Table of Contents

INTRODUCTION 4

RECOMMENDATION ONE: 6

1. FUNDING 6

FUNDING COMPLEXITY AND LACK OF CONSUMER ACCESS TO EQUITY 7
BIAS IN THE LLLB LEGISLATION ERODING THE INDUSTRY CAPITAL BASE 9
RECOMMENDATION TWO: 10
ROLE OF THE PRICING COMMISSIONER 10
RECOMMENDATION THREE: 11
REMOVING THE 28-DAY DECISION PERIOD FOR RAD/DAP DECISION PAYMENTS 11
RECOMMENDATION FOUR: 11
ASSISTING OLDER AUSTRALIANS TO PAY FOR CARE AND SUPPORT 11
RECOMMENDATION FIVE: 11
RECOMMENDATION SIX: 11
CHANGES TO THE SPECIFIED CARE AND SERVICES SCHEDULE 12
RECOMMENDATION SEVEN: 12
AGED CARE PLACE TRANSFERS 12
RECOMMENDATION EIGHT: 12
RESIDENTIAL CARE FOR THOSE OF LIMITED MEANS 13
RECOMMENDATION NINE: 13

2. ACCESS TO SERVICES 13

THE SUPPLY OF AGED CARE SERVICES IS NOT MATCHED TO DEMAND OR THE GEOGRAPHIC INCIDENCE OF THAT DEMAND 13
RECOMMENDATION TEN: 14
CONSUMERS FACE A COMPLEX AND CONFUSING ARRAY OF ENTRY POINTS INTO THE AGED CARE SYSTEM AND MULTIPLE SOURCES OF INFORMATION ABOUT AGEING AND HOW THEY CAN BEST MANAGE THEIR OWN AGEING. 14
RECOMMENDATION ELEVEN: 14
BROADENING THE ORGANISATIONS WHO CAN UNDERTAKE CLIENT ASSESSMENTS 15
THE AUSTRALIAN GOVERNMENT ENGAGES STATE AND TERRITORY GOVERNMENTS TO MANAGE AND ADMINISTER THE AGED CARE ASSESSMENT PROGRAM (ACAP), INCLUDING THE EMPLOYMENT OF ASSESSMENT STAFF FOR AGED CARE ASSESSMENT TEAMS (ACATS) AND THE DELIVERY OF ASSESSMENT SERVICES IN EACH STATE OR TERRITORY. A PERSON MUST BE ASSESSED AND APPROVED BY AN ACAT BEFORE THEY CAN ACCESS RESIDENTIAL AGED CARE, HOME CARE AND FLEXIBLE CARE SERVICES. AT 30 JUNE 2013, 99 ACATS OPERATED ACROSS ALL REGIONS IN EACH STATE AND TERRITORY. 15
RECOMMENDATION TWELVE: 16
RECOMMENDATION THIRTEEN: 16
GREATER FOCUS ON RE-ABLEMENT 16
RECOMMENDATION FOURTEEN: 16
MORE FLEXIBLE ARRANGEMENTS FOR RESPITE CARE 16
RECOMMENDATION FIFTEEN: 16
IMPROVING THE INTERFACE WITH HEALTH AND DISABILITY SERVICES 16
RECOMMENDATION SIXTEEN: 17
ACCESS TO ALLIED HEALTH 17
RECOMMENDATION SEVENTEEN: 17
TRANSITION, PALLIATIVE AND END-OF-LIFE CARE NEEDS OF OLDER AUSTRALIANS ARE NOT BEING ADEQUATELY MET UNDER THE CURRENT ARRANGEMENTS. 17
RECOMMENDATION EIGHTEEN: 17

Caring for special needs groups 17

3. QUALITY 17

Current aged care standards focus more on meeting minimum standards rather than on continuous quality improvement. 17
Recommendation Nineteen: 18
Recommendation Twenty: 18

4. ACCOMMODATION AND HOUSING 18

Improving the ability of older Australians to age in their homes and communities 18
Recommendation Twenty One: 19
Regulation of retirement-specific living options 19
Recommendation Twenty Two: 19

5. WORKFORCE AND IMPROVING PRODUCTIVITY OF THE SECTOR 19

Recommendation Twenty Three: 20
Improving employment conditions and training for the formal care workforce 20
Recommendation Twenty Four: 20
Recommendation Twenty Five: 20
Recommendation Twenty Six: 21
Skilled migration 21
Recommendation Twenty Eight: 21
Improving support for informal carers 21
Recommendation Twenty Nine: 21
Improving conditions for volunteers 21
Recommendation Thirty: 21

6. REGULATION 22

Regulatory arrangements 22
Clarifying and simplifying jurisdictional responsibilities and harmonising some regulations 22
Recommendation Thirty One: 22
Transparency in making legislation 22
Recommendation Thirty Two: 22
Regulatory process 22
Recommendation Thirty Three: 23
Recommendation Thirty Four: 23
Recommendation Thirty Five: 24

7. RED TAPE, INSPECTIONS, REPORTING AND COMPLIANCE 24

Putting streamlined reporting requirements into place 25
Consolidate multiple provider contracts into a single contract 26
Recommendation Thirty Six: 26
Removal of Residential Care Facility certification 26
Recommendation Thirty Seven: 26
Reducing the extent of some mandatory reporting requirements: 26
Recommendation Thirty Eight: 26
Recommendation Thirty Nine: 26
Client transfer documentation 27
Recommendation Forty: 27

KEY PERSONNEL DOCUMENTATION 27
RECOMMENDATION FORTY ONE: 27
AGED CARE APPROVAL ROUND PROCESS 27
RECOMMENDATION FORTY TWO: 28
ACCREDITATION SELF-ASSESSMENT 28
ESTABLISHING PRE-APPROVALS FOR PLANNED SIGNIFICANT REFURBISHMENT 28
RECOMMENDATION FORTY THREE: 28

Introduction

LASA welcomes the opportunity to submit to the Commission of Audit.

LASA is the largest national peak organisation for providers of care, services and accommodation for older Australians. LASA represents providers across the entire spectrum of the age services industry regardless of their ownership status (private sector, charity, mission or not-for-profit).
LASA is committed to improved standards, equality and efficiency throughout the industry. We advocate for the health, community and accommodation needs of older Australians, working with government and other stakeholders to advance the interests of all age services providers, and through them, the interests of older Australians.

LASA hopes that The Commission agrees that the time is right to consider broad changes that will build on the strengths of the current system, while reforming the weaker areas, to set the industry on a sustainable path to meet the challenges presented by an ageing population.

Within the context of the size, scope and cost of administering the aged care portfolio it is LASA's view that the $1 billion identified by the Abbott Government's election commitment to reduce red tape may be conservative when applied across the election commitments and possible areas as outlined in this submission for streamlining within the industry.

The ageing of Australia's society is the major social issue of our time. In 2045 there will be 7.2 million Australians aged over 65 years, roughly a quarter of the total population. Today the over 65 group is 14 per cent of the population and 30 years ago approximately 8 per cent of the population was aged more than 65 years.

In 2013, more than 14 per cent of Australia's population is aged 65 years and over (3.3 million people) and 1.9 per cent are 85 years and over (438,000 people). By 2023, it is estimated that 17 per cent of the population will be aged 65 years and over (4.6 million people)[1].

Currently, more than one million older Australians receive aged care services. By 2050, more than 3.5 million Australians are expected to use aged care services each year with around 80 per cent of those services delivered in the community.

> More than one million older people receive some form of aged care each year, with 1 in 10 people aged 70 or over receiving permanent residential care. In 2012–13, through aged care programs administered by the Australian Government under the Act:
>
> - 226,042 people received permanent residential care – equivalent to 10.1 per cent of people aged 70 years or over (estimated population at 30 June 2013);
> - 82,668 people received care through a home care package (either a CACP, EACH or EACHD package) – equivalent to 3.7 per cent of people aged 70 years or over (estimated population at 30 June 2013);
> - 48,182 people received residential respite care – equivalent to 2.1 per cent of people aged 70 years or over (estimated population at 30 June 2013) – of whom 22,867 were later admitted to permanent care; and
> - 23,180 people received care under the Transition Care Program – an increase of 6.7 per cent from 2011–12.
>
> Many older Australians receive home support through the Commonwealth HACC program. In 2012–13, 486,159 individual clients aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) received assistance through the Commonwealth HACC program. In Victoria and Western Australia, 357,446 people received services through the HACC program, of which

[1] Preliminary population projections based on 2011 Census prepared for DSS by ABS according to assumptions set by DSS.

269,989 were aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people). In addition, 110,371 carers were assisted through the NRCP. [2]

Future challenges include the increasing numbers and expectations of older people, a relative fall in the number of informal carers, a decreasing tax revenue base and the need for a significantly expanded aged care workforce[3].

The majority of older people continue to live active, independent lives in the community and continue contributing to their communities and the economy. In 2012, 34 per cent of men and 20 per cent of women aged 65-69 were active in the labour force. Some 70 per cent of Australians aged 65 years and over live at home without accessing Government subsidised aged care services while 25 per cent access some form of support or care at home. Only 5 per cent live in residential aged care.

