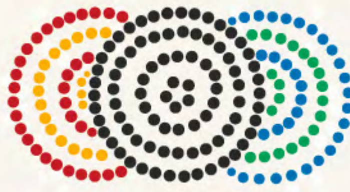

Submission to the Royal Commission into Aged Care Quality and Safety

June 2019

CONGRESS OF ABORIGINAL AND TORRES STRAIT ISLANDER NURSES AND MIDWIVES
Level 1, 15 Lancaster Place, Majura Park 2609 | Phone: 02 6262 5761 | Email: admin@catsinam.org.au | Web: catsinam.org.au

Unity and Strength through Caring

Introduction

CATSINaM welcomes the opportunity to make a submission to the Royal Commission into Aged Care.

CATSINaM is the sole representative body for Aboriginal and Torres Strait Islander nurses and midwives in Australia. CATSINaM's primary function is to implement strategies to increase the recruitment and retention of Aboriginal and Torres Strait Islander peoples into the nursing and midwifery professions. Aboriginal and Torres Strait Islander health professionals play a critical role in the delivery of improved physical, social and emotional wellbeing outcomes for all Australians. CATSINaM also provides comments and advice on national Aboriginal and Torres Strait Islander health programs and health workforce initiatives.

The National Aboriginal and Torres Strait Islander Health Plan NATSIHP) 2013 2023 (provides an evidence based framework to guide future investment and effort in relation to Aboriginal and Torres Strait Islander health and wellbeing. The Plan's vision is for an Australian health system free of racism and inequality and for all Aboriginal and Torres Strait Islander people to have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.

Importantly, the NATSIHP has a focus on the health system' effectiveness and clinically appropriate care. The involves not only have a health system that is clinically appropriate and safe, but it is also culturally safe and one that is of high quality and is responsive and accessible for all Aboriginal and Torres Strait Islander people.

There are approximately 4,176 Aboriginal or Torres Strait Islander nurses and midwives among the 379,700 nurses and midwives registered in Australia.[1] In Australia a majority of nurses work in aged care. In the mainstream nurse workforce for aged care, the ratio of nurses to patients is, 159 nurses per 100,000 persons.[2] There are 108,000 Aboriginal or Torres Strait Islander people eligible for aged care in Australia[3] However, there is no data on the number of Aboriginal or Torres Strait

[1] *See: Commonwealth Department of Health: NHWDS Data Tool and Resources: htttp://hwd.health.gov.au. See also, choosing a nursing career: Building an Indigenous nursing workforce, Derawin, L., Francis, K., Anderson, J., Journal of Hospital Administration, 2017 Vol 6 No 5.*

[2] *Nursing and Midwifery Workforce 2015*, A HW, Cat No: WEB 141, p7.

[3] *Australia Bureau of Statistics (2009) Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians,* 1991 2021.

Islander nurses who work in aged care, or data about the number of Aboriginal and Torres Strait Islander people in mainstream aged care! Just assume every Aboriginal or Torres Strait Islander nurse who gets up and goes to work today, works in aged care: if these 3,187 people went to work to care for the 108,000 Aboriginal or Torres Strait Islander people in aged care, there would be one nurse for every 628 patients.

ON BEHALF OF ITS BOARD AND MEMBERS, CATSINAM SUBMITS THAT:

- aged care workforce systems operate outside the purview of cultural safety;
- aged care systems segregate Aboriginal and Torres Strait Islander people and place the burden of care for complex conditions on Aboriginal health networks which lack the primary care infrastructure to provide a holistic health interface between the acute, primary and community care sectors;
- discrimination against Aboriginal and Torres Strait Islander people is standard practice in Australian government aged care programs for Aboriginal and Torres Strait Islander people and such discrimination may be addressed if the Department of Health itself and mainstream aged care service providers adopt and apply the Aboriginal and Torres Strait Islander Cultural Respect Framework 2016 2026;
- a national strategy for equitable access by Aboriginal and Torres Strait Islander people to aged care services is urgently required;
- a national Aboriginal and Torres Strait Islander aged care workforce strategy and workforce training curricula which supports Aboriginal and Torres Strait Islander ways of being, knowing and doing across aged care systems is required to address the bastardisation of Aboriginal and Torres Strait Islander people in aged care systems;
- the business model in primary care systems underpins the profiteering which is the darkest side of elder abuse.

