

NOT SEEN AND NOT HEARD: PROTECTING ELDER HUMAN RIGHTS IN AGED CARE

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I. INTRODUCTION

This article argues that there are significant shortfalls in the care and treatment of the elderly in aged care facilities in Australia and in the protection of their human rights. Moreover, elderly people have special vulnerabilities that make comprehensive and effective legal protection essential. This special vulnerability has been recognised by the courts:

Experience shows that in the case of boarding schools, prisons, nursing homes, old people's homes, geriatric wards, and other residential homes for the young or vulnerable, there is an inherent risk that indecent assaults on the residents will be committed by those placed in authority over them, particularly if they are in close proximity to them and occupying a position of trust.¹

The relevant provision of the UN *Principles of Older Persons* (1991) states:

14. *Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.*

Elderly people should have a right not to be exposed to violence and abuse, cruel, inhumane or degrading treatment, poor hygiene and neglect, indignity, and invasion of privacy. Indeed, the paramount, if not sole, objective of any aged care system should be to guarantee that elderly people have high quality care and quality of life. Government

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¹ *Lister & Ors v Hesley Hall Limited* [2001] 2 All ER 769, 800.

and the community should ensure that there are sufficient resources and that there is in place effective management and regulation to achieve that objective. Anything less should be regarded as a failure that ought to be rectified as expeditiously as possible. As much as is possible in all countries, elderly people's independence, participation, care, self-fulfilment and dignity must be advanced.² However, breaches of elderly rights appear to occur quite regularly in Australia within aged care facilities, even on official data released by the Department of Health and Ageing (the "Department") and, if anecdotal evidence from consumers and their advocates is at all reliable (as reported in governmental inquiries and in the media), such abuse is both widespread and frequent. As discussed further below, official Department figures for 2008-09 reveal the following:

- the Department received 7,962 complaints that were considered by the Department to be about an Approved Provider's responsibilities under the Act. In total, the Aged Care Complaints Investigation Scheme received 12, 573 contacts.
- of those complaints, there were 1,411 alleged reportable assaults and of those, 1,121 were recorded as alleged unreasonable use of force, 272 as alleged unlawful sexual contact, and 18 as both.
- the Department found that 1,093 investigations it carried out resulted in a finding of a breach by a Service Provider with 925 of those breaches being dealt with by a negotiated outcome or referral to another agency, eg. the police or a professional standards and disciplinary body for nurses or other professionals, and the remaining 168 resulting in a Notice of Required Action to the Service Provider.
- the Department identified 303 homes as being non-compliant with one or more of the expected outcomes of the accreditation standards after which they were then placed on a timetable for improvement, thus giving them the opportunity to comply.
- the Department imposed 30 sanctions on approved providers in respect of which 23 involved the Department determining that there was an immediate and severe risk to the health, safety or well being of the residents, and the other 7 involved

² Core principles as identified by UN *Principles of Older Persons* (1991).

continuing non compliance by a provider in relation to Accreditation Standards (that is, the non-compliance had continued even after the Department had identified the breaches).

- the Department issued a further 163 notices of non-compliance which had not as yet proceeded to sanctions but which might if non compliance continued.³

In the writers' view, these figures in themselves are a cause for concern, but as will be discussed below, there are a number of reasons to believe that these figures may underestimate significantly the level of abuse, neglect, and breaches of standards by aged care facilities.

For the purposes of this article, by 'elderly' we mean people whose physical and mental capacities are deteriorating primarily due to advanced age, such that they are incapable of independent living or will soon be in that position. 'Aged care' broadly means where elderly people are accommodated in residential care institutions, or who receive significant assistance in their care from external sources such as government, charities or community organisations.

We argue that a growing number of elderly people in Australia are being placed at serious risk of systemic human rights abuse because of a combination of factors including the following: their significant vulnerabilities; the fact that protecting the elderly is currently a relatively low governmental and community priority with a consequent lack of adequate funding and oversight;⁴ negative and stereotypical community attitudes towards ageing;⁵ the diffuse and problematic nature of aged care; inadequate planning and coordination of services; the weaknesses of the current Federal regulatory system; and the significant gaps and weaknesses of current legal responses to human rights abuses of the elderly in both the common law and statute.

³ Department of Health and Ageing *Report on the Operation of the Aged Care Act 1997*, Annual Report 2008-2009 Chapter 9 Regulation and Compliance 69, 71-73; Ch 10 Complaints Investigation Scheme 77-83.

⁴ This low priority and lack of funding are common problems across the world, eg see I Doron, S Alon & N Offir, 'Time for Policy: Legislative Response to Elder Abuse and Neglect in Israel' 16 (4) (2004) *Journal of Elder Abuse and Neglect* 63-82, 66, 77-78; UN Madrid International Plan of Action on Ageing 2002, 8-12 April 2002 United Nations New York; United Nations *Programme on Ageing Road Map* para 17, <http://www.un.org/esa/socdev/ageing/roadmap.html>.

⁵ Australia House of Representatives Standing Committee on Legal and Constitutional Affairs *Inquiry Into Older People and the Law* Australian Parliament, 2007, para 6.1.

The article will make recommendations that would provide more effective, enforceable rights for the elderly in aged care and indeed more generally. We make a number of specific recommendations to improve the regulatory system including the process of accreditation, quality assurance, complaints, investigation and compliance.

We further suggest that a comprehensive Australia-wide review of elder abuse and elder rights is necessary. We identify major issues that such a review should address. In addition, we suggest that the Commonwealth should legislate to introduce *The Rights of the Elderly in Aged Care Act*. This Act should include enforceable rights for the elderly in aged care facilities, including rights to participate in decision making, a right to privacy, to dignity, and to appropriate accommodation, care and treatment. The Act should also have specific provisions for creating penalties and civil liability for breaches of such rights with the potential for graduated penalties and sanctions to deal with the range of breaches. We also argue that the Act should provide that a Federal Commissioner of the Aged (to be appointed as a Commissioner of the Human Rights Commission) may bring criminal and civil actions on behalf of individuals or groups or on behalf of the Human Rights Commission and should oversee the complaints and investigation system relating to aged care.

The remainder of the article consists of the following parts: Part II examines why elder abuse is important and will become increasingly pressing as an issue; Part III provides an overview of Federal aged care provision and a profile of people who use this system and highlights the acute vulnerability of the elderly in aged care; Part IV discusses the controversial area of the actual level and type of elder abuse in aged care; Part V evaluates the current regulatory system for aged care including accreditation, quality assurance, complaints, investigation and enforcement and concludes that there are a number of significant issues and weaknesses; Part VI deals with other current legal options for dealing with elder abuse both at statute and common law and examines their significant deficiencies; Part VII discusses proposed reforms including a comprehensive review of elder abuse and elder rights throughout Australia entailing all government laws and policies, and new legislation and institutional support; lastly, Part VIII forms the conclusion.

II. IMPORTANCE OF ELDER RIGHTS PROTECTION

The phenomenon of elder abuse has been a subject of increasing concern in Australia since the 1990s.⁶ Prior to that time, public concern and interest was minimal. Elder abuse can include 'physical abuse, psychological abuse, medical abuse, economic abuse, violation of rights, sexual abuse, neglect and self neglect'⁷ or a combination of these factors.

One estimate is that about 4.6% of older people are victims of physical, sexual or financial abuse.⁸ In many cases the perpetrators of this abuse are family members, or people who have a duty of care in relation to the elderly person. Risk factors of abuse in a domestic relationship include a long history on ongoing unresolved conflict, reciprocal dependency, and the influence of drugs or alcohol. This article will not directly deal with these types of abuse, although the introduction of human rights legislation such as the *Convention on the Rights of Persons with Disabilities*⁹ (CRPD) would obviously impact favourably on this group. However, another significant area for potential abuse is the provision of aged care, particularly where elderly people live in aged care institutions commonly known as nursing homes. That issue is the focus of this article.

The most recent Federal intergenerational report estimates that the Australian population will reach 35.9 million by 2050 and that a quarter of that population will be aged over 65, compared with 13% as at 2009.¹⁰ Further, half of government spending would be used by health, age related pensions and aged care in 2050 compared with one quarter in 2009.¹¹ In relation to NSW it is estimated that by 2030 the proportion of people 65 years and over will have almost doubled (from

⁶ S Ellison et al, *The legal needs of older people in NSW* Law and Justice Foundation of NSW, Sydney 2004, Ch 8.

⁷ P Kinnear and A Graycar 'Abuse of Older People: Crime or Family Dynamics? Trends and Issues in Crime and Criminal Justice' 1, 12 May 1999, 2; S Ellison et al, above n 6, Ch 8.

⁸ A Graycar and M James 'Crime and Older Australians: Understanding and responding to Crime and Older People' (2000) Paper presented at the 7th Australian Institute of Family Studies Conference, 5-6.

⁹ Discussed below.

¹⁰ Productivity Commission *Economic implications of an ageing Australia* Commonwealth of Australia, Canberra, 2005, see Overview for general trends; Campbell Research Consulting *A literature review and description of the regulatory framework to support the project for the evaluation of the impact of accreditation on the delivery of quality care and quality of life to residents in Australian Government subsidised residential aged care homes*, November 2005, 11.

¹¹ Australian Government, Treasury, *The 2010 Intergenerational Report*, Australian Government, Canberra, released February 2, 2010, Executive Summary 2.B.