The environment into which the Abbott Government steps is stark:

- There are 3 million Australians over the age of 65, (a figure that grows by 1000 people every week)
- Every 71 minutes an older Australian is denied the care or services they need due to inadequate funding
- Age services is the 5th largest workforce and the fastest growing (700,000 more workers needed by 2050)
- There is a need for an estimated $25 billion in capital funds in the next 10 years to build 83,000 new beds and to refurbish existing stock.

As Senator Sinodinos told the Sydney Institute on 27 March 2013, productivity improvements can be achieved by streamlining compliance requirements or eliminating unnecessary regulatory hurdles. LASA concurs with those sentiments.

Deloittes Access Economics has remarked: *The aged care system is experiencing rapid growth in demand due to demographic ageing, increases in income and expectations, and increasing prevalence of chronic disease. The industry is struggling to respond to these demand pressures, due to a lack of funding and tight regulations. In particular, there is evidence that the aged care industry is unsustainable, already exhibiting signs of a shortfall in investment in high care.*[4]

In 2011, the Productivity Commission published *Caring for Older Australians*[5] (the PC report) made a number of recommendations on the administration and funding of age services, primarily based upon a transition to a 'free market' principle .

The Abbott Government's election policy stated that the 'Productivity Commission *Caring for Older Australians* Report should continue to inform future policy direction to support a more flexible and sustainable system that is focused on the provision of high quality care.'

LASA agreed with the general direction of the PC Report, if not with every recommendation made, and continues to encourage the Abbott Government to utilise the PC Report as the basis for the ongoing direction of the industry.

The Gillard Government's response is contained in legislation called the *Living Longer Living Better (LLLB)* package which adopted some of the PC recommendations but not others.[6] The *Living Longer Living Better* policy is being

[2] Report on the Operation of the Aged Care Act 1997, DSS 2013
[3] Productivity Commission 2011, Caring for Older Australians: Overview, Report No. 53, Final Inquiry Report, Canberra, p.xviii
[4] Deloitte Access Economics The Viability of Residential Aged Care Providers and the Potential Impact From Productivity Commission Recommendations on Changes to Aged Care Systems (2011):i (citations removed)
[5] Report No.53, 28 June 2011
[6] http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-living.htm

given effect through a package of Bills and instruments currently before Parliament[7]. In particular, the Government believed 'premature' removal of all supply restrictions would create significant risk[8] and used this as the basis to cherry pick a number of PC Report recommendations, however, there is no evidence presented for this assertion.

The legislation includes a proposal for a Committee that will report in 2017, giving effect to the Government promise to conduct a substantial review five years into the current ten-year plan in an endeavour to 'allow the Government and the sector to consider further relaxation of supply arrangements taking into account the development of a mature market'. [9] LASA believes this committee report, and the enactment of market-based mechanisms to guide investment in the aged care sector, cannot wait.

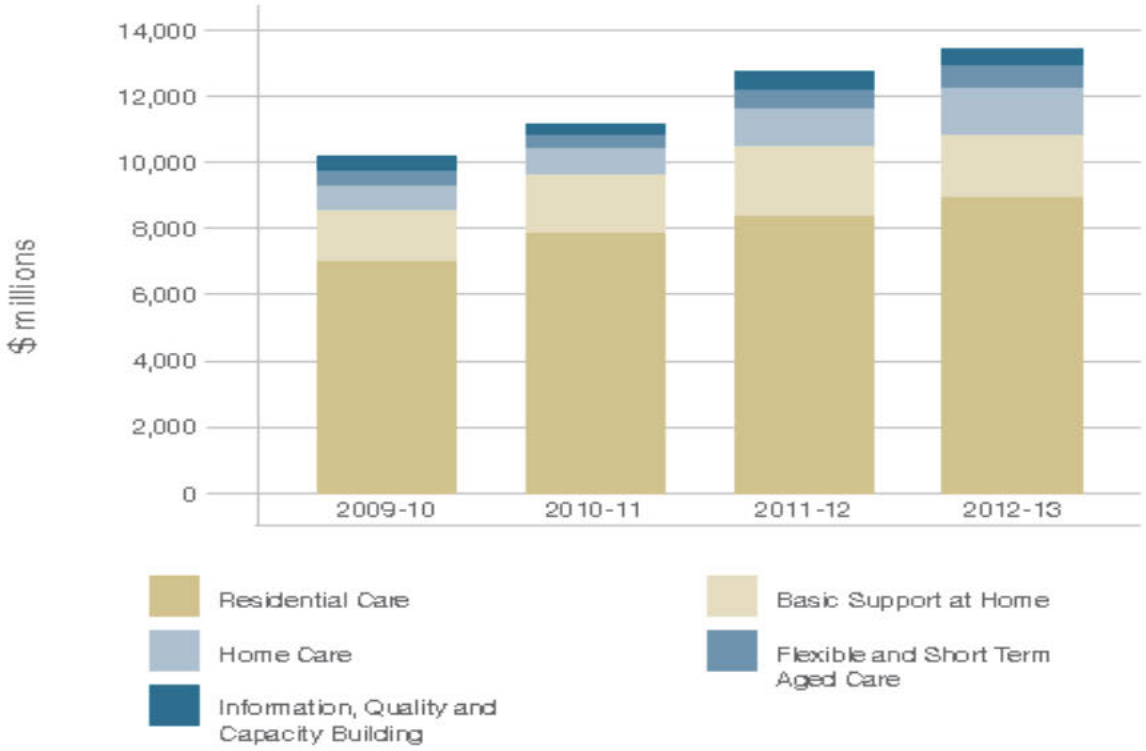
Recommendation One:

The Abbott Government has proposed that each government department will have a Ministerial Advisory Committee composed of industry stakeholders. Given the size and complexity of age services LASA calls for an industry specific committee charged with implementing the election commitments announced and recommendations of this Commission. This committee should be meaningful, practical and engaged with the business of age services to ensure that this committee remains a working committee and not simply moribund.

1. Funding

Industry is concerned the *Living Longer Living Better Package* does not recognise the difficulties faced by the sector in attracting the capital necessary to invest in services to the aged care market. The corollary is that if capital is not attracted, where will the services come from to provide the care and accommodation that an ageing Australian community requires?

Figure 1:Australian Government outlays for aged care, 2009–10 to 2012–13



[7] Constituting the Aged Care (Living Longer Living Better) Bill 2013, the Australian Aged Care Quality Agency Bill 2013, Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013, Aged Care (Bond Security) Amendment Bill 2013 and the Aged Care (Bond Security) Levy Amendment Bill 2013

[8] Australian Government Australian Government Response Productivity Commission's Caring for Older Australians Report (2012):4

[9] Australian Government (2012): ibid

The sector as a whole has assets of $28 billion, current liabilities of $12.5 billion, and non-current liabilities of $5.9 billion with a resulting net worth/equity of $9.6 billion. Included in the liabilities are accommodation deposits of $12.966 billion, which are held by the sector.

Lump sum accommodation deposits are not recorded as revenue funding, but play a significant role in the financial arrangements of the sector. Providers can earn interest from these deposits (offsetting interest on borrowings) or use them as a source of capital financing. Accommodation deposits are a significant source of funds and represent 48 per cent of assets for the sector (46 per cent of assets for the not-for-profit sector and 58 per cent of assets for the private sector). Expenses are predominantly staff related, with staff expenses making up approximately 64 per cent of total expenses.[10]

Overall, investment in the residential care sector has decreased in recent years. For example, new building work completed during the year has decreased from $873 million in 2007-08 to $535 million in 2011-12, although in 2009-10 investment peaked at $1,028 million. Estimated new building work completed during the year decreased by 28.7 per cent in the last year alone.[11]

It is estimated that approximately $3.5 billion, or approximately 12,000 beds, of capital works are currently in hiatus while uncertainty prevails in the industry over price regulations and overall funding mechanisms.

The expected growth in the demand for residential care will require a substantial amount of investment in new and refurbished facilities in the future. In early 2013 the Department of Health and Ageing estimated providers will need to build an additional 83,000 places in the next decade under current planning policies. This estimate includes replacement of current stock, with the total investment required being around $25 billion (in 2011-12 prices).

If investment were to remain at the average investment level between 2007-08 and 2011-12,[12] there is a projected investment gap of $15.0 billion in the next decade, equating to around 80,000 places.[13]

Industry is concerned that government recurrent funding of age services through ACFI does not meet the cost of care and continues to deteriorate. In 2012, total Commonwealth outlays in the aged care space were approximately $12 billion. This means that in 2045 the Commonwealth Government would need to find, in 2012 dollars, approximately $40 billion per annum just continue to provide care and services similar to current volumes and quality.

Funding complexity and lack of consumer access to equity

The impact of this large demographic change in the population structure is considerable, not least of which is the pressure it will place on the national fiscal capacity. Population ageing is changing the ratio of working age to retirement age for people. For each older person (aged 65 years or more) in 2013, there were 4.6 'traditional' working-age people (15-64 years) and by 2023 this ratio will decrease to 3.8 'traditional' working-age people for every older person.

