptoms of dementia[6]
- where context allows - 'service' rather than 'care' to underscore the autonomy of people who receive aged care services; 'care' licenses paternalism and ageism, and
- 'user' rather than 'recipient' because 'user' is more autonomy-friendly and active; 'recipient' is more passive. 'User' can also include an older person's loved ones, carers and representatives.

AGED CARE PROGRAM REDESIGN: SERVICES FOR THE FUTURE

Relationships Australia welcomes the primacy, in the list of Principles set out at p 4 of Consultation Paper 1, of 'respect and support for the rights, choices and dignity of older people.'[7] The 'rights, choices and dignity' of older people must be the foundation of a transformative approach to how our country regards older people. A pervasive commitment to acknowledging and valuing the intrinsic worth of all, regardless of cognitive capacity, physical ability and economic contribution, is the best guarantee of a free and compassionate society for all. In this connection, we acknowledge:

- the findings by Roy Morgan, in its report *What Australians Think of Ageing and Aged Care*, commissioned by the Royal Commission, and published in July 2020 as Research Paper 4, and
- the findings by Ipsos, in its report *They look after you, you look after them*, commissioned by the Royal Commission, and published in July 2020 as Research Paper 5.

[6] Dementia Australia, *Dementia Language Guidelines*, 2018.

[7] We consider that the balance of the Principles listed at p 4 of the Consultation Paper would align with, and flow from, legislative and programme arrangements that explicitly afford primacy to the autonomy and personhood of users.

We note that the research undertaken in both of these instances was conducted before the onset of the COVID-19 pandemic, and do not consider that the reports' findings detract from our concerns about ageism pervading our society and its institutions and facilities.

The unique and lasting value of this Royal Commission, we respectfully suggest, is not merely to catalyse reform of aged care legislation, policy and programmes, but to catalyse social transformation in how Australia views and values older people. Specifically, our nation must name and reject the ageism that we have woven into our public and private consciousness, as vividly apparent in the context of COVID-19, which led to the Age Discrimination Commissioner, the Hon Dr Kay Patterson AO, observing on 5 May 2020 that

> Right now, we are seeing ever-present ageist ideas playing out in a number of ways and affecting different age cohorts as our society continues to grapple with COVID-19.[8]

Regrettably, this has been unsurprising, in light of the significant body of research which has

> … shown health professionals to hold a differential treatment towards old vs. young adult and to favor the care of the latter even under similar circumstances.[9]

The commitment of the Australian Government to respecting and supporting the rights of older people must span across all of its activities, and penetrate from the most senior ranks of political and bureaucratic government to all those implementing its policies and programmes day to day. To achieve this, we need broad social transformation exposing and rejecting the ageism that is endemic across our political systems, our economy, our popular arts and entertainment. There is, we consider, a bi-directional relationship between ageism and 'othering' of older people and segregation of older people in the existence of an 'aged care system' in which people are cast as passive 'care recipients' in residential aged care facilities. We commend, in this regard, the Government's *National Plan to Respond to the Abuse of Older Australians*, which is intended, *inter alia*, to

> support the work of the Australian Human Rights Commission's Age Discrimination Commissioner in tackling ageism.[10]

This work must, we suggest, include:

- advocacy by the Australian Government for an international convention on the rights of older people (reversing the position previously taken by Australian Governments)

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[8] See https://humanrights.gov.au/about/news/ageism-and-covid-19. See also the statement by EveryAGE Counts, *Ageism in the time of COVID-19*, at https://www.everyagecounts.org.au/ageism_in_the_time_of_covid_19.

[9] See Uncapher, H & Arean, P A (2000). 'Physicians are less willing to treat suicidal ideation in older patients' *Journal of the American Geriatrics Society*, 48, 188–192, cited in Rachely Yechezkel & Liat Ayalon, 'Social Workers' Attitudes towards Intimate Partner Abuse in Younger vs. Older Women' *J Fam Viol* (2013) 28:381–391, DOI 10.1007/s10896-013-9506-0, at 383.

[10] https://www.ag.gov.au/rights-and-protections/protecting-rights-older-australians#:~:text=National%20Plan%20to%20Respond%20to%20the%20Abuse%20of%20Older%20Australians,-On%2019%20March&text=It%20sets%20out%20a%20framework,Strengthening%20service%20responses

- integrated service delivery to older people that:
    - acknowledges the heterogeneity of users of services for older people, and of their carers[11]
    - eschews 'othering' and segregation of older people, while valuing specialist knowledge and skills relevant to meeting the needs of older people
    - rejects stigmatisation of older people and those who work with them
    - facilitates access by older people to mainstream services, including recreational, educational and health services
    - is not hostage to fragmentation arising from administrative, funding, or vocational boundaries, and
- replacement of current aged care legislation, in its entirety, with legislation that has human rights at its core, framing all rights, responsibilities, resourcing and remedies by, for example:
    - defining performance, quality and safety standards and outcomes
    - transcending reductionist, bio-medically defined[12] models and norms
    - ensuring transparency and accountability, and
    - imposing sanctions in accordance with the principles of responsive regulation.

This submission offers some suggestions about how each of these elements is essential to defeat a prejudice which is uniquely self-defeating, short-sighted and self-denying – most of us hope to live long, but very few hope to grow old.

International convention on the rights of older people

We urge the Australian Government to lead by example and advance an international convention for the rights of older people. Such a convention has been advocated for some years.[13] Australian Governments have declined to take this initiative for a range of reasons, including that the rights of older people are sufficiently protected through existing international conventions such as:

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[11] In this regard, we support the call by the EveryAGE Counts campaign, in its 2019 submission to this Royal Commission, for the Government to require the Productivity Commission to conduct research into the heterogeneity of the 'older' population, and the value of their contributions to society. We would, however, caution that the human rights of older people (like the human rights of anyone else) must not be seen or suggested to be in any way contingent on their contributions, past, present or future.

[12] In this submission, 'bio-medical' refers to Western bio-medical paradigms. It is important to acknowledge that 'Australian Aboriginal people have very different views of health and illness to those of Western medicine': Healing Foundation, *Aboriginal and Torres Strait Islander Healing Programs – A Literature Review*, 10.

