Supplementary Submission: Aged Care Legislation Amendment (Financial Transparency) Bill 2020
30 April 2021

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Thank you for the opportunity to make a Supplementary Submission into the committee's Inquiry into the Aged Care Legislation Amendment (Financial Transparency) Bill 2020.

I am a community member and a family member of a former Residential Aged Care Resident. This is a Supplementary Submission taking into account the findings of the Royal Commission into Aged Care Quality and Safety or submissions made. This Supplementary Submission can be attached with my prior submission (Number 12).[i] **As indicated in my prior submission I support this much needed financial transparency bill.**

Supplementary Feedback

The bill requires approved providers to provide a written report to the Quality and Safety Commission and disclose financial details on particular items such as staff and food costs. However it is important the bill links to the current Schedule 1—Care and services for residential care services, under the Quality of Care Principles 2014.[ii] Items or services listed must be provided to all care recipients who need them or where it applies to those under a classification level. We need to know if they are using funds to provide these care services.

Aged Care Staffing

Approved providers should disclose the total cost of salaries and wages for all temporary, permanent, ongoing and agency staff by category.

Aged Care Staff is important in providing the appropriate care or service to recipients. There are a number of good reasons and significant supporting evidence that specific aged care staff is needed. It is impractical to list them all but will use allied health staff or external consultants as a good example to give you an insight why this Bill is an important step.

As mentioned in my prior submission residential aged care homes argue that they do not have sufficient funding to cover care. Residents may be told they must seek other funding, such as through Medicare or pay private fees for access to a range of allied health services. Inappropriate utilisation of the Medicare Chronic Disease Management item for assessments and other allied health services is a concern. Refer to the following additional information as it is crucial supporting evidence.

- Allied Health Services in Residential Aged Care[1]
- Royal Commission into Aged Care Quality and Safety - Submission re Allied Health in Residential Aged Care, 16 July 2020[2]

[1] Allied Health Services in Residential Aged Care: https://bit.ly/3npjFcT
[2] Royal Commission into Aged Care Quality and Safety Submission: Allied Health in Residential Aged Care https://bit.ly/3xoW9Br

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Allied health professionals are vital in aged care as it associates with the obligations of an aged care provider under the Quality of Care Principles 2014, Schedule 1 for residential care services and with the Aged Care Quality Standards.[iii] **The following care items at least relate to allied health staffing or expenses.**

Part 1— Hotel services to be provided for all care recipients who need them

1.10 Meals and refreshments

b) Special dietary requirements, having regard to either medical need or religious or cultural observance.

Part 2—Care and services to be provided for all care recipients who need them

2.2 Meals and refreshments

Special diet not normally provided.

2.6 Rehabilitation support

Individual therapy programs designed by health professionals that are aimed at maintaining or restoring a care recipient's ability to perform daily tasks for himself or herself, or assisting care recipients to obtain access to such programs

2.9 Support for care recipients with cognitive impairment

Individual attention and support to care recipients with cognitive impairment (for example, dementia and behavioural disorders), including individual therapy activities and specific programs designed and carried out to prevent or manage a particular condition or behaviour and to enhance the quality of life and care for such care recipients and ongoing support (including specific encouragement) to motivate or enable such care recipients to take part in general activities of the residential care service.

Part 3—Care and services to be provided for all care recipients who need them (additional fees may apply if those are not eligible under a classification level)

3.2 Bedding materials

Bed rails, incontinence sheets, ripple mattresses, sheepskins, tri pillows, and water and air mattresses appropriate to each care recipient's condition.

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3.4 Goods to assist care recipients to move themselves

Crutches, quadruped walkers, walking frames, walking sticks, and wheelchairs.
Excludes motorised wheelchairs and custom made aids.

3.11 Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services

a) Maintenance therapy delivered by health professionals, or care staff as directed by health professionals, designed to maintain care recipients' levels of independence in activities of daily living
(b) More intensive therapy delivered by health professionals, or care staff as directed by health professionals, on a temporary basis that is designed to allow care recipients to reach a level of independence at which maintenance therapy will meet their needs.