14% to 22%), while the number of centenarians will increase eight-fold. And for the first time, 65 years olds will outnumber 14 year olds.¹²

It is further predicted that dementia in Australia will become increasingly common with one estimate being a four fold increase from 245 000 in 2009 to around 1.13 million by 2050.¹³ Moreover, many more elderly people will increasingly have some form of cognitive impairment as longevity rates increase. The number of older people living alone is also likely to continue to increase as it has done so historically, with one fifth of people over 65 living alone in 1971 as compared to one quarter in 2001.¹⁴ This may mean that an increasing number of elderly people will not have significant direct social support.

The above statistics indicate clearly that the number of elderly people in aged care is highly likely to increase significantly, which will also greatly increase the challenge for protecting their rights.¹⁵ The demand for residential aged care is predicted to increase by more than threefold by 2045.¹⁶ This problematic situation is in addition to the inherent vulnerabilities of elderly people to human rights abuses.

Of course, besides these social, legal, medical and economic challenges, there is a moral imperative that Australian should take all appropriate measures to encourage and protect its elderly citizens and provide them with opportunities to live happy and meaningful lives because the elderly as a group have contributed to the history, advancement and prosperity of the nation. Moreover, at some stage many of the community will face the same issues, as they themselves enter aged care.

III. AUSTRALIA'S AGED CARE SYSTEM

¹² New South Wales Government, *Towards 2030: planning for our changing population*, (April 2008) 1. (<http://www.dadhc.nsw.gov.au/NR/rdonlyres/A5EB541E-00F3-4A12-BCB9-1995DFDF82DA/3675/towards2031.pdf>)

¹³ Access Economics, *Keeping dementia front of mind: incidence and prevalence 2009-2050*, (August 2009), 23

http://www.alzheimers.org.au/upload/Front_of_Mind_Full_Report1.pdf ; Australian Institute for Health and Welfare, *Dementia in Australia: national data analysis and development*, (2007), <http://www.aihw.gov.au/publications/age/dandad/dandad.pdf>.

¹⁴ Australia House of Representatives Standing Committee on Legal and Constitutional Affairs *Inquiry Into Older People and the Law* Australian Parliament, 2007, para 1.3.

¹⁵ For some general approaches to these challenges see Parliament of Australia House of Representatives Standing Committee on Health and Ageing *Inquiry into long term strategies to address the ageing of the Australian population over the next 40 years* March 2005.

¹⁶ Campbell Research Consulting above n 10, para 2.4.

TYPES OF CARE AND PROVIDERS

There are two basic types of aged care assistance, namely residential and community based care. Residential aged care is for frail or disabled older people who can no longer live in their own homes or independently and is provided for under the *Aged Care Act 1997* (Cth). The Act's main role is to regulate the use of Commonwealth money in the provision of aged care services. However, attached to that core funding role are principles and rules that introduce standards with respect to the quality of care provided. These standards are further discussed in Part V.

Facilities are intended to provide suitable accommodation and related services (such as laundry, meals and cleaning) and personal care services (such as assistance with the activities of daily living). Nursing care and specialised equipment is provided to residents requiring such assistance. The Australian Government subsidises the provision of residential aged care to those approved to receive it, with aged care residents also contributing to the cost of their care. As at 30 June 2008, there were 2,830 mainstream residential aged care services with approved places in Australia providing a total of 172,657 places.¹⁷

Community based care is provided within an elderly person's home or within a community setting. The largest source of community care assistance is provided through the Australian Government and State/Territory funded Home and Community Care (HACC) program administered under the *Home and Community Care Act 1985* (Cth).

At a national level, the main providers of residential aged care services are religious organisations (29%), private providers (28%), community-based providers (17%) and charitable organisations (16%).¹⁸ Thus there is no homogeneity in the objectives, background or philosophy of the various facilities. Of particular concern is the research that suggests that overall, profit based organisations may provide lower quality care than non profit service providers.¹⁹ There may be a real incentive or

¹⁷ The data discussed are derived from Department of Health and Ageing *Report on the Operation of the Aged Care Act 1997*, above n 3, see Executive Summary.

¹⁸ Australian Government, Australian Institute of Health and Welfare *Residential Aged Care in Australia 2007-08* Canberra June 2009 Aged Care Statistics Series No 28. Ch 3.

¹⁹ R Vikram et al, 'Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis,' *British Medical Journal* 2009 online bmj.com, 1-15.

temptation for those for profit facilities to 'cut corners' and to reduce both the number of services and also their quality to obtain greater efficiencies, particularly if government funding and supervision are inadequate. The writers stress that these financial incentives and pressures and the responses to them by aged care providers need to be further investigated.

However, aged care is made even more complex because there are a range of Commonwealth and State regulated and funded services. State legislation for the aged is found in community welfare legislation and nursing home and retirement village regulation. States may have their own anti-discrimination legislation, building standards and legislation, occupational health and safety laws, health service complaints system and consumer protection legislation that may be relevant to aged care facilities. The position of each State and Territory with respect to the Federal system needs to be examined on a case by case basis.²⁰ For example, most retirement villages operate outside the standard definition of aged care even though they are intended to have social and health benefits and provide accommodation for elderly people. However, generally retirement villages do not cater for older people who require high levels of care and supervision.²¹ There still is no unified, national system for policy, planning, funding and service delivery.²²

A PROFILE OF PEOPLE IN RESIDENTIAL AGED CARE

Overall, usage rates for permanent residential aged care increase with age. They are higher for women than men, particularly among older age groups. At 30 June 2008, those aged 85 years and over had the highest rate of use, at 235.5 persons per 1,000. The corresponding measures for the age groups 80–84 and 75–79 were 78.5 and 32.3 per 1,000, respectively.²³

²⁰ P Hanks and L De Ferrari *Regulation of Residential Aged Care. Review of legislation: Commonwealth, State and Territory* Commonwealth Department of Health and Ageing, 30 April 2003.

²¹ I Hardy 'Aged Care' [2002] *ElderLaw* Rw 2. See for example the *Retirement Villages Act 1999* (NSW).

²² I Hardy 'Aged Care' [2002] *ElderLaw* Rw 2.

²³ Australian Government, Australian Institute of Health and Welfare *Residential Aged Care in Australia 2007-08* above n 18, para 3.1 These data on compiling a profile of residential people in care are derived from Chapters 2, 3 and 4 of Australian Government, Australian Institute of Health and Welfare *Residential Aged Care in Australia 2007-08* above n 18.

The distribution of length of stay for existing permanent residents at 30 June 2008 was towards longer periods of stay. Only 7% of permanent residents had been in residential aged care for less than 3 months, while 19% had been resident for between 3 months and 1 year, 52% for 1 to 5 years and 21% for 5 years or more.²⁴ There were 105,030 admissions to residential aged care between 1 July 2007 and 30 June 2008, of which 51% (53,737) were for permanent care.²⁵

The reasons for leaving aged care are given in the data collection system as "death, return to community, admission to hospital, move to another aged care service and other". In 2007–08, for those persons whose reason for separation was specified, death accounted for separation for 89%, while 3% returned to the community, 4% moved to a different residential aged care setting and 4% were discharged to hospitals.²⁶

There were 160,250 residents in mainstream residential aged care services at 30 June 2008, compared with 156,549 residents in aged care services at 30 June 2007 and 135,991 residents at 30 June 2000. Over half (55%) of the residents in aged care services at 30 June 2008 were aged 85 years and over, and over one-quarter (27%) were aged 90 years and over.²⁷

About 98% of permanent residents at 30 June 2008 had their marital status recorded at their admission time. Excluding those with unknown status, 56% were widowed at the time of admission, 26% were either married or in a de facto relationship, 10% had never married and 8% were divorced or separated.²⁸

A high proportion of permanent residents were in receipt of a government pension, with 71% receiving a Centrelink pension, and 18% an Australian Government Department of Veterans' Affairs (DVA) pension.²⁹

Diagnoses of dementia and other mental illnesses are recorded separately from other illnesses in the Department database. Excluding missing data, 63% of residents had at least one diagnosis of dementia.³⁰

²⁴ Ibid para 3.4

²⁵ Ibid para 3.4, 3.6.

²⁶ Ibid para 3.6.

²⁷ Ibid para 4.1.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Ibid.

People with special needs are identified under the Act and include people from Aboriginal and Torres Strait Islander communities, people from non-English speaking (culturally and linguistically diverse) backgrounds, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including spouses, widows and widowers of veterans) and some with psychiatric disorders.

It is clear that the elderly in residential care are particularly vulnerable to serious abuse. There is certainly the potential for significant systemic abuse. Indeed, it would be difficult to think of more vulnerable groups within our society: many with dementia or other cognitive deficits; many with significant physical illnesses and disabilities, including for example, anxiety and depression, and often immobile; often poor; living in relatively closed environments; and often without much support or even direct contact with the outside world. In addition, they may have personal difficulties in communication and in memory and, to exacerbate these difficulties, avenues for complaint and investigation of those complaints appear to lack necessary accessibility, clarity and rigour. Moreover, quite naturally, many residents may feel reluctant to question policies or make complaints, concerned that they will be victimised or even be in jeopardy of losing their places. As noted below, there are anecdotal reports that such retribution is indeed quite common.

IV. WHAT IS THE LEVEL OF ABUSE OF ELDERLY PEOPLE IN AGED CARE?

There is no empirically based data about the frequency or the type or level of problems faced by elderly people in residential care. Problems could range from unjustified and excessive restrictions on personal freedoms such as freedom of movement, restrictions on autonomy, poor or substandard food, accommodation and hygiene, physical or mental abuse and humiliation.