[13] See, for example, speech by Elizabeth Broderick, Sex Discrimination Commissioner and Commissioner responsible for Age Discrimination, *Is it Time for a Convention on the Rights of Older People?*, International Federation of Ageing (2010). In that speech, Commissioner Broderick also other relevant, but non-binding, international instruments.

- the Convention on the Rights of People with Disability
- the Convention for the Elimination of Discrimination against Women
- the International Covenant on Economic, Social and Cultural Rights, and
- the International Covenant on Civil and Political Rights.

At the core of abuse and neglect is a sense that the person abused or neglected has not the same intrinsic value or worth as others. Australia's championing of an international convention would be a powerful public repudiation of all those who would dismiss and ignore, patronise and infantilise, segregate and 'other', neglect and abuse.

Relationships Australia considers that the evidence that has emerged during the course of the Royal Commission to date, and the observations made by the Royal Commission in its Interim Report on neglect, demonstrate the imperative for serious, explicit, and substantive recognition of, and commitment to, the human rights of older people. Reliance on a 'patchwork' of Conventions is another instance of 'othering' and obscuring the intrinsic worth and value of older people – and needs which are particular to them. Then-Commissioner Broderick considered that the benefits to older people of an international convention would include:

- public and official recognition of the intrinsic worth of older people
- a vehicle by which to introduce metrics against which nations must measure their performance in addressing ageism and valuing older people
- promoting attitudinal change across our communities, so that older people are recognised not as 'recipients of charity', but as individuals with rights, knowledge and agency, and
- 'provid[ing] a very useful focal point for co-ordinated domestic and global advocacy, as well as for public awareness and education campaigns and [could assist] in building an all-important social movement around these issues.'[14]

It was ten years ago that then-Commissioner Broderick predicted that '…the temptation to brand people in this large and expanding group as a costly problem will likely escalate.'[15] This has occurred, and been particularly pronounced in public discourse about the COVID-19 pandemic. It is past time for our country to address ageism at home and in the international community.

Our final observation in this regard is that we consider an international convention on the rights of older people also to be vitally important in publicly valuing those who provide unpaid care and paid services to older people. There is ample evidence demonstrating the links between the

[14] Speech by Elizabeth Broderick, Sex Discrimination Commissioner and Commissioner responsible for Age Discrimination, *Is it Time for a Convention on the Rights of Older People?*, International Federation of Ageing (2010), p 9.

[15] Speech by Elizabeth Broderick, Sex Discrimination Commissioner and Commissioner responsible for Age Discrimination, *Is it Time for a Convention on the Rights of Older People?*, International Federation of Ageing (2010), p 12.

wellbeing of carers and the wellbeing of those for whom they care; we therefore consider that the caring dyad must be consistently front of mind. This might play out, for example, in implementing the proposed investment stream by funding home modifications, assistive technology, respite care and social supports to support the capacity of the carer to stay at home and continue to care for their loved one while maintaining their own physical and mental health and wellbeing.

Integrated service delivery – insights from working with distressed individuals and families across the family law, child protection and family violence systems

There will inevitably be complexities in any system built to support a heterogeneous cohort. In submissions to other inquiries, we have described principles that should underpin a new Family Wellbeing System, to replace the existing family law system which, like the aged care system, is bedevilled by complexity and fragmentation.[16]

Shared traits

The aged care system and the family law system have a number of common traits which harm, distress and frustrate users, as well as adding considerably to the cost of services, including:

- users who are often approaching the system in a state of crisis and distress, during key life course transitions
- users' involvement in the system does not follow a linear pattern – as needs are complex and non-linear, so must be a system that is responsive to those needs
- legislative fragmentation, reflecting the limits of Commonwealth Constitutional power, and the Commonwealth's legislative and funding relationships with States and Territories[17]
- information overload and fragmentation:
    - users, carers and service providers must confront an overwhelming volume of information; for example, there are numerous, lengthy service directories, but their abundance alone contributes to difficulty in identifying suitable services
    - information is scattered across a sprawling galaxy of online and offline sources
    - there is little guidance on how to make meaningful comparisons
- intersecting disciplinary and occupational frameworks and hierarchies

[16] Including our submissions to the Australian Law Reform Commission inquiry and the ongoing Joint Select Committee into Australia's family law system. These submissions are available at https://www.relationships.org.au/about%20us/submissions-and-policy-statements

[17] Eg Commonwealth aged care, social security, taxation and superannuation legislation and state/territory legislation concerning family violence and abuse of older people, adult guardianship, mental health legislation; aged care funding is a Commonwealth responsibility and hospital funding is the responsibility of states and territories.

- funding grants which are often structured to align with bureaucratic divisions, rather than people's needs, and which increase compliance burdens without enhancing accountability

- the prevalent use of short-term pilots which are then abandoned (even if positively evaluated), undermining:
    - the development of trusting relationships which are vital to positive and enduring therapeutic outcomes, and
    - the ability of service providers to invest in high quality staff and capital expenditure

- budget process rules which limit how savings from investment in primary and preventative services can be taken into account to 'offset' immediate expenditure, and

- services that are fragmented to correspond with artificially drawn life span phases, rather than focusing on the duration of family dynamics, and supporting the well-being of individuals and families throughout life span (eg in response to intergenerational conflict, abuse of older people, conflict among adult siblings). The perpetuation of a hybrid health/social welfare/care and protection system that segregates and 'others' older people is inimical to full realisation of their human rights and personhood. Rather, as has been explored to some measure in Australia and internationally, the needs of older people in our society should be met through more integrated arrangements.[18]

Some useful strategies

As in the aged care system, various models have been proposed and implemented to provide people enmeshed in the family law system with navigation or case management support, including:

- sophisticated intake, screening (eg through universal screening tool DOORS[19]), and triaging – in light of our experience with these, we support the concepts, described in Consultation Paper 1, of:

    - streamlined access to low intensity and cost-effective support services through an entry level support stream, as proposed in the Consultation Paper, to address the long delays experienced by many older people in accessing home care, and

[18] Such as, for example, models such as the intergenerational communities referred to in Appendix 3 to the Royal Commission's Research Paper 3, *Review of Innovative Models of Aged Care*, 2020.