CATSINaM's response to the Terms of Reference for the Inquiry now follow

a. **The quality of aged care services to Australians, the extent to which those services meet the needs of the people accessing them, the extent of the substandard care being provided, including mistreatment and all forms of abuse, the cause of any systematic failures, and any actions that should be taken in response**

The segregation of Aboriginal and Torres Strait Islander people in aged care systems is exemplified by the Terms of Reference for this Royal Commission in that there is no regard for the personhood of Aboriginal and Torres Strait Islander people in the Terms of Reference: the substandard care being experienced by Aboriginal and Torres Strait Islander people has been made 'another matter', something which may not concern 'Australians', something which is 'managed separately' and not really of the same concern for 'Australia'.

Marginalisation in governance systems is co extensive with mistreatment in social and welfare systems.

Segregation because of ethnic identity drives systematic discrimination against Aboriginal and Torres Strait Islander people.

The separation of Aboriginal and Torres Strait Islander people from the body of Australians makes discrimination acceptable because it allows Aboriginal people to be stereotyped as a different class of citizen, a subset of Australians, a subset which may not expect social equality because policies and standards and scrutiny are not universally applicable.

At present, advocacy for adequate aged care services for Aboriginal and Torres Strait Islander people is formalised in Department of Health functions. However, in the year 2018, the following are statements from the Department of Health in its response to an Australian National Office Audit report of the Department of Health's performance in Aboriginal and Torres Strait Islander Aged Care: at paragraph 2.11 the Department states:

'*2.11 … Health identified … barriers through My Aged Care including:*

- *Not wanting to leave their community and their land to obtain information on aged care, receive an aged care assessment or make use of aged care services;*
- *Preference for accessing Indigenous-focussed services rather than non-Indigenous services;*

- *Generally preferring intimate personal contact to be delivered by people of the same skin group and gender, reducing the number of suitable candidates that can undertake aged care assessments and deliver services; and*
- *Difficulty understanding the language and terminology used to ask questions about their health status and cognitive functions.'*

The first dot point illustrates that there is a 'social cost' that comes with being an Aboriginal person.

The second dot point normatively separates peoples' value systems so that we see that there is a 'one or the other' choice operating in health consumer dialogues.

The third dot point essentialises customs and exposes the mainstream system's marginalisation of kinship customs.

The fourth dot point exposes the monocultural privileging of the My Aged Care administrative system.

The Department of Health systems select for Aboriginal and Torres Strait Islander people with high social capital and functioning. The impact of this is that:

- fewer than 2% of the total of aged Aboriginal or Torres Strait Islander people obtain access to services; and
- the hidden cost is assimilation.

The Australian Aged Care Quality Agency assesses the quality of care for Aboriginal and Torres Strait Islander people who are a special needs group under the Aged Care Act 1977. However, the Aged Care Quality Agency does not have an employment strategy for Aboriginal or Torres Strait Islander staff nor has it adopted the Cultural Respect Framework in operational planning.

The Commonwealth Department of Health's Ageing and Aged Care Group and Health State Network lead policy and system reforms. Systems reforms however are less people centered than ever and technological discrimination has added a new layer of depersonalisation to an increasingly dehumanised system. Persons without access to web based services which themselves are constructed to project an ideal world of connection and dignity are not 'selected for' by service providers and those who enter into the world of service provision enter into a closed institutional system.