Excludes intensive, long term rehabilitation services required following, for example, serious illness or injury, surgery or trauma.

Importance of Allied Health in Aged Care

The Royal Commission has heard evidence that people accessing aged care services have limited access to allied health care. Research has shown that the number of allied health professionals employed in the residential aged care workforce has reduced over time. As a proportion of direct care employees in the residential aged care workforce, allied health professionals and assistants decreased from 7.6% in 2003 to 4.0% in 2016. Out of total staff working in residential aged care facilities in Australia, proportions of registered allied health professionals have reduced from 1.7% in 2012, to 1.1% in 2016.[iv]

According to Allied Health Professionals Australia, it is important to ensure that there are mandated requirements to ensure experienced and specialist allied health providers are employed to deliver care as part of a multidisciplinary team with the RACF and no incentive to employ cheaper and less experienced staff.[v]

Items or care provided must cater to the needs of aged care recipients and this cannot be achieved without allied health assessments, support and adequate training for all relevant aged care employees.

Speech Pathologists in Aged Care

Speech Pathology Australia recommended that Interprofessional teams must be accessible to all older people regardless of where they live, which include dietitians, oral health professionals and speech pathologists to best meet the needs of older people in food, nutrition and mealtime experience. Additionally there should be mandatory training and education for aged care staff/providers in supporting people living with swallowing difficulties, informed choice with eating/ drinking at risk and communication difficulties.[vi]

A speech pathologist might assess and then train staff to support safe eating practices that allow the older person to remain on a non-liquid diet, or a physiotherapist and occupational therapist might identify an appropriate program to support safer mobility for an older person that involves a range of strategies supported by aged care staff.[vii]

This would include adequately educating relevant staff about thickened fluids or consistency of fluids to help prevent aged care recipients experiencing Dysphagia and aspiration.

Podiatrists in Aged care

Podiatry care is another important service for aged care recipients. According to the Australian Podiatry Association failure to provide adequate podiatric care can have serious implications.[viii]

Pressure injuries, injuries from falls, blisters and wounds leading to ulceration are common amongst those in residential homes. Additionally they mention that existing accreditation standards for residential aged care facilities as set out in the Aged Care Quality Agency's Quality of Care Principles include care and services to be provided for all residents who need them (section 3.11 Therapy services, such as, recreational, speech therapy, podiatry, occupational, and physiotherapy services).

Despite this standard there is generally substandard podiatric care being delivered to aged care residents as reported by a number of podiatrists across Australia.

They too have reported misuse of government funding within facilities, in particular the utilisation of chronic disease management funding through Medicare (CDM). Many RACFs are engaging podiatrists to treat a number of residents only if they have a valid CDM referral. In these instances RACFs are using this funding mechanism to service podiatric care and not paying for this service out of their own operating budget.

> **Routine use of Medicare**
> "Residents should not routinely be referred for allied health services under Medicare. Therefore, residents who do require more frequent visits than 10 weekly or who don't have a current CDM and require podiatry should have this service paid for by the facility. Evidence obtained via our large survey of podiatrists within Australia working in this setting confirmed that in a majority of sites they are asked to only see residents 10 weekly as to not use any direct facility funding. Facilities who are relying on government health funding through the chronic disease management program are putting their resident's health at risk by not providing podiatry services every 6-8 weeks or prior based on the treating podiatrists clinical recommendations. When serious health issues arise where a resident is required to be treated more frequently, by relying on the CDM service they are detracted from providing adequate care to those residents."

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There are many cases that this is evident. A submission[ix] made to the Royal Commission into Aged Care Quality and Safety stated the following:

> **Financial abuse of residents in Residential Aged care**
> "I also would like to put forward the elder abuse comes in many forms. It's not necessarily directly monetary but sometimes being over serviced or not receiving full service for what they pay for. I have personally witnessed the following with my parents in aged care. Aged care facilities that don't provide podiatry and staff who can't toenails (despite there being no diabetes, circulation or any foot problems) and insist a podiatrist must do it and then the aged care person must use their five Medicare EPC visits for this. (Which 2 aged care facilities I know of STRETCH these 5 visits to cover the whole year – not enough for aged care residents who don't naturally wear down their toenails)."