[19] See McIntosh, 2011; Wells Y, Lee J, Li X, Tan S E and McIntosh J E, (2018) 'Re-Examination of the Family Law Detection of Overall Risk Screen (FL-DOORS): Establishing Fitness for Purpose', Psychological Assessment http://dx.doi.org/10.1037pas0000581. Factors targeted by the tool include negative emotions about family separation, coping, substance use, infant and child distress, self-safety concerns, whether others are worried about the respondent's safety, whether police have been called, family violence, unemployment, financial hardship, child support, legal problems, housing issues, feelings of isolation, illness/disability, lack of access to transport. See Table 1 of Wells, Lee et al. See also the Family Safety Model run by Relationships Australia Victoria.

  - creation of an investment stream to fund interventions to help restore function, provide respite, and delay or prevent progression to more intensive forms of care, including proactive home modifications or home-based support services

- warm referrals to other specialist supports (including, where appropriate, expert safety planning)
- ongoing support and case management for users with intense and high complexity needs (which should translate to case management for both people in the caring dyad)[20]
- a strengths-based approach which empowers users[21]
- navigation services, and
- co-located and multi-disciplinary services.[22]

Applicable insights

Our experience with assisting families to cope, in times of trauma, with fragmented legislation, policies and programmes supports observations that are applicable to services intended to serve older people, including that:

- the needs of users should drive design, not existing legal, administrative, funding or single disciplinary structures, distinctions and hierarchies
- legislation, policy and funding arrangements must all be predicated on integration and seamlessness of the user experience
- the aim of all services must be to respond to the needs and values of users
- geographic inequities are pervasive, and sometimes result from arbitrary and artificial administrative divisions
- services must be available on the basis of universal service and accessibility, emphasising, in this context, prevention, early intervention, reablement and restorative services, and

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[20] Including proactive check ins with carers, accompanied, where appropriate, with preventative restorative and respite care services, at home or out of home.

[21] See the submission to this Royal Commission of EveryAGE Counts, and the observations about the role of strengths-based approaches, including in addressing ageism (2019), 10.

[22] For example, Family Relationships Centres, headspace facilities, the Collingwood Neighbourhood Justice Centre (which offers an array of services, including with housing and accommodation, financial counselling, mental health, drug and alcohol services, legal advice, specialist support for Aboriginal and Torres Strait Islander people, members of migrant and refugee communities, chaplaincy, etc; see https://www.neighbourhoodjustice.vic.gov.au/); health justice partnership models (see https://www.healthjustice.org.au/ for more information on this multi-disciplinary service model, which has been used for nearly 40 years), Family and Advocacy Support Services. See also the Access Gateway for another example of a service that offers multiple co-located services to support people with complex needs (https://www.accesscommunity.org.au/).

- service integration and collaboration must happen at an organisational level, invisible to users.

Administrative fragmentation – a report from our frontline

The **GP Connect** social work case management service provided in the Northern Beaches and Hills District is not provided in other regions. However, in the Hunter Region, a similar service operates called **Healthy at Home**, which can provide case management and geriatric support team to older people over a period of weeks, beyond its actual remit of transitioning older people from a hospital stay back home. In Eastern Sydney, a similar type of service is provided by the **Geriatric Flying Squad** who will assess an older person's needs and provide case management and social work, nursing or mental health support as required over a period of weeks. In Sutherland, this is provided by the **Southcare Outreach Service**. Other services such as **Dementia Australia**, and registered care providers can provide some case management, but this is usually either under NDIS or as part of the MyAgedCare package. Not only is this confusing when seeking a particular service, but complicated if services are similar, but not the same, requiring anyone making a referral to be very sure that the service is able to provide support needed, in the precise location in which it is required.

While integrated services can take various forms, according to the exigencies of the communities they serve, the key is that individuals and families experiencing stress, grief and trauma (which often accompanies life course transitions), should not bear the onus of navigating a complex and multi-layered array of services and sources of information. Whether integration takes form through physical co-location, or occurs as part of virtual or other networking structures and approaches used by government and providers, this must be seamless and invisible to the end user.

In view of this, we would propose that arrangements for the support and care of older people – and their carers - be integrated into a human rights-centred Family Wellbeing System, along the lines we have described in submissions to other inquiries. Such a system would:

- acknowledge ageing as part of the normal life course (rather than pathologising ageing and segregating older people), and hence embed the needs of older people within an explicitly inclusive service framework
- better facilitate co-ordinated and multi-disciplinary support through life transitions, and
- from a social service perspective, enable governments to leverage existing investments in Family Relationships Centres and other existing multi-disciplinary hubs for the provision of information, advice and support in initially accessing care and support, case management and navigation as required, and referral to appropriate long-term care as well as respite support and services.[23]

[23] Relationships Australia State and Territory organisations, along with our consortium partners, operate around one third of the 66 Family Relationship Centres across the country. In addition, Relationships Australia Queensland operates the national Family Relationships Advice Line and the Telephone Dispute Resolution Service.

Relationships Australia considers that the entry point to supports for older people must:

- first and foremost – be warm and welcoming, developed with peer-led co-design
- be easy to identify and well-publicised across the community – we note evidence to the Royal Commission thus far that My Aged Care, as well as being labyrinthine to navigate, is not well known
- provide clear, contemporary and trustworthy information that:
    - is accessible across rural, regional and remote Australia, safely and privately
    - empowers users, including by leveraging their expertise and lived experience
    - is available at all hours, and
    - accommodates particular considerations of users (eg is compliant with disability access standards, compatible with assistive technology, available in multiple languages and formats)
- involve and engage peer-led services
- be culturally congruent
- be accessible in different ways – face to face, by telephone and online, and
- have local connections to and in communities – we note the increasing tendency of government and commercial enterprises to contract their physical foot prints; this may be exacerbated during and beyond COVID-19. However, contributions to the Royal Commission's work thus far have underlined the value and importance of offering local services with local knowledge.