Commonwealth programs for aged Aboriginal and Torres Strait Islander people include the Home Support Program; the Home Care Packages Program; and the Aboriginal and Torres Strait Islander Flexible Aged Care Program. However, the Flexible Aged Care program which is administered by Aboriginal and Torres Strait

Islander organisations, is the only program which receives scrutiny from the government in terms of consumer impact.[4]

Access to aged care may be approved from the age of 50 for Aboriginal or Torres Strait Islander people, and the official figures say that in 2016, there were 2,423 Aboriginal or Torres Strait Islander people in residential care; 2,100 in Home Care; and 820 in a Flexible Program.[5] These figures do not include information from the Victorian or Western Australian jurisdictions, so given that the official figure is that there are 108,000 Aboriginal or Torres Strait Islander people eligible for aged care services, what actually is life like for the 102,657 Aboriginal or Torres Strait Islander people who do not have access to aged care?

Outside of the Flexible Program there are no Aboriginal person centred services in any major city in Australia, yet 78% of Aboriginal or Torres Strait Islander people receive residential services from a mainstream provider. When Aboriginal and Torres Strait Islander people with the highest levels of social functioning feel the full impact of social segregation on capacity and potential, what connection with care might be reasonably assumed for disaffected Aboriginal or Torres Strait Islander people, in particular within systems where there are no accountability mechanisms for cultural care?

NSW has the highest population of Aboriginal people in Australia yet receives 14% of Flexible Program places in city areas and 13% of Flexible Program places in inner regional areas. In this context the 'preference for care' is also recognition that mainstream services do not provide services to Aboriginal and Torres Strait Islander people by choice, in fact they would prefer not to, so that you have a situation where social inclusion is refracted onto Aboriginal or Torres Strait Islander organisations: the dicta here appears to be, we can be racist, and we are!

The My Aged Care Gateway is geared towards highly functioning individuals with high levels of health literacy and social capital. This framework provides employment opportunities all along the line for Australians, but Aboriginal and Torres Strait Islander people only enter into this administrative regime as a 'special measure' and

---

[4] See https://www.anao.gov.au/work/performance-audit/indigenous-aged-care

[5] Tab e 2.1 Aborigina and Torres Strait Is ander aged care usage by program: https://www.anano.gov.au/work/performance-audit/indigenous-aged-care

Note that these tota s do not inc ude data from Victoria or Western Austra ia, and in this context, note the paucity of paucity in reporting systems in that it appears that program access may on y pertain to person with re ative y high socia capita . Note a so Tab e 2.2 Location of services used by Aborigina and Torres Strait Is ander aged care recipients that the eve of service avai abi ity is far be ow the eve of need.

in this context, more often than not, programs for our people are applied to subsidise the employment of other people while everyone nods and turns a blind eye and says, oh we just couldn't find someone 'suitable'.

National Screening and Assessment is conducted by people with scant understanding of Aboriginal and Torres Strait Islander family functioning and daily living struggles. Aboriginal and Torres Strait Islander people who are given a token 'special measure' role in these contexts work within structural and organisational discrimination because 'inclusiveness' is optional in the business models which drive primary care functions.

Workforce entry programs are produced for a virtual world rather than a lived world. Note in particular that online training modules allow contracted services to profit from aged care and that in large part, are part of producing an acquiescent workforce which absorbs all the built in detachment from human interactions with the old and frail. This resource draining profits training providers and there are actually no interactions with the lived world of people in aged care, just interaction with a virtual world where all the scenarios are pre set. This itself encourages behaviour which frames the person in care: they become the fiction of a case study; they are already dehumanised. Hey but it's cheaper.

Social and cultural exclusion of Aboriginal people is so entrenched that service providers allow Aged Care places allocated to Aboriginal people to be taken up by persons who are not ethnically Aboriginal.[6] Is this theft? It really sounds like it.

The range of services which are applicable under public programs do not meet the needs of people with complex care needs and no steps have been taken to develop a dementia care workforce irrespective of the fact that dementia is now a prevalent condition in Aboriginal or Torres Strait Islander people over 50. Oh, these people don't have any social capital to start with: who actually cares what happens to them? We'll all keep quiet about it if you will: here's some money to write about quality care standards, now they look good don't they. Yes, they read very well, let's frame them and stick them on the wall so everyone has total confidence in us!

