AAG
Australian Association of Gerontology

To improve the experience of ageing through CONNECTING RESEARCH, POLICY and PRACTICE

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

Response to Productivity Commission Interim Report

Pillar 4: Delivering quality care more efficiently

Description of the submitting organisation

Since 1964, the Australian Association of Gerontology (AAG) has been Australia's peak national body linking researchers, educators, policymakers, practitioners, and other experts engaged in ageing issues. AAG's purpose is to improve the experience of ageing through connecting research, policy and practice. AAG has a growing membership of over 1,300 professionals working across every State and Territory in Australia representing all sectors and disciplines in ageing including research, policy, education, aged care, health and allied health, and consumer advocacy.

AAG's approach to evidence-based policy and practice incorporates all types of evidence, namely: research evidence, professional knowledge and expertise, the full diversity of older people's needs and wishes, and the policy environment. We are funded to undertake this work in part by a grant from the Australian Government Department of Health, Disability and Ageing. The aim is to support Australian governments, professionals, and providers to deliver evidence-based policy and services to meet the needs of all older Australians.

Introductory comments

AAG welcomes the opportunity to provide feedback to the Productivity Commission on the Interim Report on Pillar 4: Delivering quality care more efficiently.

We note that many of the proposals in the Interim Report directly address the key issues and challenges highlighted in the initial submissions and responses from diverse stakeholders, although some areas are covered with varying degrees of detail or are outside the immediate scope of the Interim Report's recommendations. We note that several of the concerns we and other stakeholders have about the current care systems, including relating to

- accessibility and inclusion,
- the need for a cultural shift regarding person-centred and person-led care,
- the undervaluation of and lack of support for informal and family carers,
- integration between the *aged care* and *health* systems, and
- broader funding and affordability models

AAG
Australian Association of Gerontology
To improve the experience of ageing through CONNECTING RESEARCH, POLICY and PRACTICE

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

are outside the current scope. In this submission we respond to the proposals listed in the interim report.

Action area 1. Fragmentation and regulatory inefficiencies

A large number and diverse range of stakeholders have identified significant fragmentation and inconsistency in quality and safety regulations across different care sectors (aged care, disability, health, early childhood) and jurisdictions. This leads to costly and complex compliance for providers, duplication and confusion, a heavy system navigation burden for carers people using care services, and inadequate information sharing, which can put vulnerable individuals at risk. Stakeholders have called for regulatory alignment, unified national frameworks, a focus on outcomes over inputs, and digital capability investment, among other reforms.

The Interim Report's Draft Recommendation 1.1 proposes several strategies to address these concerns. Two of these relate to unified worker regulation:

- a national screening clearance for workers across aged care, NDIS, veterans' care, and early childhood education and care (ECEC) and
- a unified approach to worker registration across aged care, NDIS, and veterans' care, supported by a national registration system and single portal.

Additional proposed changes relate to unification and streamlining of provider registration and management:

- establishment of a common suitability assessment for providers operating across aged care, NDIS, veterans' care, and ECEC, and mutual recognition of audits between aged care and NDIS standards and
- creating a single digital portal for providers to manage registration and audits across aged care, NDIS, and veterans' care.

Longer-term goals include:

- a single (potentially modular) set of practice and quality standards across aged care and NDIS services, and a cross-sectoral registration system for registered providers across aged care, NDIS, and veterans' care and
- aligning the broader regulatory landscape including establishing a standardised quality and safety reporting framework and data repository, exploring the suitability of a single regulator, and aligning regulation of behaviour support plans and restrictive practices across sectors.

AAG
Australian Association of Gerontology

To improve the experience of ageing through CONNECTING RESEARCH, POLICY and PRACTICE

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

We are pleased to see practical actions proposed to provide greater alignment and safety. We applaud actions to reduce the risk of unsuitable individuals moving between sectors without scrutiny, while making it easier for qualified workers to work across sectors, aiding workforce mobility. In principle, these changes have the potential to address several sector concerns including ability to:

- minimise duplication of workload and make tracking of worker credentials and history easier,
- give better data to inform policy and workforce strategies,
- ensure a minimum uniform safety standard and quicker identification of compliance or disciplinary issues
- lower administrative costs and burdens for providers operating across sectors, and
- support continuity of care.

There is the potential for efficiencies that will allow for greater re-investment into the care economy.

We do, however, have some concerns about the practical implementation and unintended consequences of these actions.