Entry points, access, navigation, information and advice – the potential of Family Wellbeing Hubs to serve older people

FRCs and similar existing services could be funded to expand in scope and geographic reach to provide co-located and multi-disciplinary services along the lines of Family Wellbeing Hubs,[24] described in submissions to other inquiries.[25] Integrating the entry points to aged care into Family Wellbeing Hubs would reinforce and complement strategies to tackle ageism, and the 'othering' and segregation of older people (and those who work with them), while also taking advantage of proximity to a range of multi-disciplinary services that would be useful and appealing to older people. Hubs would enable readier access to face to face, locally knowledgeable service providers.

The 'hub concept' is flexible, scalable and deliberately non-prescriptive - hubs must take a range of forms to meet the circumstances of the communities which they serve. They could be

[24] We note similar suggestions from other sources: see, eg, Health Design Lab, *Dementia in the community report*, 2019, 11, recommending 'Dementia shopfronts, providing information, counselling, planning, crisis response, case management, transition support, reablement, GP and specialists [sic] clinical services, would bring together many of the services needed for people living with dementia. The shopfronts would support both proactive and episodic care across people's dementia journey. They would need to include the ability to deal with high needs and emergency cases, which currently tend to go unmet outside acute and sub-acute care settings.'

[25] At https://www.relationships.org.au/about%20us/submissions-and-policy-statements

housed in bricks and mortar premises (in accordance with dementia-friendly design principles); they may be online; they may exist by virtue of robust and effective inter-disciplinary collaboration, or they may combine any or all of these. Relationships Australia envisages that the Hubs would extrapolate from the original concept of FRCs as front doors, and some of them could well be located in existing FRC sites,[26] where infrastructure, community relationships, and professional linkages and partnerships are established and have been evaluated as working effectively. This will be particularly important in communities that have been affected by complex trauma, where significant time and effort has already been invested in developing relationships that can have therapeutic benefit. The overriding principle should be that sites should be located where older people choose to live their lives.

The essential characteristics of 'hubs' in this submission, are:

- one door only/no wrong door
- ease of access, physically, by telephone, online or in combination
- continuum of assistance, from simply providing information, through navigation, to intensive case management
- integration and collaboration between services for the benefit of users, and
- regular cross-disciplinary continuing education and training, as one way to dissolve professional silos.

For some communities, a physical hub may not be practical, resource-efficient or helpful to serve the community, and its purposes will be better achieved by other flexible means of collaboration (including, but not only, shopfronts that offer face to face contact, or online services). For example, in some smaller communities, people will often need a choice of services and service delivery modalities to offer appropriate assurance as to privacy and confidentiality. Recruitment and retention of specialised professionals to live and work in particular areas can also pose significant challenges.

It is necessary to keep front of mind that Australians simply do not yet have universal access to fast, reliable, safe and discreet internet access. The Australian Digital Inclusion Index 2019 reported that

> Across the nation the so-called 'digital divide' follows some clear economic, social and geographic contours and broadly Australians with low levels of income, education, employment or in some regional areas are significantly less digitally included.
>
> This report – the fourth Australian Digital Inclusion Index – brings a sharp focus to digital inclusion in Australia and while it is encouraging to see improvement year-on-year, and particularly in regional Australia, it is clear there is still a lot to be done.[27]

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[26] Depending on data as to need and existing service offerings; see ALRC Discussion Paper 86, paragraph 4.35.

[27] https://digitalinclusionindex.org.au/wp-content/uploads/2019/10/TLS_ADII_Report-2019_Final_web_.pdf This is not unique to Australia; a recent report from the United Kingdom stated that 'Although a significant and growing number of older adults are online, only 47% of adults aged 75 years and over recently used the internet. This means a significant proportion of older people self-isolating [from COVID19] may be stuck in their homes with limited options to avoid social isolation, get essentials and stay safe': cited in Australian Association of Gerontology practice report, *March to June 2020*.

Accordingly, while use of online mechanisms to access goods and services is likely to continue to increase, tendencies to look to technology to resolve all issues of large scale service delivery across a dispersed population must be kept in check. We share the reservations expressed by the Royal Commission in its Interim Report.[28]

What kinds of services could Family Wellbeing Hubs deliver to older people?

The services offered at and through particular Hubs should reflect the needs of the people who live in the community. Potentially, in this context, they could include:

- a peer-led 'concierge' service for older people approaching the Hubs; concierges could undertake risk screening (as front desk staff do in many Relationships Australia facilities), as well as offering triage and warm referrals
- independent, impartial and peer-led system navigation[29] across services focusing on aged care, health and allied health services and systems, relationship services, legal systems and services (including, for example, to address issues of abuse of older people, family violence, enduring instruments, child protection, social security)[30]
- aged care advocacy services
- aged care specialist case-management for people with complex, high intensity needs (including a clear and bi-directional pathway between navigation services and case-management, to respond to a person's needs as they evolve and fluctuate) – we emphasise that integration of aged care services within mainstream services must embrace professionals who specialise in working with older people, as FRCs currently include professionals who have specialist knowledge in a range of fields, such as experts who work with older people, those who work with children and young people, and those who specialise in other subject matters, such as family violence, or mental health
- Aboriginal and Torres Strait Islander workers, including traditional healers[31] where available; the Healing Foundation has observed that 'Aboriginal traditional healers still practice in most regions of Australia, although they are more visible in remote regions. Many Aboriginal people will consult traditional healers at the same time as being treated by a Western physician' (McKendrick 1997; McCoy 2006)….women and men usually have different ways of healing (McCoy 2006)[32]

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[28] Royal Commission into Aged Care Quality and Safety, *Interim Report - Neglect*, 186.

[29] We consider that independence and impartiality are key to building community faith in a transformed system. We further consider it to be vital that navigators and case managers have proven expertise and experience; anecdotally, this seems to have been a significant shortcoming in the implementation of the NDIS.

[30] We welcome the pilot of navigation services in aged care, as described at p 140 of the Interim Report. We hope that, subject to positive evaluation, this will continue beyond the 18 month trial period.