Anecdotal and media reports certainly suggest that there may be widespread abuse. These reports have been made over a long period of time, are consistent in their criticisms and come from a variety of sources. A number of aged care advocates suggest that abuse is very prevalent if not rife with the problem being exacerbated by poor staff

levels and inadequate training.³¹ It is argued that increasing workloads, high stress and low pay are causing aged care nurses to leave the aged care sector. Poorly qualified and poorly trained hands on staff are employed who often lack the necessary communication skills in English to communicate effectively with residents and to comprehend written case notes and care plans. These personal care workers comprise about 60% of the aged care workforce, but according to the Australian Nursing Federation they do not have the training to deal with complex patient care. This is significant because about 70% of the people in aged care had high care needs.³² Those people need highly qualified staff.

Braithwaite *et al* in their fieldwork study of Australian aged care facilities report that a state advocacy agency suggested that they believed that sexual assaults by staff to have occurred at 22% of the nursing homes in their jurisdiction.³³ It is also believed that many of these assaults do not result in criminal prosecution because nursing homes act to cover them up. There have been numerous media reports of sexual abuse allegations.

The consultations of the Human Rights Consultation Committee report³⁴ expressed widespread unease about the vulnerability of elderly people, particularly in aged care. As the report noted:

*Many people are becoming increasingly concerned about the inadequacy of services for the ageing, the conditions inside retirement hostels and nursing homes, and the general vulnerability of people who become invisible because they are elderly.*³⁵

The report recorded that a nursing home worker resigned after less than a month because she was horrified by the human rights abuses she witnessed: 'I worked there for a while and it changed my life. When you are old you are ... tossed on the hay and forgotten'.³⁶

³¹ B Packham Herald Sun Brisbane December 13, 2009 at

<http://www.heraldsun.com.au/news/victoria/abuse-allegations-on-the-rise-in-nursing-homes/story-e6frf7kx-1225809984812>

³² R Browne 'Alarm at violence in aged care' Sydney Sun Herald March 28, 2010, 8-9.

³³ J Braithwaite, T Makkai and V Braithwaite *Regulating aged care: ritualism and the new pyramid* Edward Elgar Publishing, Cheltenham 2007, 186.

³⁴ National Human Rights Consultation Committee *Report on the Consultation into Human Rights in Australia* Commonwealth of Australia 2009 (report handed down on 30 September 2009), 33-34.

³⁵ Ibid 33-34.

³⁶ Ibid 33.

Many participants told the Committee more attention must be paid to the needs and care of people as they age and that mechanisms must be introduced to alert responsible authorities if conditions fail to meet expectations. The ACT Disability, Aged and Carer Advocacy Service commented to the Committee

Advocacy groups concerned with the rights of frail older people and people with disabilities say protections existing in Australian law in relation to their rights [are] woefully inadequate.³⁷

The report continued:

The right to be free from degrading treatment is especially pertinent to older people living in aged care facilities and nursing homes. This is because they are entirely dependent on facility staff and their carers. Seniors Rights Victoria echoed a commonly expressed fear: 'Older people have limited ability to protect themselves and assert their rights in an environment where efficiency is often the main priority of caregivers'.³⁸

Organisations such as the Aged Care Crisis Team attempt to monitor conditions in nursing homes. The Aged Care Crisis Team maintains data which seems to reflect the reality that current protections against abuse in nursing homes are failing to reduce it in any significant way.³⁹ It has argued that standards in aged care facilities are actually declining and that there is evidence that aged care residents regularly go without proper pain relief and palliative care. Problems include the following: poor infection control; inadequate clinical care; failure to provide safe medicine, adequate nutrition and hydration; painful and avoidable bed sores; and inappropriate use of physical and chemical restraints.⁴⁰

The Australian Nursing Federation Federal Secretary has said that the aged care system is under pressure and that 'awful stories were coming out'.⁴¹ She also said that incidents could be prevented if there was adequate staffing, adequate numbers of qualified staff, and if the workloads were manageable and reasonable. The Dieticians

³⁷ Ibid 34.

³⁸ Ibid.

³⁹ Aged Care Crisis Team, *Elder Abuse*, (2008) <<http://www.agedcarecrisis.com/elder-abuse>> at 22 June 2008.

⁴⁰ R Browne 'Alarm at violence in aged care' Sydney Sun Herald March 28, 2010, 8.

⁴¹ Ibid.

Association reported that one in two aged care residents was malnourished increasing their risk of falls and fractures.⁴²

As further discussed below it is imperative that the real level of abuse be formally investigated and that this investigation should include some empirically based studies.

V. CURRENT REGULATORY RESPONSES TO ABUSE AND REFORMS

The *Aged Care Act 1997* (Cth) ("*Aged Care Act*") introduced a number of reforms to the regulation of aged care. The current regulatory system as developed by that Act has a number of components, including the following: an accreditation process for service providers; a complaint and investigation process; and the potential for sanctions against clearly recalcitrant service providers.

The Department has also established a Community Visitors Scheme for volunteer visitors to assist residents who may be isolated or lonely. This is a very worthwhile project, but it cannot be properly described as forming part of a complaints and investigation process. In fact, community visitors are directed not to become involved in matters of compliance or legal conflicts.⁴³

In addition, there is a Charter of Resident Rights and Responsibilities, which includes basic rights of residents, but has no enforcement or compliance mechanisms and is therefore exhortatory. There is also an advocacy service which is further discussed below.

While these reforms are welcome and worthwhile, a number of deficiencies need to be rectified. Above all, these processes do not confer rights on abused individuals to a legal remedy. Instead, the official response and framework is patchy and under-resourced, the response is discretionary and difficult to legally challenge by the ordinary citizen.

ACCREDITATION OF SERVICE PROVIDERS

All service providers must be accredited under the *Aged Care Act*. The Aged Care Standards and Accreditation Agency Ltd (the Agency)

⁴² Ibid.

⁴³ Braithwaite et al above n 33, 186.

accredits all Australian Government funded aged care homes, with 91.6 per cent of homes accredited for at least three years.⁴⁴

During 2008-09, the Agency identified 303 homes as being non-compliant with one or more of the 44 expected outcomes of the Accreditation Standards and 2.4 per cent of homes (68 homes) were identified as not meeting one or more of the expected outcomes of the Accreditation Standards.⁴⁵

It is beyond the scope of this article to give a detailed analysis of accreditation system and regulatory systems generally. A 2007 report commissioned by the Department of Health and Ageing found that the accreditation system was fundamentally sound, but that the implementation of measures to assess quality improvement was desirable.⁴⁶ While accreditation systems are used widely as a form of regulation there are issues concerning their evaluation, including a lack of evidence as to their effectiveness, concerns that accreditation that focuses on minimum standards will only produce limited performance and not excellence, and that accreditation can be costly, administratively burdensome and time consuming.⁴⁷ The Australian system has been the subject of some criticism, for example, for fostering tokenism or ritualistic compliance that does no more than achieve the bare minimum standard and may in fact encourage less than the minimum.⁴⁸ While the standards of aged care facilities have improved because of accreditation,⁴⁹ there is still significant room for improvement, for example, in dealing with long term systemic problems.⁵⁰ One area to consider is that Departmental assessors and inspectors need further training on the application of standards as there are concerns about their consistency of approach and that they overall tend to be lenient in relation to breaches.⁵¹

⁴⁴ Report on the operation of the *Aged Care Act 1997*, 2008-2009 above n 3, 70.

⁴⁵ *Ibid* 88. For the primary responsibilities of approved service providers see *Aged Care Act 1997*, s 63.1. The 44 outcomes relate to 4 main standards or areas: management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safe systems.

⁴⁶ Department of Health and Ageing *Evaluation of the impact of accreditation in the delivery of quality care and quality of life to residents in Australia* Commonwealth of Australia 2007, Executive Summary i.

⁴⁷ Campbell Research Consulting above n 10, Executive Summary xv.

⁴⁸ Braithwaite et al above n 33 Chapter 6, pp 176-215.

⁴⁹ *Ibid* 195.

⁵⁰ L Gray *Two year review of aged care reforms*, Commonwealth of Australia Department of Health and Aged Care, Canberra 2001.

⁵¹ Parliament of Australia Senate *Quality and Equity in Aged Care* Canberra, Commonwealth of Australia 2005 para 3.27-3.36.

It is also argued that there are mandated staffing levels for child care centres, kindergartens, schools and hospitals and the same requirement should exist for aged care.⁵² The Aged Care Crisis Team has reported that it was told that one nursing home had only one person on duty for 80 residents.⁵³ What would be desirable would be the development of very clear benchmarks for key indicia such as staff-client ratios, the level of expertise of staff, and reasonable standards for health, accommodation and hygiene that do reflect quality care and treatment. A failure to achieve these minimum levels should be responded to with expeditious action including where infringements are serious, sanctions such as suspension or revocation of accreditation.

BEST PRACTICE GUIDELINES AND STANDARDS

The Department of Health and Ageing in its last annual report relating to aged care indicates that it has designed the Encouraging Best Practice in Residential Aged Care (EBPRAC) program to support the uptake of existing evidence-based guidelines by funding organisations to translate this evidence into practice for staff to use in everyday practice. The best practice guidelines are exhortatory only. There are no enforcement mechanisms for best practice and there is no comprehensive, ongoing supervisory role of each service provider in relation to best practice and quality care. Developing an environment of continuous improvement for facilities is clearly worthwhile and can be fostered by rewards and, on occasions, re-integrative shaming that encourages facilities and their staff to do better.⁵⁴ It is clear that greater resources and efforts need to be allocated to improving the quality of facilities and care and that, for example, accreditation decisions need to more clearly consider staff-client ratios and the quality and training of staff.