Misunderstanding by health systems OR direct discrimination?

---

[6] See 2.24 – Accessing Aged Care Services

The first step in changing direct discrimination is to require aged care workforce systems, including Department of Health systems, to operate within the purview of cultural safety.[7]

In this context, the Department of Health itself needs to apply the Cultural Respect Framework 2016 2026 in its own systems rather than offer it to service providers as a front for respect.

National frameworks which stem from the Australian government's administration of Aboriginal and Torres Strait Islander people, in particular the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and National Aboriginal and Torres Strait Islander Flexible Aged Care Quality Standards need to include an Aboriginal and Torres Strait Islander Workforce Strategy for Aged Care. A Workforce Strategy is required to:

- support Aboriginal and Torres Strait Islander ways of being, knowing and doing in across aged care nursing functions including:
  - workforce training models which are aimed at preventing *elder abuse*[8]*;*
  - workforce roles which enable services to integrate care and comfort supports in organisational planning and engagement with the public so that the community has responsibility and capacity to maintain the inter personal relationships which prevent major depression; drug and alcohol induced dementia; and institutions which continue the horror in the average care and protection experience;
  - living interactions with real people not virtual case studies which entrench dehumanising treatment;
  - a primary care model which is not a business model because this model generates the profiteering which drives elder abuse.

Reform in both the structures and values of the workforce is required to improve the standard of care provided. Service providers receiving public funding and the Department of Health itself need to adopt the domains of the Aboriginal and Torres Strait Islander Cultural Respect Framework 2016 2026 as a first principle for removing

---

[7] https://www.catsinam.org.au/static/uploads/files/embedding-cultural-safety-accross-australian-nursing-and-midwifery-may-2017-wfca.pdf

[8] See Australian Law Reform Commission 2017 Issues Paper, *Elder Abuse (IP 47)*: https://www.alrc.gov.au/publications/what-elder-abuse

direct discrimination against Aboriginal and Torres Strait Islander people in aged care systems and practice.

b. how best to deliver aged care services to

I. people with disabilities residing in aged care facilities, including younger people; and

II. the increasing number of Australians living with dementia, having regard to the importance of dementia care for the future of aged care providers?

The call for a separate stream of care allows people to be sorted into exclusion zones and resources to be rationed in ways which reflect overarching social fear of disability or dementia. It also allows a medical model to creep into the care space so that there are fewer and fewer social connections which allow people with disabilities and dementia to have a right to a healthy lifestyle and experience motivation and purpose.

There is a high need to balance medical care with healthy lifestyle activity functions so that nurses are supported by a full range of allied health staff to make the best use of public facilities.

The values which make disability and dementia coextensive with isolation are dispassionate profiteering ones. Isolation fuels depression and trauma which make it harder for people to experience equanimity. This in turn generates cruelty from people in the workforce because there is 'no other way' to deal with 'aggression'.

Workforce systems need to be arranged so that elder abuse through over medication or restraint do not occur. More pointedly, however, the business model for primary care needs to be seen as a driver of profiteering and abuse.

c. The future challenges and opportunities for delivering accessible, affordable and high-quality aged care services in Australia, including:

I. in the context of changing demographics and preferences, in particular people's desire to remain living at home as they age; and

II. in remote, rural and regional Australia.

"High quality services" is bureaucratic speak and supports functions of government / regulators rather than services for the elderly and frail. The profile of 'the ageing population' itself is a label which demonises the elderly. The very language of the bureaucracy generates a paternalism which gives people a 'use by' date. Old people are not represented in the aged care workforce bureaucracy and it is a farce if not malpractice that people who are not old make decisions about what the aged need.