Scale of change

As the Interim Report acknowledges, the changes are proposed within a care sector that is already undergoing significant reforms. These changes would, in some cases, interact with or change reforms in which the care sector has already invested significantly in implementing. In the aged care sector in particular, there is considerable change fatigue, uncertainty, and anxiety among both providers and care users, even though the need for change is well acknowledged. These additional changes would need to be carefully managed and will result in high setup costs, both direct and in terms of sector morale and innovation. The proposed actions will require a significant upfront investment in systems, governance, change management, support, and training.

Scope of change

At the same time, we are concerned that the proposed changes do not go far enough to address a number of fundamental issues within the care systems. The redesign of the care system should be an opportunity to address some of these existing failings.

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

For example, the care economy is more dispersed, bigger, and messier than is addressed in this report. One such concern from our membership is that there is a growing market of actors including brokerage services that remain unregulated and unmonitored, with lack of transparency and safety for people using services. Our members have also highlighted that under current safety and quality mechanisms bad actors – providers failing to provide safe and high-quality services – continue to operate. While the proposed changes are designed to make these bad operators easier to identify and track across sectors, it is not clear how they will be prevented from moving into new sectors and areas of service while they remain registered and approved.

Further, the proposed creation of a single regulator should also address existing issues with the Commissions' powers. In particular, our members have highlighted the inherent conflict of interest in the role of the Quality and Safety Commissioner, who is expected to both advocate for service users and support and develop providers, which may undermine trust, accountability, and the effectiveness of regulation in an integrated care system. To resolve this, the design should include clear separation of functions, robust governance, and transparency mechanisms to ensure that user advocacy and provider oversight, education, and support are not in conflict. Clarification and separation of mandates, internal firewalls within the Commission, or ideally the establishment of separate bodies will be essential to ensure that consumer advocacy and provider development are both effective, but not entangled.

These are simply a few examples of failings in the current system that the proposed changes do not address and may in fact exacerbate as sectors are more integrated.

We recommend that a clear, staged roadmap for implementing any integration reforms be developed in close consultation with sector stakeholders, ensuring sufficient upfront investment in systems, governance, training, and change management. The roadmap must also prioritise addressing persistent structural issues in the care system, such as the lack of oversight of emerging, unregulated service providers, the ongoing presence of unsafe operators, and the conflict of interest within current regulatory roles, as a priority over efficiency.

Nuance and complexity

Our main concern about the proposals has to do with the complexity and nuance that a single overarching system may struggle to navigate. While all these sectors share a focus on care, the contexts of providing care for older people, children, and people with

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

disabilities are not identical. A unified approach carries significant benefits, but also risks, in particular of equating, or conflating, care contexts. These will need to be carefully monitored and managed.

The Interim Report argues that the care systems are similar because "service provision and regulation is rooted in the human rights of care users". We argue that this is not, in fact, the case. Australia currently does not have a human rights act or overarching human rights framework, which has been an ongoing criticism relating to the aged care system. As we and others have argued in relation to the aged care reforms, this issue remains under the new Aged Care Act, which addresses a set of rights that relate only to users of aged care services, and are not legally enforceable. This issue has also been raised by Natalie Siegel-Brown, the Inspector-General of Aged Care[1]. Our members have expressed concern that there is a risk of adopting "consumer rights" across the care economy in place of human rights and creating a false equivalence between these "consumers" across systems.

We recommend that the reforms and any recommendations by the Productivity Commission be designed using a firm human rights basis and that ideally, the Australian Human Rights Commission be involved in development of reforms.

The report also argues that the care systems are similar because "the skills required to deliver care are often similar", citing the Certificate III in Individual Support in which "the nine core units of the course and 21 of the 27 possible electives are sector-neutral". We argue that the similarity in current training should not be used as a measure of suitability, as there are significant known gaps in training including critical aspects of dementia care, palliative care, oral health, mental health, and cultural competency. While there are some core, fundamental elements of care, the current lack of specialisation and nuance in skills for care of different groups is problematic and should not be taken to signify greater similarity between care contexts than actually exists. This serves as one example of the dilution of needs among those using different types of services that already occurs across sectors and that may further occur from the proposed reforms.