However, this positive system of incentives must be balanced with an effective enforcement system. Thus, the aged care system needs two models that can complement each other: a regulatory model supported by effective enforcement to achieve and maintain minimum standards; and a strengths based best practice model supported by rewards.⁵⁵

COMPLIANCE

⁵² R Browne 'How less qualified workers are taking up the slack' *Sydney Sun Herald* March 8.

⁵³ Ibid.

⁵⁴ Braithwaite et al above n 33, 199-214.

⁵⁵ Ibid 330.

The Office of Aged Care Quality and Compliance (the Office) within the Australian Government Department of Health and Ageing is responsible for ensuring the quality and accountability of Australian Government-subsidised aged care services. The Office manages national programs that seek to ensure the safety and security of people in aged care services; promotes good practice in delivery of aged care; enhances the skills and availability of the aged care workforce; and ensures the financial security of aged care residents.

The Office's key responsibilities include: managing the Aged Care Complaints Investigation Scheme, the Community Visitors Scheme and the National Aged Care Advocacy Program; promoting the aged care sector's awareness of the importance of providing high quality of care; and the prudential regulation of approved providers charging accommodation bonds.⁵⁶

The role of the Office is commendable, but the issue is whether there is sufficient funding for programs to ensure the quality of care across the nation, and covering all service providers. The rate and number of complaints and the concerns about accreditation, and the feedback from various consumers and advocacy groups discussed in this article, strongly suggest that there is insufficient funding.

This quality assurance system is intended to be reinforced by a program of unannounced visits, and audits for residential care and follow-up action as appropriate for all aged care services.

COMPLAINTS INVESTIGATION SCHEME

The Aged Care Complaints Investigation Scheme (CIS) establishes a process for investigating complaints made under the *Aged Care Act*. It commenced operation on 1 May 2007 and was established through changes to the *Aged Care Act* and the introduction of regulations under the Act, namely the *Investigation Principles 2007*.

The CIS is based on alternative dispute resolution principles, is free, and allows a complaint to be made independently from a residential facility.⁵⁷ Resolution processes under the Scheme include the following: preliminary assessment handled by complaints resolution officers prior to the acceptance or non-acceptance of a complaint; negotiation by

⁵⁶ For an overview of these functions see Report on the operation of the *Aged Care Act 1997, 2008-2009* above n 3, Ch 8, 9, 10.

⁵⁷ This description of the CIS is based upon the analysis of the Senate 2005 Inquiry above n 51 para 3.127-3.135.

complaints resolution officers; mediation by qualified, external officers; determination of complaints conducted by committees, which are constituted of independent members with skills in aged care; and complaints resolution if complaints cannot be resolved through negotiation or mediation. Oversight of the Scheme is conducted by the Commissioner for Complaints.

For 2008-09, 63 per cent (or 7,962) of these complaints were considered 'in-scope' cases, that is, relating to an Approved Provider's responsibilities under the Act and subsequently investigated. Breaches of an Approved Provider's responsibilities were identified in 1,093 cases (which includes where a Notice of Required Action was issued).⁵⁸ The CIS made 1,629 referrals to external agencies more appropriately placed to deal with the matters raised; conducted 3,151 site visits during the course of investigating a case; and issued 181 Notices of Required Action where Approved Providers were found in breach of their responsibilities under the Act and had not already taken action to address the breach.⁵⁹

The position of Aged Care Commissioner has also been created under the *Aged Care Act*.⁶⁰ The Commissioner can in response to a complaint, or on their own initiative, examine the Secretary's processes and decisions in relation to complaints and their investigation. The introduction of the Aged Care Commissioner is a welcome reform, but it does have some limitations. The Commissioner is within the portfolio of the Minister for Health and Ageing and there may still be perceptions at least that the external oversight process is not at arms length. In addition, the Commissioner has a recommendatory role only and cannot make any decisions. Moreover, while the Commissioner has an 'own motion' power, the Departmental 2008-09 annual report noted that there had been no 'own motion' reviews.⁶¹ There is a danger that the Commissioner will neither have the resources, nor the committed support of the Department, to make frequent and wide-ranging investigations of complaints or suggested problem areas. The role could be essentially limited to 'paper' reviews of complaint processes conducted by the Department. Moreover, the Aged Commissioner may not have a human rights focus but instead adopt a more bureaucratic modus operandi. It is for these reasons that we have suggested below that a Federal Human Rights Commissioner for the Aged should have the role of external oversight of the complaints and

⁵⁸ Report on the operation of the *Aged Care Act 1997*, 2008-2009 above n 3, 73-80.

⁵⁹ *Ibid* 81-83.

⁶⁰ *Aged Care Act 1997* (Cth) s 95A1(2).

⁶¹ Report on the operation of the *Aged Care Act 1997*, 2008-2009, above n 3, p 84-85.

investigation process with a dedicated and properly funded investigatory staff.

PROBLEMS WITH THE COMPLAINTS AND REGULATORY SYSTEM

The Senate Inquiry Report of 2005 concluded that the complaints system was not user friendly, that the mechanisms were unclear, and that it was unresponsive to the needs of many complainants.⁶² Aged care advocates said to the Inquiry that many family members gave up on complaining because their complaints are trivialised. Concerns were also expressed that some complainants were actively discouraged by service providers and/or the Department. The 'culling' of complaints by the Department may not always be justified or transparent.⁶³ The report recommended a review of the complaints system, that there be greater differentiation made on the basis of the severity of the complaint (eg serious, moderate and minor complaint), and that the mediation process be made more responsive and open and with greater support for complainants.⁶⁴ Moreover, complainants could feel shunted from one agency to another with no clear pathway of procedures or information.⁶⁵

The Walton Review was subsequently requested by the Federal Government to identify areas of improvement to ensure the CIS scheme achieves best practice aged care complaints management arrangements.⁶⁶ The Review summarised concerns about the scheme from the perspective of complainants as follows:

- Difficulty of accessing the complaints scheme;
- Complainants not involved or engaged in the complaint processes;
- Inadequate information about the complaint process and lack of transparency;
- A failure to adequately explain the reasons for the CIS decisions;

⁶² Parliament of Australia. *Senate Quality and Equity in Aged Care* Canberra, Commonwealth of Australia 2005 ('Senate 2005 Inquiry'), para 3.136-3.148; also see Braithwaite et al above n 33, 185.

⁶³ See, for example, the Senate 2005 Inquiry para 3.140.

⁶⁴ Rec 16, Senate 2005 Inquiry.

⁶⁵ See, for example, Senate 2005 Inquiry para 3.84-3.90, 3.18-19.

⁶⁶ M Walton *Review of the Aged Care Complaints Investigation Scheme* October 2009 Department of Health and Ageing Canberra 2009.

- Inadequate information on the outcome of an investigation;
- Inadequate protections for staff who are complainants;
- Fear of reprisals from the service if a person makes a complaint;
- The weight given to the complainant (family/friend) is less than that given to the provider;
- The standard of proof is unreasonably high; and
- The 14 day time frame to lodge an appeal to the Aged Care Commissioner is unnecessarily restrictive.⁶⁷

The Walton Review made a number of recommendations with the main ones being

- That the aged care complaint scheme be restructured into the following three divisions: Assessment and Early Resolution (essentially to deal with non serious complaints); Investigations (to deal with serious complaints); and Communications and Stakeholder Relations.
- The establishment of an independent Aged Care Complaints Commission and the creation of the position of Aged Care Complaints Commissioner who would report directly to the Minister for Ageing.⁶⁸

The Aged Care Complaints Commission would replace the current CIS and be a statutory body headed by the Aged Care Complaints Commissioner who would be appointed as a statutory office holder appointed by and reportable to the Minister for Ageing. Thus, the new Commission and Commissioner would be separate from the Department and therefore reduce concerns that the complaints process was not impartial and was too tied to the Department of Health and Ageing.⁶⁹

We are of the view that these recommendations, and the other

⁶⁷ Ibid para 4.3.

⁶⁸ Ibid. For a list of the recommendations see Ch 3.

⁶⁹ Ibid.

recommendations of the Walton Review about matters such as recruitment and training of complaints officers and development of better investigation standards and better promotion of the complaints system, are all useful and to be welcomed. We would also submit that the recommendations made by the Walton review are unlikely to deal satisfactorily with all of the concerns expressed about the complaints system as described above. We would assert that more is needed. In particular, the Aged Care Commission and its Commissioner would still report to the Minister for Ageing and not be completely external to the Department. The Commission and its Commissioner would be limited to a broad investigatory role and the non-litigious resolution of disputes that relies on the parties coming to a negotiated agreement. It could not initiate, conduct or supervise any litigation arising from complaints or investigations. Nor would it would a have a clear human rights focus as would the Human Rights Commission.

The complaint system in Australia is not rights focussed and complaints tend to be steered to dispute resolution strategies thereby excluding sanctions and enforcement.⁷⁰ Care must be taken to ensure that dispute resolution methods do not coerce or otherwise pressure complainants into agreeing to negotiated settlements. Mediation can be problematic when there are serious power imbalances between the parties. This is likely to be the case in such disputes where the elderly person may have physical and psychological disabilities, and may feel dependent on the goodwill of the aged care facility. There has been a lack of rights based culture in aged care homes and it lags behind the broader disability sector.⁷¹ Our recommendations advocating the introduction *The Rights of the Elderly in Aged Care Act* and the role of the Federal Human Rights Commissioner for the Aged would assist to make the complaints and investigation process more rights orientated.