> **ACFI and Auditing**
> "I've recently discovered my Dad has been assessed under ACFI as a 4b Physio and he is not receiving physio. On top of this the facility know that I have been paying for Physio."
>
> "The Government continue to pour money into aged care facilities, and will probably pour more in as a result of the Royal Commission. We need excellent levels of auditing to ensure money is being spent as required by the government."

Occupational therapists in Aged Care

Occupational therapists play an essential role in aged care also. They assist with health, wellbeing and physical function. Services include assessment of current abilities and intervention plans, falls prevention, management of the environment to reduce challenging behaviours, palliative care interventions, pain management, pressure care management, relaxation therapy, sleep assessment/strategies, continence management and upper limb assessment and prescribing assistive technology/equipment.[x]

In a submission made to the Royal Commission into Aged Care Quality and Safety by Occupational Therapy Australia (OTA) revealed that occupational therapy provided to residents of aged care facilities was too often focussed almost exclusively on pain management, and that occupational therapists were being actively trained to provide pre-determined care, and that this care was a means of generating funds via the Aged Care Funding Instrument. One occupational therapist who has worked in a number of RACFs reported that they responded to a job advertisement and were promised that they would gain experience across a range of clinical skills and have opportunities to perform splinting. This was completely false, as the job only involved managing the 4a/4b caseload using hand massagers. Residents often did not want a massage, however management strongly encourage staff to ask again and again if this is refused. If they continually refuse, the manager of the facility will talk to the resident and persuade them to change their mind.

Other therapists have reported that they have been employed to deliver pain management programs so that RACFs can claim extra funding under the ACFI. Many are finding that their work roles do not allow for 'occupational practice' and at times they are being asked to work 'out of scope' (in terms of treatment modalities).[xi]

Occupational therapists widely report being contracted to manage said pain using predetermined treatments.[xii]

> **Aged Care Funding Instrument**
> "This care is not clinically determined. Rather, it is prescribed by RACFs as a means of generating funds under the Aged Care Funding Instrument (ACFI)."

Furthermore concerns were expressed in regards to understaffed facilities.[xiii]

> **Chronic understaffing**
> "Arguably the most pertinent factor contributing to poor standards of care in RACFs is chronic understaffing (Harrington, Schnelle, McGregor, & Simmons, 2016). This is a common trend across RACFs, despite the fact that these facilities are often allocated a more than adequate level of funding through the ACFI."

> **Inexperienced Staff**
> "Staff in RACFs are often inexperienced and underqualified. OTA understands that many facilities use personal care assistants (PCAs) to assist residents to participate in activities of daily living (ADLs). There is no registration body overseeing PCAs."

According to Allied Health Professionals Australia the use of allied health assistants without appropriate supervision, training or direction by qualified allied health professionals need addressing/investment in order to improve future access to allied health and optimum outcomes for aged care recipients. What also needs addressing is the lack of data collected and made publicly available regarding the allied health workforce and service provision.[xiv]

> "Information must be made accessible if recipients of aged care and their families are to understand their care options, make informed choices and be effectively engaged in the care process."

The MBS Review Taskforce Allied Health Reference Group identified several themes that are relevant to the current challenges and future directions of allied health care in Australia and there is an opportunity to improve data collection and transparency for allied health use across Australia. There is limited available data linking allied health use across funding streams and patient journeys in Australia.

Improving this data would enhance primary health network (PHN), state and federal understanding of the drivers of patient choice and clinical outcomes, as well as strengthening decision-making. It could also lead to cost savings and improved patient outcomes in the medium to long term.[xv]
It is reasonable to accept that this would be helpful in the aged care system and the bill would support this.