[31] For a discussion of the scope and role of traditional healing in Australia, see Mayi Kuwayu and the Lowitja Institute, *Defining the Indefinable: Descriptors of Aboriginal and Torres Strait Islander peoples' cultures and their links to health and wellbeing*, 2019. In this connection, we note that failure to offer culturally safe services leads to poor social, cultural and health outcomes: see, eg, Blackman 2011; McMurray & Param 2008; Williams 1999, cited in Mayi Kuwayu and the Lowitja Institute, 28. For a description of characteristics of effective healing programmes, see Healing Foundation, *Aboriginal and Torres Strait Islander Healing Programs – A Literature Review*, 2.

[32] Healing Foundation, *Aboriginal and Torres Strait Islander Healing Programs – A Literature Review*, 14.

- support services for carers, including referral pathways for carers of (for example) older family members who may be having their own struggles (eg with mental health issues, substance misuse etc)
- palliative and end of life care specialists
- CALD workers
- mental health services
- legal practitioners to provide early advice and urgent legal/safety responses (eg where family violence - including abuse of older people - presents in screening or later on)
- social workers
- psychologists
- financial counsellors
- addiction counselling
- behavioural change programmes
- housing assistance
- an embedded social security agency presence
- existing FRC services (including mediation and Family Group Conferencing)
- space for relationships and personal education programmes to be conducted
- facilities for service users to access, in safety and privacy, online information and online services, and
- information-sharing databases for professionals, allowing them real time access to relevant information from across Australia.

Hub workers interacting with older people should be:

- trauma-informed[33]
- dementia-literate, and
- both able to work with users in a culturally safe way and be culturally safe themselves.[34]

Hubs would need to have close relationships with local service providers, including:

- educational, retail and recreational services
- local GPs, pharmacies and allied health providers, and
- legal, financial and other professional advice services.

These relationships should be built at the strategic leadership level, and be supported by 'business as usual' in-posting, embedding and outreach between the Hubs and external

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[33] In this regard, we note the guidance booklet published by the Commonwealth Department of Health, *Caring for Forgotten Australians, Former Child Migrants and Stolen Generations* (2016), at https://www.health.gov.au/sites/default/files/documents/2020/01/booklet-caring-for-forgotten-australians-former-child-migrants-and-stolen-generations.pdf. While we welcomed this publication, we understand from our practitioners who work with these groups that there has been little follow up with aged care service providers about practical implementation of the guidance contained within it. It does not appear to have been the subject of systematic communication and implementation planning. Further, Relationships Australia New South Wales service, Wattle Place, and other providers serving Forgotten Australians have encouraged making familiarity with the guidance part of compulsory training for aged care staff. However, this does not appear to have occurred, and aged care providers, in any event, experience practical difficulties releasing staff for ongoing training.

[34] Mayi Kuwayu and the Lowitja Institute, *Defining the Indefinable: Descriptors of Aboriginal and Torres Strait Islander peoples' cultures and their links to health and wellbeing*, 2019, 28-29.

providers. These kinds of relationships already exist in, for example, health justice partnerships and other multi-disciplinary service models such as the Family Advocacy and Support Services and Access Gateway.

It is important to emphasise that Hubs, as conceptualised by Relationships Australia, would not necessarily require services to move into the Hubs, but could (for example) involve outposting staff in the Hubs, as occurs at the Neighbourhood Justice Centre in Collingwood.

To complement these arrangements, and maximise geographic distribution, staff of such services could be supported to undertake outreach to local facilities in rural, regional and remote locations. The overriding principle, though, should be ease of access; older people and their carers should not need to travel into large urban centres, locate and pay for expensive parking, or be at the mercy of erratic public transport to have face to face contact.

Particular attention should also be paid to continuity of service in communities. For services to be seen as trusted and approachable, time is needed to build relationships.[35] This takes on even greater significance in communities that are affected by trauma (including intergenerational trauma) and polyvictimisation. A 'FIFO' approach does not work in such communities – it fosters distrust and aversion, which deters help seeking.

Where continuity of service and care relationships is fostered, this contributes to minimising the trauma and loss that people currently experience. It is important to support older people to maintain valued community relationships and connections, and mitigate the isolation of moving into residential care where that is required. We acknowledge that there will need to be work done to ensure adequate remuneration and other incentives for external providers to visit older people who cannot get to them, as well as to further develop models such as telehealth (which has seen accelerated development to meet the challenges posed by the pandemic).[36]

Finally in this respect, Relationships Australia considers that a necessary element of efforts to defeat ageism is integration of older people in the broader community, so that they are visible as full participants in our families and communities. We acknowledge, however, that reforms to break down this institutional and social 'othering' cannot be done hastily; apart from the harm that can be done by de-institutionalisation without adequate resources and support in the community, the current circumstances of the COVID-19 pandemic preclude short term implementation of some of the very promising models which bring generations together in day to day life, as well as for specific activities.[37] We respectfully concur with the observation of the Royal Commission that future models

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[35] As acknowledged by the Royal Commission in its Interim Report; see, eg, 171, 177.

[36] Royal Commission into Aged Care Quality and Safety, *Interim Report - Neglect*, 207-208.