The burden of paying for Australia's care will fall on a much smaller tax-paying cohort unless other components of the Australian economy, and the increasing wealth locked into home equity, are changed to reflect the evolving demographic.

It is expected that most of the wealth older generations possess is within the illiquid security of their home with over 80 per cent of older households owning their home, overwhelmingly without any mortgage. Even those on the Age

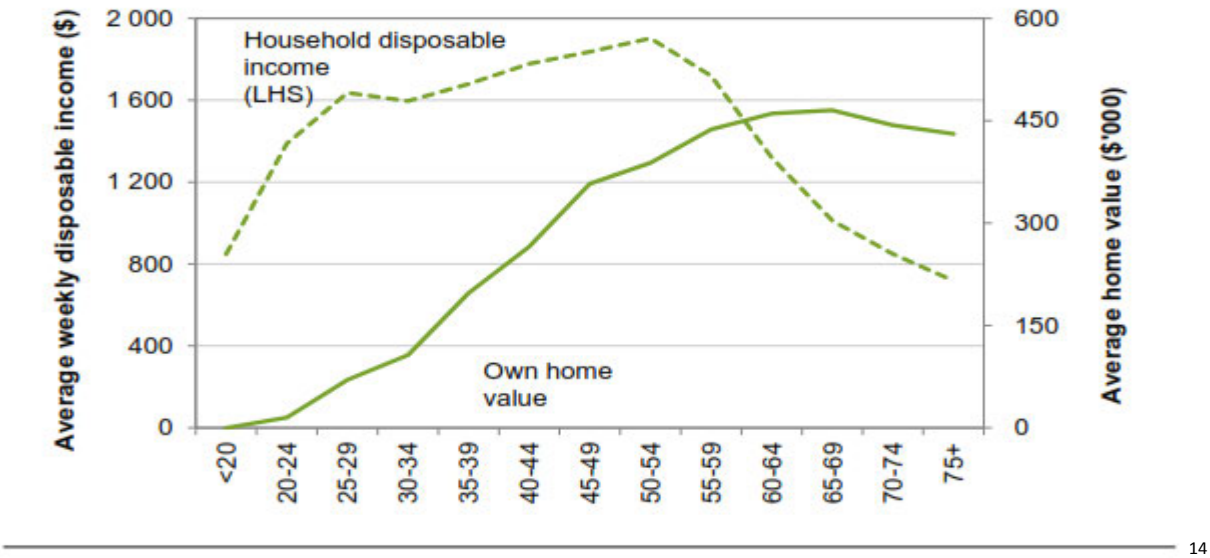
[10] Aged Care Financing Authority, Inaugural Report on the funding and financing of the Aged Care Sector, 30 June 2013
[11] Report on the residential aged care sector, Aged Care Financing Authority (ACFA), July 2013 page 15
[12] The average investment level over five years was used to smooth out potential investment anomalies associated with the global financial crisis and uncertainty surrounding changes to the aged care sector. The average estimated new building work completed during the year between 2007-08 and 2011-12 is $831 million, and the average estimated rebuilding work completed during the year is $166 million.
[13] Report on the residential aged care sector, Aged Care Financing Authority (ACFA), July 2013 page 15

Pension often fully own their own home. Evidence on bequests over the past ten years, which most commonly relate to the family home, suggests this trend is continuing.

As such, stakeholders must be considering methods to access this equity in a responsible way to ensure that government and consumers are able to provide and access the services required through closing the fiscal gap.

Figure 12 **Older Australians are often income poor but asset rich**

2009-10



[14]

However, there is a need for some form of social compact between older citizens and the rest of the community. This social compact needs to reflect that the average person is living longer and that the quid pro quo for ongoing community support via health and social services is a new way of thinking about how older persons can continue to contribute effectively to the broader good whether in paid employment, unpaid employment or some other manner.

Every Australian is entitled to quality care. Care must be funded adequately by government and consumer to ensure that their individual care needs are met. Outcomes of inadequate matching of funds to assessed need are:

a) care recipient choice will be impacted;
b) lack of access to services, particularly challenging for those living in regional and remote Australia;
c) prioritisation of resources – leads to inequity for clients;
d) reduced flexibility of services to adequately accommodate older people's needs and preferences;
e) lack of staff leads to fewer services offered;
f) pressure on carers to fill the gap;
g) social dislocation if clients have to move to access services;
h) providers may be forced to 'select' care recipients to reduce cost implications (bariatric, dementia, special needs); and
i) increased pressure on the health system including extended lengths of stay in hospitals and wait times for primary health care.

These will be issues that the Abbott Government must deal with.

[14] An Ageing Australia: Preparing for the Future Productivity Commission Research Paper November 2013 p 16

Bias in the LLLB legislation eroding the industry capital base

The Gillard Government proposed to change the way accommodation and care payments are structured. One of the most important elements was the inclusion of the accommodation deposit into the assets and means test arrangements when the accommodation deposit (bond) had previously been exempt.

Consumers who elect to fund their Residential Accommodation Deposit (RAD) through the sale of their home will now have the RAD amount included in their means test, an important fiscal item that has not been included in the past. Consequently, someone of modest means will be impacted adversely; further driving a loss of value for the consumer and putting added pressure on an already stressed care sector. The flow-on effects are clear: fewer facilities to provide services to a rapidly growing ageing population.

Deposits are typically used to pay back 'bridging finance' when undergoing construction of new facilities. In this way, commercial debt is sourced from financial market institutions (e.g. banks) for the construction period, and then paid back as residents enter the new residential aged care facility and provide further accommodation deposits.

Using accommodation deposits to reduce commercial debt provides advantages to providers as there is a shorter period of debt repayment compared to funding construction finance through other means - such as periodic payments - and there is a lower required rate of return paid on deposit debt relative to commercial debt.[15]

Based on current policies, the Department of Health estimates that the residential care industry will need to build in the order of 83,000 additional places over the next decade. At the same time, the industry will need to rebuild some of its current stock. It is industry experience that existing accommodation payment and funding arrangements have not provided sufficient incentive for investors and providers to build and improve existing aged care facilities, further underscoring that the proposed changes would erode the ability of providers to increase supply of beds and services.

Figure 2: Majority of consumer concerns are for funding

Caller Type	Number of calls	Percentage of all calls
Main category of caller:		
Friend or family member	39,355	70.8%
Providers of residential care	4,988	9.0%
Self or general public	2,345	4.2%
Health service / support service	1,399	2.5%
Main issue or reason for call:		
Asset assessment	22,723	40.9%
Accommodation bond / charge	20,766	37.4%
Daily fee	18,856	33.9%
Income test / means test	16,980	30.5%

Note: Totals do not add to 100 per cent as this table shows only the major categories of caller and reason for call.

[15] Report on the Operation of the Aged Care Act 1997, DSS 2013

Additionally, changes in consumer demands are leading to the expansion of home care packages. This is acting to ensure that older people delay their entry to residential care until they require high-level care. Diverging from the current residential business models will act to lower the traditional 'low-care' occupancy rates, and therefore access to capital financing through accommodation payments.

Coupled with lower investment due to the modest financial returns gained by providers under the current funding arrangements, providers will have less access to capital to build and invest in aged care facilities.

> *"The biggest area of concern for our business and investing in new Residential Age Care Facilities, are the LLLB changes which create a bias to daily payments and dramatically reduce Residential Accommodation Deposit payments by residents, which will reduce our ability to fund the construction of new Residential Age Care Facilities.*
>
> *The crazy thing with the legislation is it allows affluent home owners the ability to avoid paying means tested fee by renting out their homes and paying a DAP."*
>
> [redacted] *Greengate Care*

The impacts of changes to how industry capital is secured can be summarised as follows;

1. ***Government:*** Consumers who elect to fund their Residential Accommodation Deposit (RAD) through the sale of their home will now have the RAD amount included in their means test, an important fiscal item that has not been included in the past. Government will not benefit from means tested fees and reduced pension commitments from the care recipient cohort most able to contribute. Conversely, those with relatively less assets will contribute more to their care costs and receive less pension benefits, which perversely means that there are fewer contributions from those residents who can afford to contribute, while forcing the less affluent to pay more.
2. ***Industry:*** With new care recipients transitioning to daily or periodic payments over an anticipated three-year period, existing operators with substantial accommodation deposit liabilities will experience a large outflow of funds, as a provider must repay accommodation deposits for clients who exit their facility. At a minimum, further investment in the sector will cease until operators are able to secure additional funding sources and stabilise their balance sheets.
3. ***Capital Providers:*** Banks and lenders are reducing debt lending as less accommodation deposits are received, and will not lend against daily or periodic payments. Equity and debt providers have started to limit capital for the construction of new facilities. A new aged care service costs more than double the cost of purchasing an existing aged care facility, so capital is focussed on purchasing and refurbishing existing facilities rather than constructing new facilities
4. ***New Aged Care Operators:*** New operators will either cease or limit further investment in the sector.