Food and food supplements

Under Schedule 1, item 1.10 Meals and refreshments it makes it clear that providers must provide meals of adequate variety, quality and quantity for each care recipient, including taking in account of special dietary requirements or medical needs. Additionally food supplements or thickeners for people with Dysphagia or swallowing difficulties may need to be assessed by an allied health professional.

According to the Speech Pathology Australia,[xvi] 40-60% of people in residential aged care are living with swallowing difficulties and can lead to a range of serious health consequences including:

- reduced oral intake leading to malnutrition and dehydration
- choking – which has been found to be the second highest cause of preventable deaths in
- residential aged care
- chest infections / aspiration pneumonia which can lead to unplanned hospitalisations. Death can be a possible outcome of these sequelae.

A submission[xvii] made to the Royal Commission into Aged Care Quality and Safety by a carer regarding his parents expressed the following:

> **Aspiration Pneumonia**
> *"Without thickened liquids my father suffered from aspiration pneumonia. In not too long a time his evening meal arrived. It included soup and a drink and a cup of tea none of which were thickened. This was a fundamental failure in meeting his care needs and I started to wonder why the nursing home could not get right something so simple."*

Dietitians Association of Australia (DDA) reveal that service providers say cost is a barrier to engagement of dietitians or other allied health practitioners as consultants or as employees. However, this fails to account for the high costs associated with malnutrition (falls, pressure wounds and increased staff requirements to support malnourished residents etc).[xviii]

Furthermore DDA members observed the following:

- Very small amounts of meat in casserole dishes so the protein content of the finished menu item is inadequate
- Poor quality meat which has gristle and is tough, entirely unsuitable for soft or modified texture diets
- Recipes not followed with impacts on nutrient composition and suitability for special diets

- Missing high energy/high protein beverages or snacks on mid-meal refreshment trolleys
- Meals left to sit in front of residents that have difficulty in feeding themselves and then being removed without adequate feeding assistance
- Meals provided in the form of inappropriate textures that are not appealing or cannot be eaten
- Fluids left with no support staff available to encourage consumption.
- When trying to advocate for suitable finger food to be provided to residents with dementia, they are often provided with party pies or other deep fried foods of little nutritional value.
- Extremely limited choices with meals (e.g. only one item on the menu), with a sandwich provided if the item is disliked, with sandwich fillings often limited to processed meat (e.g. ham or salami).
- Extremely limited choices among residents on modified texture diets, with some sites only offering 3 vegetable options: mashed potatoes, mashed pumpkin or mashed carrots.
- Residents being provided with foods that they have documented allergies or intolerances to (e.g. exposure to gluten on a gluten-free diet).
- Special diets being catered for by omission (e.g. omitting milk and not providing an alternative to clients with a milk protein allergy or lactose intolerance).
- Residents requiring specialised diets (e.g. low potassium) receiving foods that are the same as everyone else.
- Some residents on vegetarian diets being provided with meals of just vegetables only because the cooks are not confident cooking with pulses and legumes, resulting in very low protein intakes and an increased risk of malnutrition.
- Care staff rejecting Accredited Practising Dietitian requests for food fortification as the first approach for a client, with the rationale given that this is not possible for the kitchen to carry out.
- Residents on maximum food fortified meals and also supplements continuing to lose weight. It has been subsequently discovered that the residents weren't receiving these supplements because the staff were too busy, or didn't read the supplement list.
- In other situations, high protein/high energy supplements have been ceased by the facility because they are "too expensive" and they "don't have the money".

According to an Australian survey over 2015 and 2016 and data compiled by 817 RACFs indicated that the average total spend on raw food and ingredients on the budget alone was $6.08 per aged care resident per day. Increasing the aged care profit margin by reducing food spend impacts the quality of resident care and can contribute to malnutrition rates in aged care.[xix]

It is sensible to include the requirement in the proposed Bill that approved providers disclose the cost of food and food supplements.