There is also a need to examine the internal complaints processes of the Service providers. The Aged Complaints Resolution Scheme provides that at first instance complaints are to be processed through the internal process of the provider and only then to proceed to the external scheme, although it is possible for a complainant to by-pass the internal scheme. There is a mixed response to the effectiveness and fairness of such procedures.⁷² It would be worthwhile for there to be a study on the fairness and effectiveness of these internal processes to see, for example, the number of internal complaints made, the nature

⁷⁰ Braithwaite et al above n 33, 185.

⁷¹ C Ronalds, P Godwin and J Fiebig *Residents' Rights in Nursing Homes and Hostels: Final Report* Canberra, Australian Government Publishing Service 1989.

⁷² eg see Senate 2005 Inquiry above n 51, para 3.31-3.32.

and seriousness of such complaints, how they are resolved and dealt with, and the numbers that proceed to external system. It may be that some human rights infringements are not being identified and processed by the Department system at all. We also suggest that there should be some regular reporting mechanism on the number and nature and resolution of internal complaints that do not proceed to the external system.

Extra efforts also must be made to ensure that continuing information about the right to complain is made available to residents, to their friends and relatives. Staff should also be subject to a continuing process of being made aware of the complaints process and of their duty to cooperate in the complaints process. The legislation should contain offence provisions about intentionally or recklessly hindering or interfering with the making of a complaint or the investigation of a complaint, and there should also be a provision making it mandatory for all staff to report breaches of human rights. These obligations should be regularly discussed and reinforced.

The ACT Disability, Aged and Carer Advocacy Service said to the Senate Inquiry that complaints were 'chilled' by provider retribution against complainants, reporting 55 instances of actual retribution in aged care facilities in the Act between 2001-2004.⁷³ The 2005 Senate report recommended that there should be an investigation of allegations of retribution and intimidation against those who make complaints or who intend to make complaints.⁷⁴ There needs to be comprehensive whistleblower protection provisions in the Aged Care Act.⁷⁵

The investigation process needs to be timely and where possible interviews of parties and witnesses should take place separately and as soon as possible. Our consultations have indicated that many complaints, even ones containing serious allegations such as assault or neglect are done 'on the papers' with no interviewing of victims or witnesses. For example, in a recent allegation of a nurse spanking a dementia patient, the victim was not interviewed.⁷⁶ Concerns about limited 'paper' investigations are borne out by the Department's report that site visits were only undertaken in 40% of all complaints

⁷³ Braithwaite et al above n 33, 186.

⁷⁴ Senate 2005 Inquiry report above n 51, Rec 18.

⁷⁵ T Faunce and S Bolsin 'Three Australian whistleblowing sagas: lessons for internal and external regulation (2004) 181 *Medical Journal of Australia* 44-7; Braithwaite et al above n 33, 187.

⁷⁶ Our consultations with seniors' groups in 2009-10.

concerning providers' responsibilities. Moreover, 41% of these visits that were made were announced, that is the service provider was given notice that the visit was to occur.⁷⁷

Most Australian complaints do not result in a visit to the nursing home, unlike the situation in the United States.⁷⁸ Resolving complaints 'on the papers' should be avoided, particularly where the allegation is at all serious. Appropriate records of incidents must be kept by service providers. There is a special need in the investigation of complaints for investigators to have face to face contact with complainants and other potential witnesses and also staff and all relevant records. The vulnerability of elderly people and their potential cognitive and physical deficits means that care, sensitivity and persistence, and skills and experience may be necessary to investigate the matter properly. Family members and friends may need to be given information on the need to take photographs of injuries or defects in the residence and to get the names and identities of witnesses and staff.

Specific concerns⁷⁹ expressed about the regulatory system include the following:

- Many audits and impending visits by the accreditation agency are known by the service provider ahead of time, allowing them to prepare and, if necessary, change practices for the duration of the visit including, for example, increasing the number of staff and improving the quality of the resources (eg. food and hygiene).
- Audits are not conducted in a manner calculated to reveal any abuse. The guidelines allow the accreditation body to merely follow a paper trail. For example, for dental care, the guidelines require that there be a plan. However, there is not enough consideration of what the plan contains. For example, the guidelines do not require a dental nurse.
- Service providers engage consultants to improve their services and use the right jargon to prepare for accreditation without engaging in real or sustained improvements to their practices.

⁷⁷ Report on Operation of the *Aged Care Act 1997*, 2008-2009 above n 3, 81.

⁷⁸ Braithwaite et al above n 33, 186.

⁷⁹ Agedcarecrisis.com *How effective is the complaints process?* at <http://www.agedcarecrisis.com/aged-care-complaints?tmpl=component&print>.

- Service providers may attempt to persuade or coerce staff not to communicate concerns to assessors or investigators.
- Resident records about the frequency of care and medication may not reflect actual everyday practice and this may make it difficult for residents and their families to justify complaints when the formal figures do not reflect the allegation.
- Some records may be 'lost or hidden' or sent to head office when assessment occurs.
- Many working in nursing homes have received no training.⁸⁰ Pushing and hitting patients may be common place. Measures such as surveillance cameras are not used.
- Service providers may respond to deficiencies by formulating plans and reforms that are then never put into practice or soon lapse.⁸¹
- If an agency or investigation find some serious deficiency, service providers are often given great leeway in making changes.
- Investigators and assessors may face pressure, both direct and more subtle, to 'go easy' on service providers, both from service providers and from their superiors in the Department.⁸² This assertion is supported by the fieldwork of Braithwaite et al which indicates that assessors may fail to include negative findings in reports where such a finding is justified or where their negative findings are later changed by superiors without a reason being given. These situations breed cynicism from the assessors and a reluctance to report non-compliance.⁸³
- Talented accreditation assessors may be lured into private sector positions.⁸⁴

Consultations and the views of many advocates and workers at aged care centres indicate that poorly trained and inexperienced staff

⁸⁰ Writers' consultations with National Seniors organisation.

⁸¹ Agedcarecrisis.com *How effective is the complaints process?* at <http://www.agedcarecrisis.com/aged-care-complaints?tmpl=component&print>.

⁸² Eg see Senate 2005 Inquiry above n 51, para 3.27-34.

⁸³ Braithwaite et al above n 33, 193.

⁸⁴ Ibid 197.

continue to be employed and that there is an increasing 'casualisation' of the work force that exacerbates those problems and reduces the quality of care.⁸⁵

Each of these above allegations or assertions needs to be thoroughly investigated, preferably by an independent body. Measures must be taken to ensure, for example, that audits are random and unknown to service providers beforehand, and that they are thorough and professional.

In 2008-09, the Agency conducted 7,595 visits to homes, which represents an average of 2.7 visits per home. According to the Department, all homes received at least one unannounced visit from the Agency during the year.⁸⁶ In relation to audits in 2008-09 there were 1,622 accreditation site audits which give the service provider notice of the audit. There were in addition 104 review audits of which only 57 were unannounced. There were also 5,869 'support contacts' of which 3,481 were unannounced.⁸⁷

This would suggest that only on 57 occasions was there a full audit into a service provider which was unannounced. In all other cases there was either no full investigation or audit of the provider's service provision or if there was, the relevant service provider was given prior notice. As mentioned, there are 2,830 mainstream residential aged care services so a figure of 57 unannounced full audits seems to be a very low figure, particularly given the vulnerability of residents and the consistent anecdotal reservations about the audit, complaints and investigation processes. There is clearly a need for a significant increase in the number of un-announced audits, visits, inspections and investigation of complaints.

SANCTIONS

Where providers are found not to be meeting their responsibilities under the Act and fail to remedy the situation, there is the possibility of regulatory action by the Department, such as the imposition of sanctions.⁸⁸ As noted above, in 2008-09, the Department took action against 27 Approved Providers, issuing 30 Notices of Decision to Impose Sanctions. At 30 June 2009, 13 of the sanctions remained in place. The Department also issued 163 Notices of Non-Compliance.

⁸⁵ Senate 2005 Inquiry above n 51, para 3.84-3.90, 3.18-19.

⁸⁶ Report on the operation of the *Aged Care Act 1997*, 2008-2009 above n 3, 69.

⁸⁷ *Ibid*, 81-83.

⁸⁸ *Aged Care Act 1997*, s 65.1, 65.2, 66.1.

A comparative study of the United States, English and Australian aged care systems by Braithwaite, Makkai and Braithwaite found that the Australian system, particularly with the new accreditation system after 1997, was 'more captured by the aged care industry' than either the United States or England.⁸⁹

As Braithwaite et al conclude:

*Things have to be bad for non compliance to be recorded or strong criticisms to be made in an accreditation report. Over 99% of occasions when compliance with an expected outcome is assessed, compliance is the finding. In the very few cases where non compliance is found, sanctions are rare.*⁹⁰

Under accreditation if non compliance is found the agency has to put in place a timetable for improvement. During this phase a series of 'support contacts' are scheduled to assess the agency's progress.⁹¹ It is only if progress lags behind expectations that a review audit, that is, a full inspection covering all standards, will be undertaken. It is only after the end of the defined period to remedy defects that sanctions might be imposed if there is still non compliance or there is evidence of a serious risk to the health, safety or well being of a person receiving care.

If sanctions are contemplated, the Department sends out a compliance team to visit the home and make recommendations to the Department's legal section. There are multiple occasions for a home to rectify a situation or put in a place a plan to rectify non compliance before sanctions are actually imposed (unless the non compliance is an immediate and severe risk - in which in 80% of sanctions cases it is).⁹² The home then has to show that it has a sustainable system to ensure that non compliance will not re-occur. There will be regular checks (often weekly) to ensure that the home is removing the risk.