Recommendation Two:

Residential Accommodation deposits remain exempt from the means and asset test in the short term, while transitioning to Recommendation Five and six.

Role of the Pricing Commissioner

The Productivity Commission determined pricing control was unnecessary so long as a transparent pricing process was established and prices were published. LASA supports transparency in pricing and appropriate publishing of prices across the industry. LASA believes additional requirements are unnecessary and burdensome. Recently announced changes to the original LLLB pricing process are welcomed but the shift to a 'light touch' regime adds cost without purpose. Further intervention will constrain development of the 80,000 beds required and extend the operational life of obsolete facilities.

Recommendation Three:

LASA advocates that the role of Pricing Commissioner should be transitioned to reflect the recommendation of the PC Report or delegated to the Minister with a simple reporting procedure that embeds transparency of pricing with no or minimal further administration.

Removing the 28-day decision period for RAD/DAP decision payments

LASA members have expressed a strong view that consumers should formally agree and commit to their particular accommodation payment option before entry (that is lump sum, or periodic payment or some combination of both) into residential aged care. Aged care service provision is a commercial enterprise, regardless of mission/church or private aspects, and as such commercial certainty should be properly determined from the outset. This of course, includes the mode of payment for the care. For this reason, we suggest that residents and their families be required to agree formally to the preferred accommodation payment option (i.e. lump sum, periodic payment or a combination of some sort) prior to entry into care.

It is uncommercial:

a) to allow someone to take possession of a property without agreeing the terms of payment;
b) for an approved provider not to know whether there will be an accommodation deposit (Refundable Accommodation Deposit) to replace an accommodation deposit (when an accommodation deposit paying resident leaves); or
c) from the resident's perspective, not having made financial arrangements to enter a place of accommodation before the resident moves in.

LASA is concerned that the choice of payment (or 'cooling off') period could inadvertently cause cost increases as providers must cater for circumstances where the resident changes his or her mind as to how to pay for accommodation. Commercial certainty requires that both parties have properly determined their commercial relationship, including mode of payment before it has commenced.

Recommendation Four:

The choice of payment (or 'cooling off') provisions contained in proposed Division 52F of the Aged Care Act 1997 should be removed.

Assisting older Australians to pay for care and support

Recommendation Five:

LASA sees the need for the establishment of an Australian Age Pensioners Savings Account scheme to allow age pensioners to deposit proceeds from the sale of their principal residence. The account would be exempt from the assets and income tests, and could be drawn on flexibly to fund living expenses and care costs. Pensioners would have more choice in how they use their housing wealth. If they choose to sell their home they could retain their pension benefits, and access the savings account to pay for living, accommodation and care costs while maintaining the real value of their asset.

Recommendation Six:

Financial products to access equity in one's home are limited in scope, expensive and not well supported by older Australians. Banks, Superannuation funds and stakeholders should develop together a Government-backed Australian Aged Care Home Credit scheme which would assist older Australians meet their aged care costs, including for accommodation, whilst retaining their primary residence. Dependents living in the residence would be protected and it would allow individuals to draw on the equity in their home to contribute to the costs of their aged care and support, in an easy and secure manner with a very low interest rate. Repayment would not be due until the care recipient and all protected persons choose to vacate the residence.

Changes to the Specified Care and Services Schedule

One of the features of the Living Longer Living Better Package is that the distinction between high-care and low-care care recipients will be removed. This means the Specified Care and Services Schedule for Residential Care Services, which is part of subordinate legislation known as the Quality of Care Principles, will require amendment.

With the removal of the high-care / low-care distinction, the new Schedule will outline what are the 'basic' care and services that are required to be provided to **ALL** residents, with the issue being that industry has little knowledge as to which items that were formally required to be provided to 'high-care' residents will now need to be provided to all residents.

The review has been proceeding on the basis that a revised Schedule of Specified Care and Services would outline what services must be provided to all residents, with no distinction between low-care and high-care residents. A consequence of this approach is that proposed changes to the Schedule will result in additional costs for the sector, including in relation to staffing levels for low-care providers but also more generally. There is also a concern that some of the proposed revisions to the Schedule would either duplicate provisions in, or be more appropriately included within, more relevant regulations such as the Charter of Residents' Rights, the Accreditation Standards or State and Territory legislation. The review is also proceeding on the basis that additional funding to cover the costs to providers of a revised Schedule will be provided in the 2014-15 Budget.

Our concern is that given the current short and medium-term outlook for the Commonwealth Budget, the revised Schedule may be adopted without recognition of the additional costs for providers, the consequence of which would be that many providers would be confronted with unfunded additional costs. For example, a provider who cares for homeless persons who are aged will often be required to purchase everything required for that care recipient as they have nothing of their own or have been homeless in the interim. Many of the items are not covered by the schedule and are therefore not funded. Another example is for those providers who have CALD care recipients and do not possess staff who speak the native tongue of that person, requiring the use of an interpreter. This is not included within the schedule.

Recommendation Seven:

Revisions to the Schedule should not proceed at this time unless there is a commitment to increase care prices in the 2014-15 Budget to cover the additional costs of service delivery. If such a commitment cannot be provided due to the Government's overall fiscal objectives, an alternative to incurring this potential cost to the Budget would be to keep the current Schedule and maintain the distinction between low care and high care residents (as measured by each individual's score under the Aged Care Financing Instrument) either legislatively or administratively, but apply it only to the Schedule and not to accommodation payments.

Aged care place transfers

An Approved Aged Care Provider who wishes to purchase licences will need Departmental approval.

A decision to transfer licences across planning regions, whether purchased or already owned, will also require Departmental approval.

Replacing a residential approval with a community care package approval requires Departmental approval. There are examples of Providers who have vacant residential places in a local area and a long waiting list for home based services in the same region and the provider is willing to replace one with the other but has the request to transfer denied.

Recommendation Eight:

As an interim measure, approved providers be permitted to move allocated places to any geographic location and to be able to swap residential and community care licences so as to best meet the local demand.

Residential care for those of limited means

Providers are currently mandated to accept a ratio of 40% of supported residents without reference to their location, demography or population size. This set ratio is not attainable in many regions due to the population mix in those areas and as such Providers should be obliged to make available a proportion of their accommodation (set on a regional or demographic basis) to supported residents.

Recommendation Nine:

A limited pilot would test the benefits of allowing the trading of the obligation between providers in the same region, ensuring equitable access to residential care for those unable to pay for their own accommodation costs. This flexibility will allow providers to pursue more efficient and innovative residential business models. An interim step would be to enable access to care assessment and information services through the myagedcare.gov.au Gateway to allow approvals to be administratively easier and partially or fully automated.

2. Access to services

The supply of aged care services is not matched to demand or the geographic incidence of that demand

Rationing of aged care services through the Aged Care Approvals Round (ACAR) is of benefit to government in constraining access, supply and cost. However, the current process for approval of services has a number of problems due to the supply of aged care services not matching the level of demand or the geographic incidence of that demand, hence this:

- creates a mismatch between where services are located and where they are needed;
- limits access to services and choices including preferred service provider and where you can receive services – in their own home or in a residential setting;
- blunts competition, therefore potentially making aged care more expensive for the Government and the consumer;
- discourages service innovation as providers are told what they can provide; and
- generates a requirement for further regulation and unnecessary red tape.

Each year, aged care providers who wish to grow their residential or aged care services are required to submit a substantial application document to the Department outlining the reasons for the application, the service offering that will be achieved if the application is approved and the financial capacity of the provider.

The system is rationed so that approximately 113 of every 1,000 head of population over the age of 70 get the care and services they need. If you are number 114 or 115 you miss out. For the 5800 odd places in the last Aged Care Approvals Round there were more than 108,000 applications, suggesting a clear disconnect between supply and demand. Moreover, a disconnect exists between ration numbers and the failure of the “competitive” application process, where the ACAR requires provider applicants to identify what market research and demographic analysis has been conducted to ascertain the demand for the service.

Assuming ACAR continues it would be of significant benefit if the ACAR was simplified, application costs and administration reduced and it was scheduled for a set time each year. It is currently random and this randomness makes it difficult to plan for and allocate resources to the ACAR. More often than not an ACAR is announced out of the blue forcing providers to “drop” other business and focus on the ACAR, sometimes to the detriment of other business. Also the application process window is 6 weeks on average yet it takes 4-6 months for the Department to announce the successful providers, so a tighter turn around to enable better planning, budgeting and resourcing would be welcomed.

Simplification and rationalisation of the process, with a view to aligning it to the PC recommendations would see:

- assessments as a part of the age services armament and not simply an ACAT process to determine a level of resources for eligible individuals (determined by a needs based assessment as a part of the gateway

information) to meet their needs however they choose to do so – in their own home or a residential care home;
- providers able to better respond to the level of demand and the preferences of a wider range of care recipients;
- consumer access to care, being substantially improved, regardless of their type of accommodation, and;
- removal of the current regulatory restrictions on the quantity and type of services providers can offer. This would enable providers to be more responsive to older people's needs and preferences. This could be introduced gradually with an initial focus on freeing up the provision of home based and community care.