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Medical products

In my prior submission I expressed that if you take into account the care and services items under Schedule 1, requesting the cost of medical products should be altered to reflect at least what is currently included in Schedule 1. Alterations should also be made in the bill to clarify to providers exactly what they need to disclose. The following points or examples confirm the reason why it's inadequate (recognising that it's not an exhaustive list).

Part 1— Hotel services to be provided for all care recipients who need them

1.9 Toiletry goods

Bath towels, face washers, soap, toilet paper, tissues, toothpaste, toothbrushes, denture cleaning preparations, mouthwashes, moisturiser, shampoo, conditioner, shaving cream, disposable razors and deodorant

Soap, moisturiser, shampoo and conditioner are included under toiletry goods. Providers cannot charge recipients for suitable soap, or soap substitute, if the resident's care needs mean the resident cannot use the soap normally provided. They can charge if using a different product, or brand of product, in place of an effective alternative. This includes moisturiser, shampoo and conditioner. However how do we know that providers actually do spend on these items? Do they charge additional fees to provide the items needed? These are necessary hygiene and skin care products. Moisturiser may also be part of skin or wound care. Do these items then fall under medical products? Additionally under part 3 of Schedule 1 it includes complex wound management as part of nursing services (for those eligible under a classification level).

Under the National Aged Care Mandatory Quality Indicator Program aged care providers must measure and report on pressure injuries. The National Aged Care Mandatory Quality Indicator Program Manual (1.0) includes links to resources from Australian Wound Management Association, Wound Innovations and the National Pressure Injury Advisory Panel (NPIAP).

The Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury (published by the Australian Wound Management Association) outlines preventative strategies to protect a person's skin and to practice wound and skin hygiene such as applying a moisturiser to contribute to the maintenance of the healthy skin, use of pH appropriate skin cleanser and water based skin emollients to maintain skin hydration.[xx]

In a submission made by Wounds Australia to the aged care commission skin tears are common in nursing home patients; prevalence may be reduced with preventative measures including good skin care. Emollient needs to be an appropriate type with the avoidance of brands that can contribute to dryness or products that are cheaper to purchase however not effective on the aged skin such as oils. Standard skin care should involve using effective moisturisers to protect skin integrity and avoiding moisturisers with petrochemicals, aqueous cream and fragranced products. Using soap free wash and avoiding soaps that can increase the pH of the skin.[xxi]

In March 2021, a media release by Wounds Australia stated that Royal Commission into Aged Care has been an “almost complete failure” for older Australians suffering from chronic wounds. Wounds Australia Chair Hayley Ryan said it was "inconceivable wounds were barely mentioned in the Royal Commission's Report", with just four of 148 Recommendations mentioning wound care.[xxii]

It is important that there is financial transparency in this type of care and service and therefore the bill should be amended to include disclosure of expenses for **skin and wound products**. This would prevent the difficulty of providers determining if some toiletry goods i.e. moisturisers for skin care or skin and wound products fall under medical products.

Bedding materials and mobility goods

Under part 3 of Schedule 1 it includes air and water mattresses. Therefore do these items fall under medical products? They also do relate to skin care and wound prevention and management. Providers may assume the expense amount for these items are excluded as they fall under Schedule 1, Item 3.2 Bedding Materials. Wheelchairs sit under item 3.4. This is another important item that should be provided and sadly there is evidence that this is not happening. Refer to reference 2 in this submission for additional information.

Part 3— Care and services—to be provided for all care recipients who need them (classified under a specific level)

3.2	Bedding materials Bed rails, incontinence sheets, ripple mattresses, sheepskins, tri pillows, and water and air mattresses appropriate to each care recipient’s condition.
3.4	Goods to assist care recipients to move themselves Crutches, quadruped walkers, walking frames, walking sticks, and wheelchairs. Excludes motorised wheelchairs and custom made aids.

Senate Community Affairs Legislation Committee (Answers to Questions on Notice)

Several submitters, including the ACT Government, Queensland Health, the Health Services Union, the Queensland Nurses and Midwives' Union and the Federation of Ethnic Communities Councils of Australia, have raised concerns about the list of information included at proposed subsection 9-2A(2) of the bill which would be required in the proposed financial transparency reports.