[1] *The illusion of rights: Australia's new Aged Care Act has "very little" to enforce human rights*. HelloCare, accessed from https://hellocare.com.au/the-illusion-of-rights-australias-new-aged-care-act-has-very-little-to-enforce-human-rights/

AAG
Australian Association of Gerontology

To improve the experience of ageing through CONNECTING RESEARCH, POLICY and PRACTICE

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

The proposed modular approach to standards would be one essential feature to ensure that sector-specific needs can be accommodated. However, there remains the risk that in the process of navigating the needs and expectations of such diverse stakeholders, standards may either be diluted or may become too rigid and less suited to the unique aspects of each sector. Similarly, a unified suitability assessment and management of risks across the different care contexts risks diluting the specific risks and concerns within each. Extensive consultation and piloting will be required. A single regulator would need extensive resourcing and capacity to manage the scope of overarching standards, particularly modular standards. Once again there is a risk that enforcement could become too rigid and unsuitable to the actual needs and contexts of each sector. However, without a single regulator, oversight and enforcement of shared and modular standards would become exceedingly complex.

One example raised by our members is that of culturally appropriate care. This is an outcome that is difficult to measure and is not currently adequately embedded in legislation. For example, the definition of culturally safe care for Aboriginal and Torres Strait Islander peoples is included only in the Explanatory memorandum of the Aged Care Act, and there is no equivalent definition for other groups. As one of our members has highlighted, culturally appropriate care is often treated as a luxury or an 'add-on' due to its difficulty in measurement and prioritisation, leading to unintended negative consequences for service providers and older individuals. Despite ongoing work in this area, and a new Aged Care Act, there remains a need for better integration of culturally appropriate care into core business processes to ensure its delivery and prevent it from being deprioritised. This is a complex and nuanced area in which, as standards and regulation are 'harmonised', there is risk of expectations and requirements becoming diluted or not suitable for the context of care.

Further, worker roles may not align well across sectors. Significant work will be required to create a registration system with sufficient nuance and flexibility to accommodate this. Otherwise, the system will create confusion and mismatch and will hinder, rather than support, the delivery of person-centred, human rights-based care. We support the proposed concept of a system that can "accommodate different skills, qualifications or experience requirements" without tying registration classes to a particular sector, as this would allow for further development and recognition of specialisations and specific skillsets required for care in different contexts.

AAG
Australian Association of Gerontology

To improve the experience of ageing through CONNECTING RESEARCH, POLICY and PRACTICE

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

We recommend that implementation of any sector integration reforms include specific initiatives to ensure the flexibility and nuance required to provide high quality care, including ensuring that care standards and workforce assessment and registration systems are co-designed, piloted, and resourced to avoid both dilution and rigidity.

Action area 2: Barriers to integrated care

Efforts to break down silos between service systems and increase integration between services are vital to improve outcomes and efficiency, and person-centred care. The proposed actions have the potential to improve care coordination, reduce duplication and service gaps as well as to better target resources and align investments with local needs. This model may support contextual relevance of care, tailoring, innovation, and cultural safety.

Support for community engagement and inclusion

However, we once again caution that there are equity risks that will need to be addressed. Smaller organisations, including ACCHOs, may be sidelined and that the needs and preferences of their communities may be diluted or deprioritised, particularly where these do not align with the priorities of their partners. As the report notes, these organisations may also require more support to engage in the kind of joint governance required. We support the proposal that joint collaborative commissioning committees should include "representatives of ACCHOs, other care sectors, service providers and relevant independent experts", but argue that either greater incentives, or more structured requirements, may be needed to ensure appropriate, and appropriately diverse, representation and influence are supported.

We are also concerned that outcome-based funding may create financial uncertainty, and funding models will need to ensure equity for disadvantaged regions, particularly given the challenging and resource-intensive nature of monitoring and evaluation. Larger, better resourced, and more established organisations will likely benefit more quickly, creating disparity. We note however that the Interim Report acknowledges the need for adjustment relating to the risk profile and needs of the community, highlighting the needs for flexibility within this arrangement.

AAG
Australian Association of Gerontology

To improve the experience of ageing through CONNECTING RESEARCH, POLICY and PRACTICE

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

The proposed changes to further integrate care include only a small range of actors; namely, Commonwealth health bodies, "in partnership with ACCHOs and other relevant organisations, such as local government". LHAs and PHNs should be encouraged and incentivised to work more effectively with bodies such as local Governments, which play a vital role in the health, particularly the preventive health, of local communities, in order to support the "place-based approach" proposed in the report.

Processes and supports will need to be established to ensure that collaborative commissioning is responsive to local and community needs and that marginalised and underserved communities are properly and appropriately included. ***We recommend that any collaborative commissioning framework be accompanied by structures and funding supports that ensure adequate and appropriate engagement with local communities.***

Finally, we note the initial focus is restricted to "quality improvements or more services that lower potential future costs", more specifically relating to "reducing potentially preventable hospitalisations". We agree that this type of outcome could provide a useful, bounded starting point to build case studies for the collaborative commissioning model as it offers a documented measure with established benchmarks. However, we caution that this should be carefully managed in order to avoid perverse incentives for premature and inappropriate hospital discharge – once again, ensuring that efficiency and cost savings are not gained at the expense of high-quality care.