Recommendation Ten:

Align the Aged Care Approval Round to the Productivity Commission report over a transitional period. The exception would be that some modified funding model be developed for rural, remote, special needs and lower socio-economic service providers, who are focussed on particular services which will not operate adequately in a market driven environment.
As interim steps ACAR should;
- be at known times throughout the financial year
- have approved providers submit a full application once, unless there has been significant change in the size, scope or operations of the Approved Provider.
- have applications processed within 60 days of the submission date
- align all care services and package care applications and approvals harmonised

Consumers face a complex and confusing array of entry points into the aged care system and multiple sources of information about ageing and how they can best manage their own ageing.

The original intent of the myagedcare.gov.au Gateway was to make the aged care system easier to access and navigate for potential aged care recipients. The Gateway was also to facilitate the assessment of capacity to pay for the purpose of co-contributions to remove duplication of some services and provide greater care coordination.

It is widely understood that the current aged care system is difficult to navigate and can be complex. Issues at large are:

- people don't know where to go to access information about aged care services;
- information sources are not consistent or of the same quality; and
- no authoritative body is responsible for ensuring the quality and accuracy of information provided to consumers and service providers

The implementation of the Gateway has been scaled back from its original 'one-stop shop' approach to simply being an information portal. However, the introduction of the Gateway has not been altogether smooth – there has been a lack of uptake from the community, the Gateway is hard to navigate and data is missing, incomplete or wrong.

Further, there are concerns that need to be addressed about access to the Gateway by financially and socially disadvantaged people, those who are illiterate and those from a culturally and linguistically diverse background.

Recommendation Eleven:

MyAgedCare.gov.au Gateway - Multiple programs, 1 Online Process.

A strategy is needed to improve the operational profile of the Gateway for both providers and the general community to ensure that co-ordination of age services is consolidated into a meaningful platform. Advantages of the Gateway approach are that it:

- is one body creating a consistent and transparent process and approach to assessment and entitlement;
- enables major structural change and reduction in duplication of roles;
- is easily identified in each region;

- is a consistent approach (rather than current piecemeal approach and practice);
- is a consistent and robust national system for determining eligibility for subsidies and is essential to manage the Federal Government's fiscal risk;
- provides better cost control for Government (e.g. standard % spent on case management and overheads) and better outcomes for individuals; and
- gives separation from DSS consistent with the Commission separation of policy and service delivery

Broadening the organisations who can undertake client assessments

The Australian Government engages state and Territory Governments to manage and administer the Aged Care Assessment Program (ACAP), including the employment of assessment staff for Aged Care Assessment Teams (ACATs) and the delivery of assessment services in each State or Territory. A person must be assessed and approved by an ACAT before they can access residential aged care, home care and flexible care services. At 30 June 2013, 99 ACATs operated across all regions in each state and territory.

In residential care, approved providers are responsible for assessing a care recipient's eligibility for particular supplements under the Aged Care Funding Instrument (ACFI), and each assessment must be carried out by a registered nurse, clinical nurse specialist, nurse practitioner or medical practitioner using one of the prescribed assessment tools.

In home care the cost of the professional undertaking the assessment is met from the consumer's package under CDC and the cost of the assessment, including travel, is not easily recouped through the subsidy. This is exacerbated where the service is brokered, requires an interpreter or occurs in rural and remote areas. There are also issues with the current access and assessment arrangements. The result is:

- People are assessed differently by different organisations (including ACATs) with different care and financial outcomes for individuals.
- Different assessment and allocation processes create variable financial outcomes for Government funding.
- Once assessed through ACAT for residential and packaged care, aged care service providers undertake ongoing assessment and review.
- Unaligned resources lead to increased overheads and case co-ordination/management costs at the expense of direct service delivery.

One of the main aims of bringing these programs together as Federal Government responsibilities is to achieve standardised and consistent approaches to information, access and assessment. It is envisaged there would be a small central Gateway Agency responsible for contracting and management of services at a regional level. This would include:

- setting standard assessment tools procedures, and managing and assessing performance to ensure consistency and fairness;
- operational policies and procedures; and
- IT systems and software that will support e-health records and enable consistent reporting.

As well, concern has been expressed about the extent to which documentation associated with the Aged Care Funding Instrument creates a workload and cost to industry.

A 2006 report found the time allocated to satisfying Resident Classification Scheme (pre-ACFI) regulations is 5,844,449 aged care staff hours or 243,519 complete days per year. On this basis, industry expenditure arising from RCS processes is (in 2006 dollars) $142,350,977 and of that, $93,902,695.00 relates to aspects of the scheme that have little margin for discretionary decisions by approved providers.[16] Evidence from providers is that the complexity

[16] ACU National Aged Care Industry Costs Arising From Residential Classification Scheme Processes (2006)

and time required to complete ACFI assessments continues to grow year on year with the consequent loss of productivity and efficiency in the system. The Aged Care Workforce Survey showed that nursing staff spent almost 66 per cent of their time doing administrative work and only 33 per cent in direct care.[17] This is a stark indicator that client assessment requirements, administrative compliance and reporting within age services is out of control.

Recommendation Twelve:

Devolve the current state based ACAT process further to approved providers who can verify assessment competency, opening up access and improving consistency through a nationally mediated approach underpinned by the myagecare.gov.au gateway.

Recommendation Thirteen:

Move to reduce and even out the number of ACFI payment levels – potentially look to better classify people and pay accordingly. Classify through the Gateway system and abolish validations.

Greater focus on re-ablement

The current system emphasises services to address symptoms of functional decline rather than on halting and reversing the decline.

Recommendation Fourteen:

Introduce an intensive time-limited re-ablement service, with eligibility and entitlement assessed by the Gateway. Develop a greater focus on independence for the aged, through providing rehabilitation and restorative care.

More flexible arrangements for respite care

Current arrangements inhibit the delivery of respite care that is best suited to individual circumstances while asking providers to offer the service at a fixed cost, although the provider mandated service commitments through the specified care and services schedule have variable cost.

Recommendation Fifteen:

Remove respite allocation program that requires providers to constantly monitor and increase/decrease allocation in order to retain respite incentive program. Instead state that any service that uses more than their original respite allocation or 730 bed days (2 respite places) receives the higher subsidy. Respite services should be funded to match the care requirement of the recipient.

Improving the interface with health and disability services

On 1 July 2012, the Australian Government assumed full policy, funding and day-to-day responsibility for HACC services for people aged 65 years and over and for Aboriginal and Torres Strait Islander people aged 50 years and over in all States and Territories except Victoria and Western Australia.

The Commonwealth HACC program arrangements do not apply to Victoria and Western Australia. In these States, HACC services will continue to be delivered as a jointly funded Commonwealth-State program that provides services to older people and younger people with disabilities. The Australian Government and the Victorian and Western Australian Governments maintain bilateral agreements for that purpose.

While service delivery mechanisms for basic home support are not being substantially altered before 1 July 2015, The Commonwealth Home Support Program aims to combine, under the one program, services currently providing basic home support, including the Commonwealth HACC program, the NRCP, the DTC program and the Assistance with Care and Housing for the Aged program.

[17] http://health.gov.au/internet/publications/publishing.nsf/Content/ageing-2012-nacwcas~03-residential~3-4-experiences-residential

Limited integration of services between health and aged care service providers leads to inappropriate hospital admissions and care. Current health services are not sufficiently responsive to aged care needs, and residents in aged care facilities face difficulties in accessing a range of health care services. More flexible arrangements would improve the wellbeing of residents from not having to move between residential and hospital care and reduce cost burdens on the health system. In addition, teams would develop expertise in aged care, deliver more responsive services and attract health workers to this sector, thus assisting providers to deliver a more flexible range of care services, and diversify their client and revenue bases

Recommendation Sixteen:

Promote the expanded use of inreach and outreach services to residential aged care facilities and the development of visiting multidisciplinary aged care health teams. The Australian Government to set cost-reflective fees for certain sub-acute services delivered in a residential care facility

Access to allied health

Older people in residential care or in their homes do not always have ready access to medical services. Our proposal would improve older people's access to medical services at a time in their life when their care needs are highest.

Recommendation Seventeen:

Review the Medicare and other health rebates for services provided by GPs and allied health visiting residential care facilities or people in their homes as the current subsidies are inadequate and do not incentivise GPs and allied health professionals to visit aged care residents in both residential care facilities and in their homes. Additional investigation into scope of practice would also benefit the industry to ascertain what services could be performed by specialisations such as nurse practitioners.

Transition, Palliative and end-of-life care needs of older Australians are not being adequately met under the current arrangements.

A greater role by residential and home care providers in delivering these services will provide more appropriate care and will be less expensive than services delivered in a hospital as the daily bed cost differential between Hospital ($800) and Aged Care ($200) is consumed by administrative layers in federal, state and area health services. Direct funding of transition beds in aged care has potential to halve costs and incentivise providers to allocate beds and up skill staff to undertake this role. Government is well placed to benefit from reducing the cost differential.