There are people all over Australia in the 50s and 60s struggling to find work. Aging is a truism for any human person and giving it a spin, which makes it suddenly appear or suddenly threaten is a problem of values. Similarly, breaking our people up into remote, rural and regional supports politicking not old people. Providing advocacy from a context where information is sorted so that there are different expectations across citizenships services is 'selection for political value'. The politicisation of the aged drives inhuman treatment across remote, rural and regional Australia. There should not be a different way of doing business 'for old people'. Services need to be designed 'with old people'. The primary care business model is the fundamental and underpinning basis for scarcity of resources for old people's services.

d. What the Australian Government, aged care industry, Australian families and the wider community can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe

No government, industry, family or wider community is ever safe when profit is more esteemed than looking after people most in need as a human principle. The whole system which 'supports' the sector is complicit in elder abuse while the business model is sanctioned as the basis of the operation of functions and values of the sector.

e. How to ensure that aged care services are person-centred, including through allowing people to exercise greater choice, control and independence in relation to their care, and improving engagement with families and carers on care-related matters

Overlaying a sector model which is not based on business profit and which increases the care and comfort role of workers and breaking down the values which allow the aged and the frail to be isolated and shunned is the first step.

f. how best to deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure.

The primary care business model generates profiteering. The focus on technology is a driver of dehumanising practices and a new layer of selecting for only those with social capital and then mistreating them anyway. There needs to be a focus on decreasing the role of technology because it incrementally diminishes human to human feeling. The notion of investment in the aged care workforce is misguided and sets the code for profit as the motivator in human to human relations. 'Capital infrastructure' or 'safe joyful homes for old people'?

g. **any matter reasonably incidental to a matter referred to in paragraphs (a) to (f) or that [the Commissioners] believe is reasonably relevant to the inquiry.**

CATSINaM supports the call for the Australian Government to amend the Aged Care Act 1997 (Cth) to mandate safe staffing and skill mix levels.

CATSINaM supports the recommendations put forward by the Australian College of Nurses (ACN) ***White Paper on the Regulation of the Unregulated Health Care Workforce across the health Care System***. Their recommendations are relevant to the Aged Care System, which is about the provision of quality care to the aged and overwhelmingly about providing care to the most vulnerable and that may include health care. CATSINaM also supports the recommendations put forward to the Royal Commission by the ***ANMF submission about Aged Care in the Home***. The proposal for staffing ratio and staffing skill mix does not just apply to residential aged care but also to care in the home. To ensure quality and safe care there needs to be the right staff in the right place to provide the right and appropriate service.

The aim of these submissions by these leading nursing organisations is to address the poor quality care that has evolved with a for profit driven mindset rather than a care mindset. There has been much anecdotal evidence that the role of the Enrolled Nurse is disappearing in aged care to be replaced by assistance in nursing or personal care workers who are supervised by Registered Nurses (RNs), but there are not enough of them on site to provide the adequate supervision. There is also evidence that RNs are providing off site supervision through an on arrangement leaving the care workforce on site comprising of people with minimal training, the insufficient clinical skills set or who are not themselves suitable to be in a caring role. The lack of RN onsite has meant that the availability of clinical placement training for a future nursing workforce has reduced and this is likely to compound our care and service provision in the future.

The assessment of the quality of aged care services must be viewed from a holistic perspective not just from a clinical perspective. The work being done around quality indicators for aged care needs to ensure that the indicators being used cover the physical, emotional and social wellbeing of the clients of the aged care system. Clinical data such as falls prevention, pressure sores and mobility will only provide an indication of the physical health setting of a service, but it won't tell the social and emotional wellbeing story such as loneliness an individual may experience either within a residential setting or living in their own home.

CATSINaM goes further to call for consumer advocates to access aged care services and enabled to speak to clients and advocate on their behalf. Having outsiders come into services on a regular basis can act as the canary and call out bad behaviour and poor care given to individuals that have no voice.

Ultimately, it is not possible to regulate for the 'care factor' within aged care sector, rather what the government needs to ensure is that those they grant license to be an aged care service provider is that the care factor is embedded in their way of doing business.