[37] See, for example, models in Europe which co-locate aged care facilities in apartment blocks with various services that are used more broadly by community members, such as childcare and library services: Health Design Lab, *Dementia in the community report*, 2019, 14; EveryAGE Counts submission to the Royal Commission, 2019, 18. See also models described in Appendix 3 to the Royal Commission's Research Paper 3, *Review of Innovative Models of Aged Care*, 2020, such as Humanitas Bergweg (The Netherlands), Gojikara Village (Japan), The Mount Neighborhood (the USA, which includes a Learning Childcare Centre), and various models which combine long-term aged care with educational facilities, such as Cooinda Aged Care Centre in

> …will involve finding a way to bring the outside world into residential care homes, or taking those in care out.[38]

From market-based to human rights-centred regulation

The existing aged care system retains characteristics of hospitals, as apparent in, for example:

- physical design (although there is a growing, and very welcome, trend to designs that more closely resemble family homes and small communities of independent dwellings); in its report on abuse of older people, the Australian Law Reform Commission observed that '…routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of individuals'[39]
- consistent location of legislative, funding, regulatory responsibility for aged care within health or health-adjacent ministerial portfolios, and
- pervasive bio-medical values, manifested in various ways, and significantly in the definition of valued outputs and metrics.[40]

We agree with the observation that

> …even if there were no quality of care problems in nursing homes, conventional nursing homes arguably fail the quality test because of the severe strictures on life in these settings. Put simply, the total disenfranchisement associated with living in a nursing home is too high a price to pay for even high-quality technical care.[41]

Since at least 1997, bio-medical models, values and outcomes have been supplemented by ones born of free market principles, as has been noted by the Royal Commission.[42] There were early messages of caution in implementing free market principles in the aged care sector; the Royal Commission itself has noted that the 1993 Gregory Review

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Queensland and the teaching nursing homes. Relationships Australia notes that many of these models are not, as yet, supported by a robust evidence base.

[38] Royal Commission into Aged Care Quality and Safety, *Interim Report - Neglect, About the Interim Report*, 4.

[39] ALRC Report 131, paragraph 4.39.

[40] Such as those measured by the National Aged Care Mandatory Quality Indicator Program: see https://www.gen-agedcaredata.gov.au/Topics/Quality-in-aged-care/Residential-Quality-Indicators-%e2%80%93-January-to-March-/Residential-Quality-Indicators-%e2%80%93-October-to-Decemb

[41] Rosalie A Kane, 'Long-Term Care and a Good Quality of Life: Bringing Them Closer Together', *The Gerontologist* 41(3) (June 2001), 293-304.

[42] Eg Royal Commission into Aged Care Quality and Safety, Interim Report - Neglect, 133.

> …cautioned that market-based proposals (such as removing acquittal requirements for providers) could jeopardise the ability of the funding system to ensure proper levels of quality care.'[43]

Nevertheless, reforms to Commonwealth aged care policy and programs since 1997 have been consciously 'market-focused', and aimed at positioning aged care increasingly as a service sold and purchased in a free and competitive market, rather than as a essential social service.[44] The Australian Law Reform Commission noted that market-oriented reforms were broadly accepted, while expressing its concern about the applicability of market principles in aged care.[45]

Where flaws in the aged care system have attracted attention, the assumption by governments seems to have been that problems arise from insufficient implementation of free market principles, rather than with such principles themselves, and how they operated in a dispersed market characterised by dramatic asymmetries of knowledge and power. Such assumptions, for example, seem to have underpinned the Productivity Commission's recommendations in 2011,[46] the 2016 Roadmap, and observations made in the Tune Review in 2017. The 2016 Roadmap suggested that the problem with regulatory arrangements was that they were unduly onerous. However, the Royal Commission has found that these 'onerous' requirements 'often fail' to detect 'poor practices' and, when they do,

> …remedial action is frequently ineffective. The regulatory regime appears to do little to encourage better practice beyond a minimum standard.[47]

Increasing 'marketisation' of aged care services has been justified as empowering users to choose facilities that best meet their needs and preferences[48] and providing incentives, through the lever of competition, for providers to be efficient and innovative in providing high quality services.[49] Thus, the Foreword to the 2016 Aged Care Roadmap indicates an expectation that 'As consumers exercise choice, increased market competition will provide incentives to providers to respond to consumer needs and expectations, and drive competition in quality'.[50]

The 2016 Aged Care Roadmap identified as a medium term (3-5 years) objective that providers would develop their capacity to engage with 'co-regulation and earned autonomy' and, as a long

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[43] Royal Commission into Aged Care Quality and Safety, Interim Report - Neglect, 70, citing R Gregory, *Review of the Structure of Nursing Home Funding Arrangement: Stage 1*, Department of Human Services and Health, 1993, pp 21, 32, 79.

[44] See, for example, the 2016 *Aged Care Roadmap* (https://www.health.gov.au/sites/default/files/aged-care-roadmap_0.pdf, viewed 27 June 2020). Cf Department of Health. 2017-18 *Report on the Operation of the Aged Care Act 1997*. Canberra: Australian Government (2018), Australian Institute of Health and Welfare. GEN fact sheet 2017-18: *Government spending on aged care*. Canberra: AIHW (2019).

[45] ALRC Report 131, *Elder Abuse – A National Legal Response*, 2017, pp 106-107.

[46] See Productivity Commission, *Caring for Older Australians*, Inquiry Report 2011.

[47] Royal Commission into Aged Care Quality and Safety, *Interim Report - Neglect, About the Interim Report*, 8.

[48] Bishop CE 'Competition in the Market for Nursing Home Care', *Journal of Health Politics, Policy and Law*. 1988;13(2) pp 341-60.

[49] Productivity Commission. *Caring for Older Australians: Overview*, 2011; D Tune, *Legislated Review of Aged Care*, 2017.

[50] *Aged Care Roadmap*, 2016, 13.

term (5-7 years) objective, that 'co-regulation and earned autonomy' would be 'fully implemented', freeing government from the responsibility of regulating beyond consumer protections.[51] This was in the context of legislative arrangements that, in 2016, appear to have been considered disproportionate by the Aged Care Sector Committee.[52] There seems, then, to be a profound dissonance between the 'letter of the law' and what actually happens in the day to day routine of regulating aged care, the latter having been described at length in the Carnell-Paterson review, and in the evidence given to this Royal Commission by Professor Paterson.[53]

Given that Oakden was shut down a year after the Roadmap was released, and the Earle Haven closure occurred in mid-2019, Relationships Australia considers that co-regulation and earned autonomy should be regarded as very far distant goals indeed.