Recommendation Eighteen:

Streamline the allocation of services to ensure that residential and home care providers receive appropriate payments for delivering transition, palliative and end-of-life care.

Caring for special needs groups

Older people from culturally and linguistically diverse backgrounds can have difficulty in communicating their care needs or having their preferences, safety and cultural needs respected. These circumstances can adversely affect the wellbeing of the older person receiving care. Improved assessments of care needs and improved delivery of appropriate care for people from ATSI and culturally diverse backgrounds will help enhance consumer wellbeing. Newer diversity needs will be better recognised including refugees and sexually diverse care recipients.

3. Quality

Current aged care standards focus more on meeting minimum standards rather than on continuous quality improvement.

The quality framework is not focussed enough on outcomes for care recipients and abounds with regulatory and administrative overhead for providers.

LASA is a firm believer in the continuous improvement philosophy within accreditation processes and believes that age services should move from its current compliance methodology to a quality improvement basis rather a one-size-fits-all approach.

Age Services regularly achieves an accreditation rate of 95% or higher in an industry where care, accommodation and service complexity exist every day, of every year and as the Accreditation agency Annual Report states "instances of poor care, should be seen in the context of a generally high-performing industry, run by knowledgeable managers, health professionals and aged care specialists, and dedicated and committed front-line staff."

As such, the industry has no acknowledgement for these high performers and uses a one size fits all approach to managing risk and responsibility that contributes greatly to the overall administrative burden. The 44 standards that comprise the accreditation process have 'aged in place' since their inception in 1997 and have not been reviewed to determine if they still meet the needs of all stakeholders adequately, something with advancing technology, services and demographics is long overdue.

To compensate for this shortfall it will be essential for the industry to utilise all avenues in the most sophisticated and efficient manner possible such as;

- Technology: the Aged Care industry has been a later starter in the use and application of information and communication technologies. Following the $152 million investment by the Federal Government in 2005 and the enablement of electronic lodgement of subsidy claims in 2008, the capability of the industry is rapidly changing.
- Workforce: one of the greatest contributors to service access and quality – workforce - will need to triple over the next thirty years if service volumes and quality are to be maintained at current levels. At the same time, a proportionate decline in workforce size in the over 65 age group means it is highly unlikely that this sector can achieve a workforce growth of this proportion.

Recommendation Nineteen:

Age service providers who are deemed by the appropriate authority to have high quality systems and processes should be rewarded for their performance with a reduction in the administrative burden imposed by the current accreditation process. Examples of appropriate recognition could be based upon the ISO 9000:1 system, for instance where accreditation is only required every three years.

Recommendation Twenty:

LASA commends the election commitment to revert quality management to an independent authority and recommends that the Ministerial Advisory Committee be charged with reviewing the quality framework of age services to ensure that:

- it is administratively efficient

- it has quality improvement is at its core; and

- standards are streamlined to be consistent with current practice and the requirements for consumers

4. Accommodation and housing

Improving the ability of older Australians to age in their homes and communities

Access standards in building regulations have not been developed specifically for residential dwellings or been based on the characteristics of people 65 and older. Such a development would improve the ability of older people to remain living in their homes and communities by using more appropriate standards, if they wish to modify their house.

Australia has a shortage of affordable rental housing, and rental markets are pressed to meet the demands of older renters. This shortage is expected to worsen.

Recommendation Twenty One:

COAG to develop a strategic policy framework for providing affordable housing that would cost effectively meet the demands of an ageing population. Identify what changes or additional policies (including assessing current initiatives) are required to ensure the housing needs of people as they age are being met.

Regulation of retirement-specific living options

Differing state and territory retirement village legislation impose costs which deters investment. Consistency would reduce a significant impediment to new investment in the industry.

Recommendation Twenty Two:

State and territory governments should pursue nationally consistent retirement village legislation under the hand of COAG.

5. Workforce and improving productivity of the sector

The current workforce of 350,000 age service workers will need to grow to almost 1 million (1 in 20 Australians) by 2050 to meet the increasing age services demand.

A resourced, capable and skilled workforce that meets the needs of aged care recipients is essential to a strong and effective aged care system. It will provide the appropriate number of workers with the right skill mix to deliver quality care.

The Gillard Government proposed a workforce supplement to be enacted through subordinate legislation[18] to give effect to a 'workforce compact' designed to encourage workforce participation and retention[19].

Unfortunately the use of the term 'compact' was a misnomer as there was no general agreement between all the relevant stakeholders. Moreover, eligibility terms and conditions need to be adhered to, including a requirement for providers to fund a minimum pay increase for care workers of 3%, for enrolled nurses 8.5% and for registered nurses 12.6%, whilst all participating employers are required to deliver minimum pay increases of 2.75% through enterprise bargaining agreements.

At the same time, $1.6 billion has been clawed back through reductions in the Commonwealth's own outlays on aged care funding and through funding decisions made under what is known as the Aged Care Funding Instrument[20], with the net result being that this reform is being fully funded by providers with limited capacity to either absorb or pass on the additional costs.

LASA welcomes the undertaking to redirect the workforce supplement into provider funding in order to encourage providers and industry to collegiately improve workforce participation and retention. Further to Minister Andrew's announcement of 26 September 2013 of the suspension of the former Government's Aged Care Workforce Supplement, LASA coordinated a written industry response comprising the peak bodies representing 97% of age service providers. This correspondence advised that the Conditional Adjustment Payment was the preferred method for returning the supplement.

ACFA is required to report in time to inform the five-year review of the LLLB reforms on longer-term options to support a stable and skilled workforce that can meet the growing demand for aged care services.

[18] Called 'subsidy principles' – see section 48-3 proposed to be inserted into the *Aged Care Act 1997* by Item 142 of Part 1 of Schedule 3 to the Living Longer Living Better Bill 2013

[19] See http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Workforce-Compact

[20] Used to calculate the Residential Aged Care Subsidy

Key workforce challenges going forward will include:

- ensuring the workforce has the appropriate number of suitably qualified and skilled staff;
- ongoing access to allied health staff to service clients at home or in residence;
- dealing with increasing rates of complex chronic conditions;
- consumer expectations for improved standards of quality and access;
- flexible working arrangements to adequately service consumer directed community care expectations; and
- addressing the increasing competition for staff from complementary areas such as hospital and disability care.

LASA acknowledges it is fundamental that increased pay and improved conditions are essential to attract and retain skilled workers to the sector, but they must be affordable and sustainable. However, labour market attractiveness is more than simply wages.

LASA is keen to see how Government and Industry can work together to provide better access to medical, nursing and allied health services in aged care.

Recommendation Twenty Three:

LASA believes that industry would benefit from a review of the scope of practice and the breaking down of artificial demarcations between some work roles e.g. Assistant in Nursing (AIN) and Personal Care Assistants (PCA).

Improving employment conditions and training for the formal care workforce

Inadequate funding and indexation mechanisms diminish aged care providers' ability to pay fair and competitive wages. The payment of fair and competitive remuneration for aged care workers should reduce the lack of parity, especially with the acute health care system, and enhance the attractiveness of the aged care sector to employees.

Recommendation Twenty Four:

Scheduled prices for aged care should take into account the need to pay fair and competitive wages to clinical, care and other staff delivering and supporting aged care services.

This would help to address a lack of vocational training packages for the aged care sector and poor quality of training provided by some registered training organisations.

Recommendation Twenty Five:

Promote skill development across the spectrum of care through an expansion of accredited courses, including specifically targeted skills sets in areas of need such as;

- assessment of the older person with multiple co-morbidities, including people with a disability who are ageing

- dementia care

- palliative care

- care of residents with complex needs, and;

- high end clinical skills to meet the care needs of those who desire to remain at home.

A limited number of specialist 'teaching aged care facilities' would increase the willingness of personal carers and health professionals to enter the aged care sector and provide the training to equip the aged care workforce to deliver better quality aged care. The national extension of these two initiatives would provide a solid framework and appropriate support for the further development of teaching aged care facilities.

Adopt a holistic regional model for workforce development lead by a consortium of LASA and ACSA, Alzheimer's Australia, National Disability Services and Carers Australia to drive the delivery of workforce development initiatives

and training programs that deliver a flexible workforce across the spectrum of ageing and disability and the right people with the right skills at all levels to the point of need.

Recommendation Twenty Six:

- Fund the expansion of 'teaching aged care services' to promote the sector and provide appropriate training for personal carers and medical, nursing and allied health students and professionals.

- Appropriately fund organisations such as LASA for their role in workforce development including;

    - funding for the implementation of the aged care leadership capability framework

    - expanding the nurse graduate program model now operating in Victoria.

Improving support for attraction and retention initiatives

As an adjunct to workforce reforms and to encourage initiatives designed expand the labour pool, Government support should be provided to educate the community of the rewarding career opportunities available within the sector. Such a public education campaign could support local initiatives to encourage school leavers and young people to work in aged and community care, as well as mature aged people returning to the workforce.

Recommendation Twenty Seven:

Government funded public campaign to promote a positive public image of the aged care sector, promote and support workforce reforms, and educate on the rewarding career opportunities available across the sector.