This includes concerns that the list does not provide clarity on terms such as 'direct and indirect care' or 'medical products' required to avoid confusion in reporting, while others have recommended further categories for financial disclosure.

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The Department of Health[xxiii] provided the following response:

> **Aged Care Financial Report**
> "As outlined in IQ20-000619, residential aged care providers are currently required to submit an annual Aged Care Financial Report (ACFR). As part of the ACFR, providers are required to report against a number of expenditure categories, including a number that are proposed in section 9-2A(2) of the bill. The attachment to IQ20-000619 sets out the expenditure categories currently required. Currently, a user guide and detailed definitions are available to assist providers complete their reporting requirements under the ACFR. This helps to ensure there is a uniform understanding of what is required for each definition. Any new data items required by providers would also have a data definition supplied to ensure a consistent understanding. The Department notes the Royal Commission into Aged Care Quality and Safety is also considering the reporting requirements for aged care providers and the Government will consider the recommendation in the final report."

The user guide or additional documents does not address my concerns or the concerns by other submitters.

I am not an expert on these particular financial reports or documents but my understanding is that the ACFR Definitions Document[xxiv] lists what expense items a provider should disclose. They do not need to disclose expenses for all items. For example they do not need to provide the cost of staff training and development whereas the bill asks for the total cost of staff member training. Amount paid to staff on individual employment contracts does not need to provided but possibly the Bill request the cost for this. Providers must reveal expense amount for bedding materials (bed sheets, pillow and pillow cases, blankets) but the Bill does not indicate to disclose expenses for these items. Air/pressure mattresses fall under bedding materials (Schedule 1 of the Quality of Care Principles 2014). Even though the bill includes 'medical products' bedding products or devices may not be recognised as falling under medical products.

The ACFR Definitions sheet includes the following:

Other Care Expenses

- Medications and unit doses for residents,
- Oxygen and oxygen equipment.
- Treatments and procedures.
- Equipment and incontinence aids purchased for client use,
- Items that assist resident's mobility,
- Recreational and social activities of the clients,
- Rehabilitation support.
- Items for personal grooming of the clients (e.g. hairdressing etc.),
- Specific cultural and social events.

Do air/pressure mattress fall under 'equipment' if purchased for client use?

Toiletry and sanitary goods (soaps, face wash, paper products) fall under Other Catering, Cleaning & Laundry Expenses in the ACFR Definitions sheet. Under Schedule 1, moisturisers which could also be part of skin or wound care fall under toiletries but the bill has 'medical products'. If look at items listed in Schedule 1 and the ACFR Definitions sheet, then you may determine the items/wording for the bill which is appropriate to cover most listed.

However I believe that the annual Aged Care Financial Report (ACFR) isn't appropriate and the Bill is important to reveal more. The ACFR does not seem to address public concerns in regards to aged care funds and care. This is quite apparent from evidence provided by many users of aged care services.

Suggestions to be considered

In the proposed Bill approved providers will have to provide a written report to the Quality and Safety Commission, which will then become public. It must include the following information:

2 (e) the total cost of direct and indirect care expenditure which includes the aggregatedcost of the following:

(i) food and food supplements;
(ii) medical products;
(iii) continence aids

In my prior submission I suggested to include a fourth item - (IV) Bedding materials to Bill. **However in light of additional information and to cover important care items the following is suggested:**

(i) food and food supplements;
(ii) medical and bedding products or devices
(iii) continence aids
(IV) Skin and wound care products

Corporations Act 2001 - 4 After subsection 296(1B)
The following is proposed in the Bill**:**

Aged care providers
If an approved provider (within the meaning of the Aged Care Act received more than $10 million in funding from the Commonwealth in a financial year, the financial report for that financial year must comply with the Tier 1 requirements of the accounting standards.