At present, the volume of legislation and its complexity seem to act as a kind of hopeful proxy for rigour and accountability. As recently as the Interim Report, it was noted that

> There is *no* public information on the way providers use taxpayers' funds and individuals' contributions to deliver aged care services.'[54] [emphasis in original]

It is beyond the scope of this submission to determine whether a human rights based system can accommodate free market principles and free market models.[55] It is, however, appropriate to point to significant and inter-related flaws in relying on free market principles to scaffold an Australian aged care system:

- there is a marked disparity of power between residents and providers – this disparity arises from a range of factors, including the urgency and crisis which often attends decisions to seek aged care services,[56] as well as lack of real choice in providers

- lack of real choice between potential providers, arises partly from unmodifiable circumstances such as geography (which affects urban, as well as rural, regional and

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[51] *Aged Care Roadmap*, 2016, 13.

[52] See, eg, *Aged Care Roadmap*, 2016, 3, referring to a future state in which 'Government will have a more proportionate regulatory framework'.

[53] Noting also Professor Paterson's observations at paragraphs 14 and 21 of his précis of evidence, found at https://agedcare.royalcommission.gov.au/system/files/2020-06/RCD.9999.0143.0001.pdf.

[54] Royal Commission into Aged Care Quality and Safety, Interim Report - Neglect, 132, contrasting the position in the United Kingdom and the United States of America. Relationships Australia notes that, from July 2020, the Australian Government will publish a compliance rating for residential aged care services on My Aged Care. The rating system was developed by the Department of Health in partnership with the Aged Care Quality and Safety Commission and in consultation with stakeholders, including (notably) older Australians, their caregivers, aged care providers, and peak bodies.

[55] Although it is helpful to note here that market principles which confer value on a person according to their past, present and future capacity to make economic contributions sits uneasily with recognition of intrinsic worth that underpins human rights.

[56] This includes home-based services; many older people delay as long as possible seeking help with activities such as shopping and cleaning because they see every such request as a point in a continuum in which they relinquish control and agency in their lives, in spheres over which they have long been accustomed to enjoying complete autonomy.

remote areas; it can be profoundly disruptive and distressing to enter into urban residential aged care on the other side of the city from where your spouse remains), and

- intervention by governments to moderate supply and demand, as well as regulating for quality, safety and financial performance, described in the Consultation Paper as 'market management'.[57]

In 2017, the Tune Review acknowledged government must continue as a regulator and safeguard, and that, as observed by the Royal Commission

> … people living in remote areas, hard-to-reach people, those with complex needs and those with limited access to technology, are struggling with access to the aged care system. He recommended the introduction of 'system navigators' and outreach services to assist those who find existing channels difficult to use.[58]

The uneasy coupling of bio-medical, 'hospital-like' models and free market principles has not served older Australians well. Bio-medical models have proven disastrously reductionist and dismissive of users' moral and legal personhood; the language of 'consumer empowerment' has rendered invisible the persistent asymmetries of knowledge and power between users, providers and government and, in doing so, further entrenched disparities. It seems improbable, too, that the best advantages offered by marketisation, such as competition which enables consumers to purchase what they need and value, at a price that is both affordable and reflects their values, can ever be achieved in the Australian environment.

For these reasons, Relationships Australia advocates a system that has human rights at its centre, with the principal aim of empowering older people and allowing them to continue to live authentically as individuals with full moral and legal personhood.

Human rights and gendered issues in aged care

As noted by the Royal Commission, users of residential services are more likely to be women.[59] In addition, a preponderance of carers of older people, unpaid and paid, are women.[60] Thus, chronic under-funding of all aged care services and government limits on home care services for older people, together with other facets of the system, have disproportionate social, economic and health impacts on women.

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[57] Noting, too, that government intervention in a range of other areas, not specifically related to aged care, will also have a bearing on supply and demand in aged care, such as environmental and land use legislation, employment law and taxation / superannuation law.

[58] Royal Commission into Aged Care Quality and Safety, *Interim Report - Neglect*, 139, citing Tune review, pp 18-19, 134.

[59] Royal Commission into Aged Care Quality and Safety, *Interim Report - Neglect*, 90, citing Cullen, 2017, and Cullen, 2011. See also the AIHW statistics published 30 June 2019: https://gen-agedcaredata.gov.au/Topics/People-using-aged-care

[60] See Mavromaras et al, *The Aged Care Workforce, 2016*, https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf (published by the Commonwealth Department of Health, 2017), at p 17 (87% of the workforce in residential aged care was female) and p 74 (89% of home care and home support care workforce was female).

Further, 2021 may see the end of additional Government funding for a range of grants in the community services sector, provided in compliance with the Fair Work Commission's Equal Remuneration Order (ERO), made in respect of the Social, Community, Home Care and Disability Services Industry Award 2010 (SACS Modern Award). The ERO mandated increases to the award rate of between 23 and 45 per cent over a phase-in period, with the increase to be applied in full by 2020 and beyond.

Acknowledging the significant importance of the ERO, as well as its impact on the sector, Commonwealth funding for SACS supplementation was enshrined in the *Social and Community Services Pay Equity Act 2012*, which established a Special Account from which ERO Supplementation Payments are drawn. Despite the ongoing nature of the ERO itself, the Act, as drafted, will sunset on 30 June 2021, at which time payments into, and out of, the Special Account will cease.

As a result, a great number of organisations in the community services sector will cease to receive ERO Supplementation Payments from July 2021. The flow on consequences for the services themselves are abundantly clear, resulting in not only a reduction of capacity and therefore service delivery to vulnerable Australians, but also a loss of jobs.

We have elsewhere urged the Commonwealth, as a matter of utmost importance, to dedicate a specific appropriation in forward estimates to fund an increase to base funding across impacted grant programs. The appropriation must take effect from 1 July 2021 and be sufficient to ensure that services are not impacted by the cessation of ERO Supplementation Payments at that time.

The inclusion of an amount commensurate to the ERO Supplementation Payments within base funding would ensure that service providers have certainty and stability into the future, thereby guaranteeing the ongoing delivery of services at the necessary levels of expertise.

Relationships Australia recognises that this would require the government to dedicate additional funds for the 2021-2022 financial year and beyond, not currently provided for in the forward estimates. However, the impending funding cliff will have significant and ongoing impact and will result in far greater costs, across a broad range of government funded institutions, well beyond the funding needed to ensure a suitable level of service delivery in the community services sector into the future.