Skilled migration

To complement the training and development of the Australian workforce, and in the current context of health care work labour shortages, LASA also encourages Government to ensure that the legal obligations and responsibilities associated skilled migration programs are not too onerous on employers.

Recommendation Twenty Eight:

Skilled migration applications should enable a clear and efficient process; particularly for employers in rural and regional locations where the only way community health care needs are able to be met is by the utilisation of appropriately skilled overseas workers.

Improving support for informal carers

Carer support is currently administered in an ad hoc way across a number of programs and jurisdictions. The Gateway, when assessing the care needs of older people, should also assess the capacity of informal carers to provide ongoing support. The Gateway processes should be structured to encourage a strong and sustainable community of informal carers.

Recommendation Twenty Nine:

Government and stakeholders must ensure carers access the services they, and those they care for, need and are entitled to receive. Making respite and other services more easily accessible and responsive to the needs of informal carers is a priority through streamlining of assessment and access.

Improving conditions for volunteers

Organisations face significant costs associated with organising, training and managing volunteers.

Recommendation Thirty:

Funding for services that engage volunteers should take into account the costs associated with volunteer administration and regulation (such as Police checks) as well as appropriate training and support for volunteers. Reducing barriers to individuals volunteering would improve organisations' ability to harness volunteers.

6. Regulation

Regulatory arrangements

Governance arrangements in aged care do not clearly separate policy, regulation and appeals, which created inherent conflicts of interest within Department of Health and now Department of Social Services. A number of regulatory functions are undertaken by multiple jurisdictions, agencies and departments. This duplication creates confusion for providers, adds to regulatory costs incurred by the industry and can compromise the quality of care. Removal of potential conflicts of interest and ensuring greater independence of regulatory roles would help to establish a more effective regulatory governance structure. We urge the creation of an independent complaints handling process which is separate from the funding and policy department.

Clarifying and simplifying jurisdictional responsibilities and harmonising some regulations

Duplicate and inconsistent regulations impose unnecessary costs and impede achieving the objectives of those regulations. COAG should identify and remove, as far as possible, onerous duplicate and inconsistent regulations, while also improving the efficiency and effectiveness of regulations.

Recommendation Thirty One:

Greater co-ordination between Commonwealth and State regulatory bodies to ensure that the Commonwealth has devolved any duplicated activities to the states, while reducing other mandatory reporting requirements to an audit process. Areas of duplication include inspections such as certification, Fire systems and local council requirements such as sanitation, fire and food inspections.

Transparency in making legislation

It is a feature of the aged care portfolio that many of the details are left to subordinate instruments called 'principles'. As the Senate Community Affairs Committee said in its report on the National Disability Insurance Scheme Bill 2012, as a matter of good public policy, when a Bill seeking to institute significant national reforms is going to rely on extensive subordinate legislation, a draft of that ancillary material should be released as close as possible to the introduction of the Bill itself, to enable both Parliament and the public to fully consider the issue before it. [21]

The Parliament (and for that matter, the stakeholders of the process) will not see the precise details as to how the Living Longer Living Better package will be given effect until well after the legislative package has passed Parliament.

Moreover, whilst there is consultation with the Department, in many circumstances scant time is given to consider documents that may have significant impacts on the financial viability of authorised aged care providers.

Recommendation Thirty Two:

LASA believes regulatory impact statements for legislative instruments (such as amendments to subordinate instruments such as principles made under the *Aged Care Act 1997*) must be prepared and contain a business impact statement estimating the cost the proposed regulatory change will impose on industry in all circumstances, so proposals can be assessed against commercial reality. More generally, there needs to be established in the Aged Care Act 1997 a group that is representative of the aged care sector that should assess particular principles documents in draft, as prepared by the Department that will be judged against standards of certainty, adequacy, fairness and sustainability.

Regulatory process

LASA agrees with the observations made in pages 14-15 of the Coalition Deregulation Discussion Paper that:

[21] Senate Standing Committee on Community Affairs report *National Insurance Disability Bill 2012*, paragraphs 1.9-1.11 http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/completed_inquiries/2010-13/ndis/report/c01.htm

- Regulations are often created simply because too little critical consideration is given to both the necessity for regulations and the impact of these regulations on individuals, business and society as a whole.
- There needs to be a strengthening of the regulatory gate-keeping requirements.
- In concert with better incentive mechanisms to curb unnecessary new regulations, the role of regulatory impact statements (RIS') should once again be made more purposeful and effective.

Recommendation Thirty Three:

Because of the technical complexities involved in considering draft principle documentation, LASA encourages the Commission to uphold the election commitment that the Abbott Government will expressly direct the Department of Social Services to adhere to the ideal requirement that there be eight weeks of consultation as contained on page 11 of the Coalition Deregulation Discussion Paper.

The Commonwealth Government via the Office of Best Practice Regulation (OPBR) requires Government departments and agencies to prepare RISs for regulatory proposals that are "likely to have a regulatory impact on business or the not-for-profit sector, unless that impact is of a minor or machinery nature and does not substantially alter existing arrangements".

However, since the OBPR was transferred out of the Productivity Commission to the Department of Finance by the former Labor Government there is a widespread view that RISs have become more pro forma and less responsive to the legitimate concerns of affected parties. It has also become commonplace for the RIS process to be waived altogether for key regulatory changes.

Recommendation Thirty Four:

LASA believes regulatory impact statements for legislative instruments such as amendments to subordinate instruments (such as principles made under the *Aged Care Act 1997*) must contain a business impact statement estimating the cost the proposed regulatory change will impose on industry in <u>all</u> circumstances so proposals can be assessed against commercial reality.

More generally, there needs to be established in the *Aged Care Act 1997* a group that is representative of the aged care sector that should assess particular principles documents in draft, as prepared by the Department that will be judged against standards of certainty, adequacy, fairness and sustainability. LASA believes that the Ministerial Advisory Committee outlined in Recommendation One would constitute an appropriate body.

Finally, the Living Longer Living Better Bill proposes that an 'independent review' be undertaken of the operation of the amendments made by the legislation that implements the Government's Living Longer Living Better package, and which will look at the following things:

a) whether unmet demand for residential and home care places has been reduced;
b) whether the number and mix of places for residential care and home care should continue to be controlled;
c) whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model;
d) the effectiveness of means testing arrangements for aged care services, including an assessment of the alignment of charges across residential care and home care services;
e) the effectiveness of arrangements for regulating prices for aged care accommodation;
f) the effectiveness of arrangements for protecting equity of access to aged care services for different population groups;
g) the effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers;
h) the effectiveness of arrangements for protecting refundable deposits and accommodation deposits;
i) the effectiveness of arrangements for facilitating access to aged care services;

j) any other related matter that the Minister specifies.[22]

The review is to report by June 2017. For the reasons discussed in this submission, it is in the public interest for this review to be expedited.

Recommendation Thirty Five:

LASA would recommend that the Living Longer Living Better Bill report be provided by 31 December 2015.

Moreover, the review should not be restricted to consider the effect of legislation introduced for the purposes of the Living Longer Living Better package but should consider the provision of aged care services in Australia generally.

Finally, the Committee should also consider:

a) steps that are necessary to ensure the sustainability of the aged care sector;
b) further consider areas where administrative steps involved in the regulation of aged care provision can be minimised or removed; and
c) the structure of the legislation, including a review of the matters better dealt with in the principal act and those matters properly dealt with by subordinate legislation, such as principles documents.

7. Red tape, Inspections, Reporting and Compliance

Aged Care is replete with examples of Governments over the years dealing with performance issues by applying more and more compliance obligations on the industry with this environment leading to a dedicated staff who feel passionately that they "give their all" on behalf of their clients/residents becoming demoralised. In many cases the emphasis of government is upon intermittent minor failures rather than daily successes.

The Abbott Government has committed to a deregulatory program that aligns with the Productivity Commission's Caring for Older Australians recommendations. LASA concurs that the PC report should continue to guide future policy considerations with a particular emphasis on attaining key items within a short timeframe.

As the Productivity Commission reported:

…the current aged care system contains a plethora of unnecessary, complex and burdensome regulations. Many of them relate to quantity and price restrictions and over-reaction to specific incidents. Problematic governance arrangements have also inhibited best practice regulation.[23]

The aged care industry is characterised by centralised planning processes which result in a heavy regulatory burden on aged care providers in order to maintain the quality of care. Without tackling the underlying policy framework that constrains supply it is unlikely that the regulatory burden can be substantially reduced.[24]

The PC Report identified a number of areas where red tape ties up the sector in a manner that, according to the Commission, showed little apparent concern for minimising compliance costs as well as in some specific cases, little apparent concern for encroaching on the rights of clients and their quality of life. [25]

They include:

- a planning and allocation system for aged care that prevents aged care providers from achieving efficiencies in scale and scope, as well as limiting the extent to which price mechanisms can signal changes in market conditions to both aged care providers and care recipients;
- rigidity in the manner by which fees are approved; and

[22] Section 4 of the Living Better Living Longer Bill 2013
[23] Productivity Commission CARING FOR OLDER AUSTRALIANS: SUMMARY page XLII

[24] Productivity Commission *Caring for Older Australians* (2011):137
[25] See generally, Chapter 2

- strengthening of police checks, reporting of missing residents, the compulsory reporting of assaults and the ramping-up of unannounced visits by the accreditation agency in recent years.