Action area 3: Underinvestment in prevention and long-term benefits

We support the proposed investment in evidence-based preventative health and community interventions and reiterate the need for long-term stable funding, and a whole-of-government approach. We are pleased to see the proposed investment in prevention programs, and the focus on evaluation and development of the evidence base. As an organisation with the purpose of connecting research with policy and practice, we support evidence-based and outcome-focused decision making with a longer-term view.

Equity risks

We caution, however, that prevention outcomes are often long-term and hard to quantify. Some benefits (e.g., social cohesion) are intangible and may be excluded in "value for money" assessments. This risks inequity, in that the programs, and outcomes, most needed by vulnerable groups may be more difficult to evaluate. The relative

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

"weighting" of benefits from a program may not be straightforward, and cost-benefit ratios may fail to recognise the scale of benefits that accrue from a program

The proposed Prevention Framework Advisory Board (PFAB) would require sustained investment and high-calibre expertise, including understanding of the limits and ethical implications of actuarial models for complex social outcomes. Further, funding mechanisms will need to account for differences in capacity. Smaller jurisdictions may struggle to match funding in a co-contribution scheme, risking inequity.

We recommend that the investment framework, the Advisory Board (or similar body) structure and powers, and funding mechanisms, be designed with a focus on a broad and inclusive view on outcomes and evaluation, including the relative value of different benefits from programs.

Cohesion and strategic focus shift

Further, structural changes must include more systematic, strategic focus and commissioning of work if they are to mitigate the fragmented nature of past efforts. The proposal has a 'projects and programs' focus on prevention; this has advantages in allowing local needs and innovations to be recognised and scaled up. The proposed Advisory Board should, however, also be proactive, not only having oversight of an emerging patchwork of activity, but also recommending programs that either address gaps in the evidence base or seek to rigorously trial, implement and evaluate programs in the Australian setting for which there is existing evidence. There is no mention of national research funding bodies within the report, yet the work they fund is, or should be, the bedrock for future decision making across all levels of government. Australia needs more streamlined research funding, with an emphasis on primary prevention.

Finally, we argue that the very nature of the care systems as designed is not consistent with a prevention lens. In particular, our members have highlighted that across much of the care service system, having an impairment is an eligibility requirement. This embeds into the system a focus on deficit and establishes services as being relevant only to those already experiencing illness or loss of function. Despite attempts to embed reablement and rehabilitation into care, the basis for eligibility limits the potential for the care system to promote prevention. To embed a stronger prevention focus in the care economy, systems must shift from an impairment-based model to one that recognises risk and supports early intervention. This might include strategies such as redefining eligibility to include early risk factors, embedding preventive and reablement

57 Trevelyan St,
Elsternwick VIC 3185
www.aag.asn.au

P +61 3 8506 0525
E enquiries@aag.asn.au

services and goals into funding streams, assessments, care planning, and outcome measures, as well as strategies integrating care with public health and creating accessible entry points.

We recommend that the focus of the proposed initiatives be shifted to allow for a more strategic approach to prevention that leverages investment in research and supports and promotes prevention at a systems level.

Summary

The Interim Report's draft recommendations propose specific, actionable reforms for the core issues of fragmentation, underinvestment in prevention, and barriers to integrated care highlighted by stakeholders. The overall direction aligns with goals of improving efficiency, quality, and person-centred outcomes in the Australian care economy.

However, there are several risks that will need to be carefully managed in order to ensure these changes benefit, rather than disadvantage, those using care services. If the changes become, in practice, a blunt instrument, there is a risk of oversimplifying and even conflating diverse care contexts, enabling a lowest common denominator standard of care rather than using the opportunity to address existing issues in each system, and of disadvantaging or excluding underserved communities.

Overall, we consider that the proposals may be trying to achieve too many, disjointed objectives and there is a risk that they may unintentionally exacerbate issues of quality and rights. Our recommendations are focused on ensuring core principles that should be at the centre of any care sector reforms, including these proposed changes: a fundamental, and enforceable, human rights basis, structure and resourcing that supports and incentivises equity and inclusiveness, and the prioritisation of the highest possible quality of care over cost-savings.