



Australian Government

Office of the Aged Care Commissioner

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2009 Commonwealth Ombudsman Conference

Good, better, best – public integrity in 2010

Generic Systems: Diverse Communities.

21 September 2009

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Aged Care Commissioner**

Check against delivery

Thank you for the invitation to be present with you and for the opportunity to speak on the challenge diverse communities present for generic systems.

Background

The Office of the Aged Care Commissioner was established in 2007, and was preceded by the Aged Care Complaints Commissioner. The origins of the Aged Care Commissioner can be found in the reform of aged care that took place in 1997.

The 1997 legislation set in place requirements for all approved providers of an aged care service to have a complaints mechanism, with recourse to be available to individuals in a complaints process in the Department of Health and Ageing (the Department). For those that remained dissatisfied after those processes, the legislation provided for an independent office of review in the form of the Aged Care Commissioner. The Commissioner's role is to examine some of the actions and some decisions of the aged care 'bureaucracies' – the Department's Complaint Investigation Scheme (the Scheme) and the accreditation body, the Aged Care Standards and Accreditation Agency Ltd (the Agency).

Establishing an office of review for one aspect of health and care services – that is, aged care – was recognition of the unique characteristics of the circumstances of an aged care service.

In most complaints, the service provider and service recipients are no longer in relationship with each other. For example, the purchase of a household appliance whose functions don't match those advertised, a phone bill for a service not provided, even a hospital stay for acute care, all represent complaints for 'clients' who are no longer in relationship with the provider of the goods or the service. Aged care is different. In the great majority of aged care complaints, the complainant is still in receipt of the care service. If it is a residential care service, that means the provider and client remain in relationship 24hrs a day, 7 days a week.

As such, aged care complaints were seen to be their own 'genre' of complaints and an independent office was established rather than, say, establish the complaints function within another larger body such as the Ombudsman's office or the Health Services Commissioner's office.

In that sense, the government has recognised the special circumstances of aged care complaints and sought to keep them out of a generic system.

After two years of operation of the new complaints arrangements in aged care, the government is undertaking a review of the Department's Complaints Investigation Scheme.

Despite the system being designed specifically for a client group, I believe there are a number of aspects of the aged care complaints system that create difficulties or barriers to access. While there are a number of parties or stakeholders in the aged care system, the barriers usually affect older people themselves, or their family members. The four aspects I will briefly discuss with you today are equity of access, language and culture, the burden of proof, and age itself.

Equity of Access

When investigating a complaint against an approved provider, the Scheme contacts the approved providers in the first instance to seek relevant documents. The Scheme undertakes a site visit, at least once, in 40 per cent of all investigations.

Normal practice of the Scheme in regards to complainants is that they are not interviewed face-to-face and mostly, after the initial call lodging the complaint with an intake officer, do not have contact throughout the investigation of their complaint. In many instances, after lodging the complaint the next contact is a letter advising of the decision in regard to that complaint.

That the approved provider may have repeated contact and often a face-to-face opportunity to put their claims, and the complainant mostly is not afforded the opportunity to put their claims to the investigator, or answer the claims of the approved provider, represents an inequity between the parties.

Language

In the 65+ population cohort, Australia has the second highest level of cultural diversity of all OECD countries. In terms of our elders, Australia is a 'United Nations' all on our own.

In 2010, 23 per cent of those over 65 in Australia will be from a culturally or linguistically diverse background (CALD). In Melbourne, for example, in the 65+ age group, 21 per cent speak a language other than English in the home and 9 per cent speak no English at all.

I don't need to elaborate on how the inability to read English impacts on a person's capacity to have a complaint heard in a complicated, bureaucratic system.

Imagine the challenge with a care resident for example, who does not speak English, has dementia and needs to communicate that he is suffering pain. Challenging indeed. If you add to that mix a situation where the care recipient does not have family that visit, and has not appointed an enduring power of attorney or similar authorisation, the issues for quality care and effective complaints are further compounded.

Burden of Proof

For complainants the burden of proof often proves difficult. Complainants generally do not visit their relatives with pen and paper in hand or a camera at the ready in order to document what they observe, and the information they are able to provide must often be weighed against considerable documentation kept by the approved provider.

In bringing a complaint or seeking an appeal, complainants can have difficulties in accessing relevant hospital or approved provider documentation, even in cases where they hold an Enduring Power of Attorney or similar authorisation. The consequence of this is that complainants may lodge an application to obtain documents through Freedom of Information; which can attract a cost and, because of the time taken, seek to lodge appeals outside the legislative timeframe.

Investigators are placed in a difficult position when an complainant says they were witness to a particular activity, for example a claim about the maladministration of medications, when the approved provider can produce documentary evidence by way of a signed medication chart indicating medications were administered appropriately; or the care recipient has complained about rough handling and there is no evidence to support the claim.

Complainants often assert that staff members are unlikely to record self incriminating information, such as mistreatment or misadventure, in any document. This is exacerbated by the accepted practice of 'exception reporting' in aged care. In the absence of documentary evidence supporting the claim, investigators are left to consider the complaint on the balance of probabilities based on other forms of evidence.

Complaints lodged with the Scheme generally require the investigation of actions which purportedly occurred at a certain point in time. The Scheme's general practice is to view and note written policy documents and, in the absence of contemporaneous notes, the Scheme commonly presumes the written procedures were followed in accordance with the policy notwithstanding the claims and observations made by informants.

Age

Our elders lived and worked when Australia earned its GDP off the land – 'off the sheep's back', as it were. There was no IT industry, communication was by 'snail mail' and letters were prepared in a 'typing pool', party lines were present on most phone systems, and if you wanted print material conveyed quickly one sent a telegram. Women worked almost entirely in the home, and it wasn't until WW11 that they entered the paid workforce in large numbers.

Our elders are likely to be less familiar with administrative systems than the other parties to their complaint – either an approved provider or an aged care bureaucracy.

The approved provider is now most likely a sophisticated business handling millions of dollars a year; bureaucrats make administrative systems complex art forms. Federal, state and territory governments fund advocacy services to support older people in making their complaint, however, older people are often unaware of these services or do not access them.

This imbalance of familiarity of systems is a barrier to entry, and a barrier to equal opportunity in the system. Other aspects of age add complexity to the matter of fairness. Sensory loss, mild cognitive impairment, even the stoicism of the war babies regarding suffering all impact the likelihood of pursuing a complaint if the quality of care is believed or experienced to be compromised. Attitudes of paternalism and ageism also impact on the opportunity for quality of care and services in later life.

Conclusion

These four aspects of the complaint handling system represent the most prevalent barriers to an effective system that gives everyone, particularly our elders, the right to be heard.

Our elders have built our industries, professions, community organisations, democratic freedoms and cultural identity. They have raised and built our families.

As we consider how we will provide environments that will enable older people to enjoy a quality experience as they age, and provide care when they lose their vigour, we must never forget who they are, or forget the respect and dignity they deserve.

Thank you.