Putting streamlined reporting requirements into place

Reporting requirements are overly burdensome and duplicative, consuming management and staff time which could be better directed towards providing care services. The Commission should recommend a streamlined reporting mechanism for all service providers (across both community and residential aged care) based on the model used to develop Standard Business Reporting. Streamlining the reportage in aged care would greatly reduce unnecessary costs to providers while delivering timely reporting information to the regulator.

Each age service provider is required to fulfil an increasing amount of documentation pertaining to their approval as a provider. It is estimated that approximately a third of this information is duplicated or is held by the department already. General administrative overhead includes:

- Audited general purpose financial reports, lodged by 31 October
- Audited general purpose financial reports at provider level rather that corporate level, lodged by 31. October
- Twenty four hour requirement to report a suspected assault
- Twenty four hour requirement to report a missing resident
- Twenty four hour requirement to report and suspected infectious disease outbreak
- Unannounced visits by the Department and the Accreditation Agency
- Annual return on staff training
- Annual survey to complete the report on the aged care industry
- Annual report on liquidity
- Report of any change to Key personnel
- Constant updating and maintenance of all personnel and volunteers police checks
- Accreditation both regular visit and the three year full audit review
- From 19 May 2014 maintain in a public place a current list of all accommodation prices
- Client/resident assessment documentation
- Client clinical record
- Prescribing information
- ACFI claiming pack and assessment profile
- Validation visits to cross check ACFI claiming accuracy
- Infection control documentation
- Health and hygiene reports and documentation
- Fire and safety inspections and documentation
- Building maintenance reports and documentation
- Building certification
- Authorised Signatory Form (every time a manager changes and this must be resigned by every signatory)
- Monthly Claims Form (formally NH3)
- Survey of Aged Care Homes (annual)
- IT Survey (this year)
- Prudential Compliance Statement (annual)
- Accommodation deposit and Entry Contribution Information (annual)
- Conditional Adjusted Payment – Audited Accounts Statement (annual)
- Conditional Adjusted Payment Training Statement (Annual)
- Application for a Variation of Allocation of Respite Places (due to varying circumstances at least annually)
- Fire Safety Declaration (Annual)
- Notification of Independent Assessment against 1999 Certification Instrument (this year).
- Quarterly reports regarding progress towards completion of the Notification of Assessment against the 1999 instrument.
- Quarterly reports regarding progress on new facilities/beds acquired in ACAR.
- Self-Assessment for Accreditation 50 pages (every 3 years)

- Plan for Continuous Improvement (every 3 years)
- Written Responses to CRS (1-2 for each case)
- Equal Opportunity/Workplace Gender Equality

This list is a short list of some of the documentation that the staff in a facility or service is required to maintain. This does not touch on all the usual business documentation a business would be required to maintain in the normal course of doing business, such as personnel files, payroll, accounts receivable, accounts payable, taxation returns and purchasing and stock keeping.

Consolidate multiple provider contracts into a single contract

A significant number of age service providers have multiple agreements with DSS for delivery of the same or similar services. In some cases these agreements are for the delivery of a single package. Each of these agreements has the same activity and financial reporting requirements, audit requirements and subsidy claim process. All are replicated on a varying basis, some monthly, some annually. This represents a significant duplication of effort.

Recommendation Thirty Six:

Consolidation of package care agreements.

Removal of Residential Care Facility certification

Certification requirements have become an unnecessary burden for the industry. The vast majority of residential aged care facilities are currently certified and the intent of certification, namely to encourage an improvement in existing building stock and the provision of minimum standards relating to space and privacy, has been achieved. Standards relating to the design and construction of new and substantially renovated aged care buildings are appropriately governed through regulatory bodies and instruments, such as the Building Code of Australia (BCA). The industry views the certification process as an unnecessary and costly impediment to the timely commissioning of an aged care facility. As a minimum, new or refurbished buildings should be exempt. This reduces holding capital costs and duplicated processes.

Recommendation Thirty Seven:

Remove certification and devolve to states to govern through regulatory bodies and instruments, such as the Building Code of Australia (BCA).

Reducing the extent of some mandatory reporting requirements:

Mandatory disclosure requirements to consumers impose unnecessary costs on providers. Reducing the significant disclosure burden associated with servicing incumbent and prospective care recipients is recommended.

Missing persons reporting requirements impose a significant compliance cost and regulatory burden, and take resources from the priority of finding the missing resident. This could be addressed by reducing costs to providers and freeing up resources to find missing residents.

Recommendation Thirty Eight:

Amend the residential aged care prudential standards to allow providers to disclose information (to care recipients or prospective care recipients) on request, rather than automatically

Recommendation Thirty Nine:

Amend the mandatory reporting requirements for missing residents to reflect the recommendation of the Coalition discussion paper on deregulation reform utilising audits to replace mandatory reporting.

Client transfer documentation

When an approved provider wishes to transfer an approved place to a different provider they need to make application to the Department to gain approval for this to occur. This involves completing a 48-page application that is forwarded to the Department for consideration – either approval or refusal.

Recommendation Forty:

As a part of a nationally integrated network to enable access to care assessment and information services through the Gateway, these approvals should be administratively easier and partially or fully automated.

Key personnel documentation

Each time there is a change in key personnel within an aged care provider, forms are required. As key personnel include facility managers and turnover of facility managers throughout the aged care industry is particularly high, this means that a great deal of time is spent completing these forms. As each new key personnel member joins the provider, the provider is required to complete an 11-page "Add" form. If they cease to be key personnel, a 4-page "Cease" form is completed. If the key personnel moves from one key personnel position to another with the same approved provider, a 4-page "Change" form is required. These could be streamlined given a police clearance is required that indicates that an applicant has met the requirements, thus it is entirely bureaucratic for applicants to also answer questions that have been addressed with the police check. Also, if staff have previously been key personnel the Department would have previous information on hand regarding the applicant. Therefore it would be reasonable that:

- once a person has passed a criminal history check and satisfied bankruptcy requirements, those details could be made transportable, and that a provider need only advise the Department when a person holding a "licence" commences or ceases employment;
- through the Gateway it would be possible to establish a key person licence that allows police/finance checks to be transportable;
- a comprehensive form be completed for those who have never been key personnel;
- there is a greatly simplified process for those moving or re-applying;
- no change form to be required unless the key personnel are moving to a different approved provider/organisation, not simply to another facility within the same organisation; and
- the key personnel approval to be for the approved provider/organisation and not for the role they are performing.

Recommendation Forty One:

Streamline the key personnel process to enable transportability and remove duplication

Aged Care Approval Round Process

After successfully tendering a comprehensive business plan in an Aged Care Approval Rounds (ACAR), upon commencement that aged care provider is then required to complete another new document. This document contains similar questions regarding how it will fulfil its responsibilities as an approved provider. This is in addition to completing a 50-page self-assessment document for the Accreditation Agency and an application for certification. Whilst this document is not required to be submitted, providers are required to have it available.

ACAR application consists of Part A (28 pages) and Part B (78 pages) and are predominately an "assignment-like" submission with answers ranging from one word to 800 words or more. There is duplication between part A and part B that has been explained as being because part A is assessed by a different section of the Department than part B.

LASA understands that there may be a need for further information to be provided to the Department when the beds become operational as it can be some time between getting the bed approval and the beds becoming operational.

Recommendation Forty Two:

As interim steps ACAR should;
- be at known times throughout the financial year
- have approved providers submit a full application once, unless there has been significant change in the size, scope or operations of the Approved Provider
- have applications processed within 60 days of the submission date
- align all care services and package care applications and approvals harmonised
- allow for application and reporting items to be rationalised and streamlined to ensure that the forms/applications are constructed to reduce time when the Department holds this information already. For example RAC ID numbers should be sufficient rather than RAC number, facility name, address, year of commencement, approved provider name, contact details, number of approved places, high care numbers, low care numbers name, address, phone, fax, information about key personnel and provider history etc.

Accreditation self-assessment

The self-assessment document provided by the Agency is technically no longer required as the legislation states the approved provider can self-assess however they wish, although it must be written and be available to assessors when they attend site for accreditation. However, given this legislation is new and approved providers are unclear as to what may be acceptable most continue to use the format provided by the Agency. A Word document of this assessment (provided by the Agency) is 41 pages long.

Establishing pre-approvals for planned significant refurbishment

LASA is not supportive of the establishment of pre-approvals for planned significant refurbishment, believing that this process will significantly add to the administrative and financial burden for approved providers.

Recommendation Forty Three:

Establishment of complying development guidelines approvals for planned significant refurbishment. If the complying criterion has been met and evidence has been provided to support this, then further information should not be required. Having a complying development 'pre- approval' process will ensure that Providers planning their refurbishment projects will do so to ensure qualification to the criteria.