The most used sanction is a notice to revoke the home's status as an approved provider for federally funded residents (most residents). However, revocation can be deferred if an approved adviser (mostly an outstanding director of nursing) is appointed by the home and the Department jointly to resolve the compliance issues. The second most

⁸⁹ Braithwaite et al above n 33, 176.

⁹⁰ Ibid.

⁹¹ This description of the process for sanctions is derived from Braithwaite et al above n 33, 178-180.

⁹² Ibid.180.

common sanction is suspension of government funding support (normally for six months, although many are lifted before that period).

The Department apparently does not regard the imposition of sanctions as serving a deterrent purpose, nor does it see sanctions as part of an enforcement strategy but instead only as a strategy of ensuring compliance by the relevant provider.⁹³ Only 3 homes were closed by the Federal Government from 1997-2007 by revoking the accreditation of an approved provider for federally funded residents.⁹⁴ There are no punitive sanctions and no attempts to use sanctions as a general deterrent. Homes that are found to infringe even in admittedly serious ways may well not have their accreditation revoked or suspended, nor will they necessarily be subject to any significant sanctions.

Recent cases in which sanctions have been imposed include a case of a severe outbreak of gastroenteritis at one nursing home,⁹⁵ concerns about the lack of proper medical treatment and hygiene at a number of nursing homes,⁹⁶ insufficient qualified staff at various homes,⁹⁷ inadequate pain relief management,⁹⁸ poor wound management,⁹⁹ attacks by vermin,¹⁰⁰ and failure to have proper clinical care plans.¹⁰¹ The cases generally involve breaches of a number of standards that are

⁹³ bid 178-179.

⁹⁴ Ibid 179.

⁹⁵ The Hon Justine Elliot MP Minister for Ageing at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je013.htm?OpenDocument&yr=2009&mth=2> at Bangalor Retreat Nursing Home in February 2009 that resulted in severe illness for 44 residents and 13 staff including the death of one resident, three hospitalisations. About 60% of gastroenteritis attacks occur in nursing homes.

⁹⁶ The Hon Justine Elliot MP Minister for Ageing at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je020.htm?OpenDocument&yr=2009&mth=3>

⁹⁷ The Hon Justine Elliot MP Minister for Ageing at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je028.htm?OpenDocument&yr=2009&mth=3>

⁹⁸ The Hon Justine Elliot MP Minister for Ageing at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je125.htm?OpenDocument&yr=2009&mth=10>

⁹⁹ The Hon Justine Elliot MP Minister for Ageing at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je067.htm?OpenDocument&yr=2009&mth=5>

¹⁰⁰ The Hon Justine Elliot MP Minister for Ageing at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je059.htm?OpenDocument&yr=2009&mth=4>

¹⁰¹ The Hon Justine Elliot MP Minister for Ageing at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je070.htm?OpenDocument&yr=2009&mth=5>

long running, have not been properly addressed by the service provider, and involve significant risks to the well being and health of residents. In addition, many serious risk cases appear to be activated not by audits but by informants, sometimes by anonymous informants.

A stronger enforcement environment and culture needs to be developed. It should be expected that any serious case of non compliance by a residential facility will be the subject of a sanction; that minor breaches that continue after the facility has been put on sufficient notice of the breach should also be met with a sanction, and that there should be regular monitoring of any facility that has been found to have committed a serious breach or minor breach. Assessors must be given clearer guidelines and training to ensure that breaches are treated in this way and the Department as a whole should support such action.

PART VI. OTHER CURRENT AVENUES FOR COMPLAINT AND REDRESS

There is a patchwork of potential protection for certain human rights in Australia which creates concerns that there can be gaps in protection, ambiguities, confusion and duplication. This patchwork includes the following: a few limited rights under the Australian Constitution;¹⁰² specific human rights acts in the ACT and Victoria; Federal and State anti-discrimination legislation; international conventions and treaties; and the common law.

This limited and diffuse patchwork means that there is an overarching problem of access to justice for the elderly in residential care. Access to justice is a fundament requirement for an adequate or effective human rights system as identified by the Human Rights Consultation Committee report¹⁰³ and it is the marginalised and the disempowered (such as elderly people with disabilities) who will require considerable additional resources and support to achieve effective access to justice.

COMMON LAW

¹⁰² There are some limited Constitutional protections that have little relevance to human rights issues in aged care eg freedom of religious expression under s 116 of the Constitution and freedom of political communication as implied under the Constitution (eg see *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520).

¹⁰³ Human Rights Consultation Committee Report above n 34, 126.

The common law, especially in the areas of tort and crime, could provide legal remedies for various types of abuse of the elderly. For example, torts for trespass and assault for unlawful physical interference to an elderly person, or negligence for cases where the service provider has failed in its duty of care to provide a safe and healthy environment for an elderly resident. Physical assault can constitute both a civil wrong and a crime.

However, there are a number of limitations in relying upon torts or the criminal law as a form of redress. First, torts may not cover all aspects of elderly abuse. For example, humiliation and patronising comments and treatment are unlikely to be categorised within the current array of torts, but they may be common forms of abuse of the elderly in aged care. Generally, invasions of dignity and privacy, and degrading treatment, are not such as to constitute physical assaults justifying criminal or civil action. Secondly, the common law can be overridden by the legislature at any time.¹⁰⁴ Thirdly, the common law is less accessible for laypeople and will generally require the services of a lawyer to identify the issue and pursue a matter. Elderly people in residential care are unlikely to have the skill, financial resources or opportunity to use the common law without a great deal of assistance. Fourthly, taking common law action is expensive and time consuming and matters may not come to trial for a number of years. This problem is exacerbated by the advanced age of the plaintiffs. Fifthly, the common law may have a slow and uneven development as it can be affected by the type and number of cases brought, whether matters are settled before trial, and whether courts consider they are constrained by precedent, or whether constrained to make their decisions limited to the particular factual situation before them. Courts may be reluctant to make general statements of principle or declarations of human rights. Moreover, criticisms can be made of activist courts that appear to develop the law, particularly within the context that judges are unelected and also may lack the skills and evidence before them to make sensible policy judgments.

Our initial research indicates that very few common law actions are taken by aged residents against government or against service providers.¹⁰⁵

In relation to using the criminal law elderly people may have difficulties in that the prosecution will have to prove matters to the

¹⁰⁴ Ibid 122.

¹⁰⁵ Including case searches using various legal search engines.

criminal standard of beyond reasonable doubt. Elderly people may be reluctant to make statements or give evidence. They may also find it difficult to give such evidence given their possible mental and physical disabilities. Moreover, criminal prosecution is run by the State and the focus is on punishment of the offender and not providing a remedy to the victim. In fact, it is claimed that there has been no criminal prosecution for neglectful care.¹⁰⁶

ANTI-DISCRIMINATION LEGISLATION

The Australian Human Rights Commission under Federal legislation can investigate complaints and attempt to conciliate them under the various anti-discrimination and human rights Acts, but there are numerous criticisms of the role of the Commission as discussed in the Human Rights Consultation Committee Report. Those concerns include a narrow definition of human rights, limited enforcement powers, limited rights of a complainant to initiate court action themselves, Commonwealth-State demarcations of power allowing for confusion and gaps in enforcement, and the Commission not having any compulsory powers in terms of changing Government legislation or policy.¹⁰⁷

Moreover, in relation to discrimination based on age there are significant specific concerns. While Commonwealth and State statutes are applicable to a potentially wide area of discrimination based upon age,¹⁰⁸ age discrimination as an issue has lagged considerably behind other areas such as gender or race.¹⁰⁹ The legislation and case law has focussed on age discrimination in the workforce that, while likely to gain in importance as older people stay in the workforce or rejoin the workforce, does not cover the many other forms of discrimination against the elderly, including in aged care facilities. There have been comparatively few complaints made to the Human Rights Commission in relation to aged based discrimination, and most of those are about employment issues.¹¹⁰ This apparent underuse is in part at least due to the restricted definitions of discrimination and harassment. For example, the definitions of discrimination based upon age under the *Age Discrimination Act 2004* (Cth) refer to the discriminator treating an

¹⁰⁶ Braithwaite et al above n 33, 191.

¹⁰⁷ Ibid 124-125.

¹⁰⁸ *Age Discrimination Act 2004* (Cth); *Anti-Discrimination Act 1977* (NSW) s 49ZYA. *Equal Opportunity Act 1995* (Vic) s 6.

¹⁰⁹ S Encel, 'Age Discrimination in Law and Practice' [2004] *ElderLaw Rw* 7, 7-10.

¹¹⁰ Australia House of Representatives Standing Committee on Legal and Constitutional Affairs *Inquiry Into Older People and the Law* above n 14, para 6.13.

aggrieved person less favourably than they would treat a person of a different age. This presupposes that aged people are involved in activities that other people may be involved in. However, in relation to aged care there is no real comparator with other groups because age care is really only provided to elderly people. In addition, laws relating to prohibiting discrimination on the basis of age in the workforce are of almost no use to elderly people in aged care who do not, and in most cases could not, work. The House of Representatives Standing Committee on Legal and Constitutional Affairs has recommended a review of the effectiveness of the *Age Discrimination Act 2004* (Cth) including exemptions from the operation of the legislation.¹¹¹

In relation to human rights concerning the elderly these concerns are exacerbated by the fact that there is no focus or leadership for human rights protection for the aged. For example, there is no Federal Human Rights Commissioner for the Aged, a new position that we suggest be established.