Failure to prevent this cliff would, in itself, be a crushing blow to gender equity in Australia.

A robust human rights-centred approach to serving older people in our community would also address this inequity.

Human rights and respecting culture for Aboriginal and Torres Strait Islander older people and those who care for them

Relationships Australia welcomes indications, in the Interim Report, that the Royal Commission is seized of the importance of ensuring that culturally congruent services are available for Aboriginal and Torres Strait Islander people. We particularly draw attention to the vital importance of being able to return to Country, and to examples such as the Purple House, referred to in the Interim Report, as vital elements of a robust, human rights-centred framework.

We would also strongly support recommendations that promote cultural safety for Aboriginal and Torres Strait Islander people, when they are providing unpaid or paid care.

Human-rights centred regulation and quality and safety measures

Relationships Australia urges that the future identification and development of measures for quality and safety be done on the basis of peer-led user co-design. It should be users who identify what are valued and valuable outcomes, and this should form the basis of regulation and compliance activities. A notable recent example of this not occurring was in the development of the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*. In our submission to the Joint Parliamentary Committee on Human Rights, we observed that 'stakeholder consultation described in the Explanatory Statement seems dominated by clinicians, providers and regulators'.[61]

The absence of user voices in designing regulation, and inadequate notions of efficiency in the context of human services, have led to regulation that measures transactions and outputs, at the expense of relationship-based connection that is a prerequisite of human wellbeing throughout the life course.[62]

We consider, that in view of the various failures identified thus far by this Royal Commission, and in previous inquiries, the Government must, in the public interest, retain responsibility for regulating quality and safety, as well as (in the language of the Consultation Paper) for managing the market, to:

- address the various asymmetries of knowledge and power that, currently, preclude consumer law providing effective protection, deterrence and sanction – in this context, the Government would stand as the 'ultimate consumer', with the financial and legislative power to hold sub-standard providers to account through an array of mechanisms (including *robust* licensing and accreditation arrangements), as well as policy development 'fire power' through the public service to acquire and leverage data for effective, evidence-based planning and service delivery, and
- provide a clear line of accountability for taxpayers/users – that is, as scandals recur, taxpayers/users have the political remedy of the ballot box, should they care to use it.

Does it make a difference where care is provided?

We note, in this connection, that there has been a division between regulation of care provided in residential aged care facilities and in the home. The Royal Commission has observed

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[61] https://www.relationships.org.au/about%20us/submissions-and-policy-statements/submission-restrictive-practices-inquiry-into-quality-of-care-amendment-minimising-the-use-of-restraints-principles-2019, at p 15.

[62] Our previous submission explored in detail the evidence demonstrating this, as well as the morbidities that result from disconnection and social isolation; see https://www.relationships.org.au/about%20us/submissions-and-policy-statements/relationships-australia-national-royal-commission-into-aged-care-quality-and-safety-submission

> The most 'in-demand' aged care service is the lowest level of support and is delivered to people in their homes.[63]

While appreciating that regulation of service provision in private homes poses complexities, this division cannot stand, and we respectfully concur with the Royal Commission that

> Having implemented a positive push towards ageing in the home, it is now a matter of redefining the system to avoid harm to older Australians and increase efficiency in the aged care system.[64]

Funding accountability

Relationships Australia notes proposals along the lines of providing funding directly to older people, for them to purchase services as they see fit, which may have some immediate appeal in apparently empowering individual choice. However, like many other proposals in aged care over the years, what might seem empowering can often end up having the opposite effect, obscuring fundamental systemic barriers to services[65] and compounding existing social, health and economic inequities.

Further, we urge that, if such a path were taken, the regulatory approaches used to achieve accountability for expenditure of public funds *not* be modelled on the often shaming and punitive approaches taken in other contexts where funding is provided directly to users. Typically, too, such regulation is very complicated, onerous and time-consuming to comply with, and is likely to create a need for an additional service to assist users in discharging their compliance responsibilities. If people must pay service providers directly, rather than through the tax system, this imposes a significant onus on users to ensure accountability and quality control. Relationships Australia is concerned that this would dramatically exacerbate the imbalances of power that we have previously noted in this submission.

Where responsibility should sit – a single 'system governor'?

Relationships Australia acknowledges the complexity inherent in designing sound system governance in a market with mixed public and private funding, geographic dispersal and a continuum of user needs. We consider that there are important functions that benefit from a central system governor, noting the Commonwealth Government's access to, and control of, data from organisations such as the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, and its unique power to levy income tax and to control national economic policy levers. Equally, however, there are persuasive arguments to be made for more regional control; the Royal Commission has heard evidence noting shortcomings in service delivery arising from a lack of local knowledge. Accordingly, an optimal governance model would embrace the strengths of both central and de-centralised authority. In this context, we consider

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[63] Royal Commission into Aged Care Quality and Safety, *Interim Report - Neglect*, 90.

[64] Royal Commission into Aged Care Quality and Safety, *Interim Report - Neglect*, 164.

[65] Such as lack of appropriate services in locations that are appropriate for users, and the implications of social and cultural determinants of health.

that Family Wellbeing Hubs, as described in this submission, could provide a valuable source of local knowledge and data to inform centralised processes.

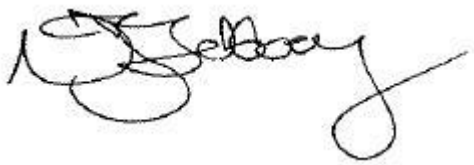
In shaping its recommendations to Government, we respectfully urge that the Royal Commission:

- avoid adding to fragmentation and complexity in ways that cast the burden of managing that complexity onto users, and
- ensure that its recommendations preserve clear lines of legal, administrative and political accountability for outcomes.

CONCLUSION

We thank the Royal Commission for the further opportunity to contribute to its work, and would be happy to discuss further the contents of this submission if this would be of assistance. I can be contacted directly on (02) 6162 9301. Alternatively, you can contact Dr Susan Cochrane, National Policy Manager, Relationships Australia National, on (02) 6162 9309 or by email: scochrane@relationships.org.au.

Yours sincerely,



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