ADMINISTRATIVE LAW

In general terms, administrative law in Australia provides little direct protection of human rights for a number of reasons. First, while administrative review may result in challenging the lawfulness of administrative decision or, in some cases, the merits of the decision, it will not usually result in an individual remedy of for example, damages for a breach of human rights. Secondly, most decision making by private based organisations is not subject to review. Thirdly, many decisions by government and its agencies are outside the scope of merit based administrative review because they do not come within the scope of the *Administrative Appeals Tribunal Act 1975* (Cth). Fourthly, judicial review of administrative decisions is limited to the lawfulness of the process and not the merits of a decision.¹¹² Fifthly, the basic principles for 'standing' give only limited capacity for an individual to intervene to compel government or a public authority to exercise a power to protect a vulnerable class, for example, to investigate a nursing home against which a complaint of a human rights abuse is made.

In relation to the rights of the elderly in aged care, administrative law offers limited scope for challenge based upon human rights

¹¹¹ Ibid para 6.39 rec 44.

¹¹² *Administrative Decisions (Judicial Review) Act 1977* (Cth); eg see J McMillan & N Williams 'Administrative law and human rights' in D Kinley ed *Human rights in Australian Law* Federation Press Sydney, 1998, 63-91.

infringements. Administrative law has been criticised as providing only ritualistic and ineffective protection for the rights of aged care residents.¹¹³ Some decisions relating to decisions by government about residential health care do fall within the jurisdiction of the Administrative Appeals Tribunal (AAT) (such as some decisions about accreditation). However, it is claimed that these decisions are relatively infrequent and add little to effective enforcement.¹¹⁴ Decisions about complaints and investigations are not subject to merits review by the AAT.

INTERNATIONAL LAW AND CONVENTIONS

Justice Kirby has said of international declarations and their impact on Australian domestic law:

*Putting it bluntly, we have so far largely ignored, or rejected, the relevance for our own legal system of the great change that came about in the protection of basic rights, following the Second World War and the creation of the United Nations.*¹¹⁵

That comment certainly applies to the area of elderly human rights protection. There are a number of international instruments that can deal with rights of the elderly, but of particular relevance are the UN's Madrid International Plan of Action on Ageing in 2002, the Principles of Older Persons in 1991, and the Proclamation on Ageing in 1992. However, these instruments tend to be general, setting out exhortatory principles, but not containing any specific requirements as to enforcement, compliance and sanctions. In any event, none of these instruments are binding domestically in Australia unless put into legislation and there is no scope for enforcement in Australia without that happening. However, member states are expected to cover the rights of older persons to promote respect for the human rights of older persons in their laws, policies and actions, and to take measures to realise them in practice. Certainly the international instruments play an educative role and encourage international scrutiny and comparisons but they thus far have not had a significant effect upon Australian domestic law.

¹¹³ Braithwaite et al above n 33, 185, L Meyer (2006) 'The shame of aged care in Australia', www.agedcare.crisis.com.

¹¹⁴ Braithwaite et al above n 33, 191.

¹¹⁵ The Hon Michael Kirby, AC, CMG, 'The ALJ @ 80: Past, Present and Future', Paper delivered to a conference to celebrate the 80th Anniversary of the Australian Law Journal, 16 March 2007, unpublished.

PART VII. MAJOR REFORMS

A COMPREHENSIVE AND CO-ORDINATED REVIEW OF ELDER ABUSE AND ELDER RIGHTS IN AUSTRALIA

One of the major weaknesses thus far in the development of effective protection of elderly rights is the lack of a co-ordinated approach that covers all major aspects of the topic. Instead the response has been piecemeal with a complex and overlapping set of Federal and State initiatives, laws and policies operating with resulting confusion, gaps and duplications. Thus a national review is necessary that examines evidence and investigates matters such as the level and types of elder abuse and the range of policies and laws that can prevent and deter human rights infringements and where necessary punish them. Each of the Commonwealth, the States, and the Territories should co-operate in developing and implementing a best practice approach to human rights that preferably results in uniform legislation and approach, or at least in the development of national standards. State and Federal laws need to be examined and, where necessary, harmonised.

A Federal Human Rights Commission that is supported with dedicated additional funding to undertake the task is likely to be the best organisation to lead such an inquiry. However, the review must include State and Territory representatives and involve elder rights groups and the community. One important part of that inquiry must be a review of elder rights in aged care including empirical study of the level and nature of elderly abuse in aged care facilities across Australia and in relation to the full spectrum of care that is provided. That Federal inquiry should also consider legal and other methods of prevention of abuse in aged care including a whole of government approach.¹¹⁶

This review should also consider the operation and effectiveness of Federal and State laws that deal with discrimination against the elderly including definitions of discrimination, exemptions, investigation, enforcement and remedies. The laws should encourage empowerment of the elderly and not merely be a form of paternalistic legislation. In particular, the elderly and the groups that represent them must be continuously consulted in the development of law and policies in relation to them.

¹¹⁶ C Hastie 'Progress in the Fight Against Elder Abuse' [2004] *ElderLaw Rw* 4, 4.

Such a review should also consider other legislation and protections of elderly rights including disability rights legislation. Most of the human rights issues in the area under discussion arise from the person's vulnerability because of declining mental and physical capacity, that is the onset of disabilities. The relevance of age to rights is not in age itself, but in the reduced capacity which can onset in old age.

One significant aspect of this consideration of disability legislation would be the introduction into Australian domestic law of the Convention on the Rights of Persons with Disabilities (CRPD) which has been ratified by Australia.¹¹⁷ Ratification does not mean that provisions of the CPRD are enforceable at a domestic law level. International law is not enforceable unless incorporated into domestic law via statute. This principle was explained by Mason CJ and Deane J in *Minister for Immigration and Ethnic Affairs v Teoh*.¹¹⁸ The Commonwealth could clearly implement the treaty domestically under the external affairs power of the Constitution.¹¹⁹

The CRPD is a comprehensive set of rights for persons with a disability and is widely regarded as having the potential to bring about very significant improvements in the protection of people with a disability.¹²⁰ The Federal Attorney-General has signed a declaration under the *Human Rights and Equal Opportunity Act 1986* to enable the Australian Human Rights Commission to conciliate complaints based on breaches of the CPRD. However, this has the fundamental deficiency that it confers no legal right to a civil remedy for compensation.

Another further reform to consider for all jurisdictions would be the introduction of the statutory office of Senior Practitioner, such as established under the Victorian *Disability Act 2006*, and who is charged with ensuring that disability service providers comply with

¹¹⁷ Commonwealth Attorney-General's Department, 'Australia Ratifies UN Disabilities Convention' (Media release, 18 July 2008) http://www.attorneygeneral.gov.au/www/ministers/robertmc.nsf/Page/MediaReleases_2008_ThirdQuarter_18July2008-AustraliaRatifiesUNDisabilitiesConvention. The final research paper submitted to the Departments of Families, Housing, Community Services, and Indigenous Affairs, and Attorney-General on whether to ratify the CRPD can be found here: <http://www.disabilityrightsnow.org.au/node/2>.
¹¹⁸ [1995] HCA 20, 25.

¹¹⁹ For a discussion of the external affairs power see A Blackshield and G Williams *Australian Constitutional Law and Theory. Commentary and Materials* 5th abridged ed Ch 19.

¹²⁰ B McSherry 'International Trends in Mental health laws: Introduction' *Law in Context Special Issue International Trends in Mental Health Laws* ed B McSherry 26(2) Federation Press 2008.

appropriate standards in relation to restrictive and compulsory treatment stipulated in the Act.

THE INTRODUCTION OF THE RIGHTS OF THE ELDERLY IN AGED CARE ACT

The protection of elderly rights because of the combination of difficulties as discussed in this article requires a robust and proactive system of human rights protection. Elderly persons may have particular problems in making complaints, seeking assistance, instructing lawyers and may have suffered no economic loss. The clear risk of abuse, degrading treatment, and invasions of dignity and privacy in nursing homes and other institutional environments for the elderly means that independently enforceable statutory protections are required.

The current compliance and enforcement environment is defective in responding to the inherent challenges. The system as a whole does little to encourage long term compliance and the maintenance of at least minimum standards. There is little deterrent power in the current complaints and regulatory system. First, the risk of infringement by service providers or their employees is great, considering the number of institutions and the range of skills and experience of staff. Secondly, as noted, there can also be financial incentives and pressures to cut corners and reduce services and quality. Thirdly, caring for elderly people, many of whom are suffering severe physical and mental disabilities can undeniably be challenging and require experienced staff and ample resources. As discussed above, there is already considerable unease about staffing levels and the experience and qualifications of staff. Fourthly, as discussed above, the potential group of victims is acutely vulnerable. Added to this is a largely bureaucratic method of enforcement and compliance with apparently a wide opportunity to avoid detection or, if detected, to avoid any sanction or to receive only lenient and short term sanctions. Infringing service providers are generally given a series of opportunities to eventually comply. The complaints system is also relatively inaccessible, lacks institutional support, and is clearly geared to mediating disputes rather than also offering the capacity of sanctions and enforcement. This comparatively lax and inadequate compliance and enforcement environment needs to be energised and given a more human rights focus.

There needs to be a set of legally enforceable rights out of which there is a legitimate ground for litigation. We are of the view that the protection of elders' human rights will best be protected not by a generalist charter of non enforceable rights, but by a specific human

rights Act that deals with aged care facilities. Many general statutory Bills of Rights, as in the ACT and Victoria¹²¹, do not create rights in that the courts are not able to strike down laws that are inconsistent with human rights enshrined within them.¹²² These types of Bills provide no damages remedy for breach of their provisions. Moreover, overseas developments suggest that the elderly need specific human rights legislation dealing only with them because if they are subsumed under more general rights legislation they will tend to be ignored or given low priority or be so stigmatised as to be regarded as helpless.¹²³ In addition, there is already in place a statutory complaints and regulatory process for aged care and the human rights protection needs to be directly linked to that existing legislation to create a coherent system.

The Act should state a series of civil obligations, which if breached, may be remedied through a civil process initiated in the Federal Court. The civil obligations would protect the human interests of the subject group, including to privacy, dignity, and protection from physical and emotional cruelty. The penalty for breach of any such civil obligations should be paid to the person violated. The Act should also make available opportunities and mechanisms to mediate and negotiate suitable disputes with criteria to be considered for when disputes are considered suitable for alternative dispute resolution.

We would suggest that such an Act would be constitutionally valid since the establishment of a regulatory scheme for aged care was upheld by the High Court in *Alexandra Private Geriatric Hospital Pty Ltd v The Commonwealth*.¹²⁴ The Court held, inter alia, that given that the Commonwealth had power to provide for the provision of sickness and hospital benefits to patients in nursing homes, some kind of scheme to ensure that the provision was effective in meeting the needs of such patients was essential and hence within the Federal power. Therefore, we would submit that providing for the human rights of such patients and the enforcement of such can be regarded as

¹²¹ *Charter of Human Rights and Responsibilities Act 2006 (Vic)*.

¹²² See Evans C & Evans S, *Australian Bill of Rights: The Law of the Victorian Charter and ACT Human Rights ACT*, Butterworths, Sydney, 2008 (Speaking also of the ACT Charter) at p 1. The ACT and Victorian Acts protect human rights by requiring the proponents of legislation and the Parliament to consider the rights-impact of their legislation; requiring courts (where possible) to interpret legislation in accordance with human rights; and by expressly or implicitly requiring government and public authorities to comply with human rights.

¹²³ I Doron, S Alon & N Offir, above n 4, 78; also see S Biggs, C Phillipson & P Kingston *Elder Abuse in Perspective* Buckingham, Open University Press 1995.

¹²⁴ (1987)162 CLR 271.

sufficiently connected to such a regulatory scheme and its major objective of meeting the needs of aged care residents.¹²⁵

APPOINTMENT OF A HUMAN RIGHTS COMMISSIONER FOR THE AGED AND A
DEDICATED INVESTIGATION AND COMPLIANCE UNIT

The Act should add a Commissioner for the Aged to the Human Rights Commission. The Commissioner should conduct a full audit of the current legislative regime that regulates aged care facilities including Federal, State and Territory law. The Commissioner should be given standing to initiate or intervene in any proceedings, prosecutions, and administrative decision-making, relating to breaches of the subject group's existing legal rights under any Australian law, or protection of the subject group. The Commissioner should report annually to the public, the Parliament and the government, on the complaints and investigation process and the extent to which inadequate funding of sectors, including nursing homes, providing for the subject group limits their ability to meet their human rights obligations under the Act.

The Commissioner should have the power to oversight and intervene in any complaints investigation undertaken under the Aged Care Act. The Commissioner should also have a power to investigate any complaint of his or her own motion. A comparable model would be the Ombudsman's power and role in relation to complaints made against the police.

A different approach to having a Human Rights Commissioner for the Aged within the Human Rights Commission would be the introduction of a completely separate office, such as a Commissioner for Older Persons with a broad mandate to deal with a vast range of matters relating to older people including breaches of their human rights in aged care facilities and elsewhere. While the writers can see the long term value of having one co-ordinated, institutional response to elder issues, we are of the view that the introduction of such a general Office with sufficient resources to undertake effectively such a broad role is highly unlikely in the short to medium term. Instead building upon an existing institution with a human rights focus is currently a preferable option, particularly given that there is already in place much of the legislative and institutional infrastructure that would be necessary for developing a Human Rights Commissioner for the Aged.

¹²⁵ Also see Campbell Research Group above n 10, 19-20.

NEED TO DEVELOP PROACTIVE, RESOURCED AND ON SITE LEGAL ADVICE
AND SERVICES

The Department of Health and Ageing funds an advocacy service across Australia called the National Aged Care Advocacy Program (NACAP), which provides advocacy and information as well as also fulfilling an educational role. In 2008-09, the NACAP undertook 3, 638 advocacy cases, handled 5,261 general enquiries and provided 1, 618 face to face education sessions.¹²⁶ There is no doubt that the NACAP is a welcome reform. However, there are questions about its scope and range. There were as at 30 June 2008, 2,830 mainstream residential aged care services, but the NACP conducted only 1,618 face-to-face education sessions. This would indicate that perhaps over 1, 000 service facilities did not receive one such education session in the entire year. Moreover, on-site education sessions by advocates are not enough. A system of regular visits to all aged care facilities by lawyers with appropriate training and skills for dealing with elderly people is needed.¹²⁷ The NACAP ought to be developed and expanded so that it can achieve such an objective.

It is important that there is an opportunity for elderly people and their friends and relatives to discuss any complaint or any legal matters with a trained lawyer who can provide advice and referral and, where appropriate, act for elderly people. It will not be sufficient given the vulnerabilities of the elderly for such an advice and referral system to be located or to operate outside the aged care facilities. It needs to be face to face and provide regular contacts. Legal aid prisoner advice services that visit gaols provide a useful comparator. In general in relation to elderly rights, legal, social and medical professionals need an effective liaison and networking service for the dissemination of materials, education and co-ordination. A specific form of human rights advocacy and jurisprudence for the elderly is also needed.

OTHER REFORMS

Without wishing to preempt the results of such a review, we would submit that there needs to be a multidisciplinary approach to the

¹²⁶ Report on the Operation of the *Aged Care Act* 2008-2009 above n 3, 66.

¹²⁷ One service that provides some assistance and advocacy for NSW residents and carers is the Aged-care Rights Inc (TARS) but this does not regularly provide services in the aged care facilities; see S Newell 'The Aged-care Rights Service including the Older Person's Legal Service (OPLS)' [2009] *ElderLaw* *Rw* 3.

prevention, identification and control of elderly abuse in aged care facilities. This needs to include Federal and State regulators, service providers, legal medical and social work professionals (including, for example, community legal services and legal aid commissions), and elderly rights interests groups. The complaints and investigation system needs to be reformed as suggested above and then information about it disseminated widely and continuously. There is a need for a well resourced and coordinated program of lifting community awareness of elder rights in aged care and the dangers of abuse. As much as possible, elder people should be given appropriate and targeted information about their rights and the means by which they can protect and vindicate those rights, including in aged care facilities. Much of this information should be provided by face to face means because of the physical and cognitive disabilities of many residents.

Professionals and service providers involved in aged care must be given appropriate human rights training. Allegations or complaints about financial abuse within aged care facilities need to be investigated and addressed and this will need the collaboration of relevant governmental and community organisations involved in areas such as guardianship and the protection of the mentally ill. Also, research across the world indicates that guardianship can sometimes be granted far too readily in relation to the elderly without sufficient attention to the rights of autonomy of the elderly or to their capacity for independent decision making.¹²⁸

We recommend that consideration be given to the development of a website in similar fashion to the recently developed MySchool.Com for Australian high schools which would allow consumers and others to gain information about the relative merits of each aged care facility.¹²⁹ Data should be available about the services and facilities offered and their costs, available in each, the number and experience of staff, the quality of service, level and nature of complaints, results of audits and official visits, and surveys undertaken. Greater information and assistance should be given to members of the public to consider their options with respect to aged care.

VIII. CONCLUSION

¹²⁸ I Doron, S Alon & N Offir, above n 4, 67.

¹²⁹ This option builds on the 2005 Senate Inquiry report (see above n 51) that a ratings system be developed – see recommendation 11 of that report.

Protection of fundamental human rights is considered vital for all people, even more so as they move towards the vulnerable state of total incapacity. Elderly people in aged care should not be denied access to justice for breach of a human right because of their loss of capacity to understand what is happening to them and what is going on around them. To do this effectively and meaningfully, there needs to be a rights statute that reflects the human value that they remain human, and deserve to be treated as though they remain fully capable.

The current policy and legal response is clearly deficient in a number of key areas, including in planning, co-ordination and funding, in its complaints and regulatory system, and in the current legal avenues for redress. We have proposed a number of reforms across those areas that will make a significant difference and give the human rights system muscle and sinew with an investigation and complaints system that is focussed on human rights protection.

Effective protection of human interests should wherever possible include viable access to a judicial process resulting in a legal remedy or legal consequence. A system of human rights protection will provide aged care residents with an appropriate range of remedies including financial compensation, apologies, remedial action, mediation and negotiation. It offers an effective and direct means of righting or assuaging wrongs and vindicating the rights and feelings of aged care residents. It also offers significant protection in response to aged care residents' clear vulnerabilities. It will assist residential facilities and government decision makers and assessors to identify what are acceptable standards of conduct, care and treatment and what are not. It will assist to create legal, cultural and moral norms in the diverse aged care sector. In addition, it will also act as a deterrent to those who may otherwise infringe such rights. Such a system can also help to raise community consciousness about the elderly and their rights in aged care facilities.

It is difficult to avoid the conclusion that our society's treatment and response thus far to the elderly in aged care has been inadequate, if not shabby. A frequent comment from elderly people in aged care is that that they lose their identity and sense of worth – they become invisible and anonymous. It is time for them to be seen and heard.