I agree with the Queensland Nurses and Midwives' Union (QNMU) submission to amend this subsection and omit 'more than $10 million'. They make a valid point that every residential aged care provider who receives funding from the Commonwealth must provide a financial report for the financial year, regardless of the amount of funding.[xxv]

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Medicines

In the submission by Aged and Community Services Australia (ACSA) relating to this inquiry they made a few points. They stated the following:

"Prescribing of medicines is a matter between an individual and their prescribing doctor. Older Australians in residential aged care pay for and receive subsidised medicines in the same manner as other older Australians. Where residential aged care providers incur medicines related costs is in the management of their own imprest systems and where charged by a community pharmacy, for the cost of having resident medicines packed into dose administration packaging (e.g. 'Webster Packs)."[xxvi]

In the Explanatory Memorandum[xxvii] under 'Overview of the Bill' it mentions that the Bill requires aged care providers to disclose their spending on medication. As ACSA noted prescribing of medicines is a matter between an individual and their prescribing doctor but in the past aged care providers were financially responsible for some pharmaceuticals items.

As mentioned in my prior submission in 2014 changes were made to the Quality of Care Principles. Under Schedule 1, Care and Services, some of the items were altered or removed. An example is in relation to item 3.7 Basic medical and pharmaceutical supplies and equipment. This has now been deleted and all specified goods to support treatments are now in Item 2.4. Items such as Analgesia, anti-nausea agents and urinary alkalising agents were removed. Now they can charge all residents for any medicines, whether prescription or over the counter.

During that time of aged care reforms and the low and high care distinction was been removed I communicated with the Department of Aging and Aged Care to ascertain if Schedule 1, under the Quality of Care Principles will be altered. I was informed it will remain unchanged. However sadly this was not true. As mentioned above it did change and providers no longer were financially responsible in providing some medicines. What was disappointing is that I did not have the opportunity to respond to any proposed changes as was not aware of any consultations regarding this.

In 2013, the National Aged Care Alliance (NACA) provided a progress report on the review of the Specified Care & Services Schedule which outlines what must be provided to all people who live in a residential aged care service (the standard package of services). The Schedule had to be reviewed and redefined as a result of Living Longer Living Better (LLLB) aged care reform package which removed the low/high care distinction in residential care.[xxviii]

The report[xxix] outlined the NACA discussions on changes to the Specified Care & Services Schedule as a result of the removal of the high/low care distinction in the Living Longer Living Better reforms and identified where changes have cost implications. NACA Specified Care and Services Advisory Group was to review the Aged Care Financing Authority (ACFA) advice and make further recommendations to the Minister on the Schedule. At the time there were some aged care industry led or peak bodies in these groups, including Aged and Community Services Australia (member of NACA). It is possible they were members of the Aged Care Financing Authority at the same time. The paper represented the combined NACA view of the wording and content of the legislated Specified Care and Services Schedule.

It seems some of the items that had cost implications were eventually altered. Were they reviewing the cost implications for providers or consumers? Because these discussions could have influenced altering basic medical and pharmaceutical items or other items and the outcome would have not been a benefit for consumers. You have to question who the changes were really for.

Item 3.7 was known as a hot topic as likely some providers were not providing the basic medicines or pharmaceuticals under this item. In my experiences with aged care facilities this was an area that I had considerable constant issues with. It is not surprising then the Department of Health (Department of Health & Ageing) Care released a guideline document[xxx] relating to services in aged care homes to assist residential aged care providers to understand care responsibilities towards residents. This was after items were amended.

Changes were made for the financial benefit of the providers, not the recipients and yet providers are continuously voicing more funds are needed. As mentioned in my prior submission, **if this is the case then prove it! Passing this bill gives them this opportunity.**

Final Report of the Royal Commission into Aged Care Quality and Safety

It supports a rigorous system of prudential regulation and financial oversight of service providers and should be a critical component of the Australian Government's oversight of the aged care sector, particularly more comprehensive financial reporting. However in evidence to the Royal Commission into Aged Care Quality and Safety the Australian, the Government and the Department of Health accepted that the prudential framework for aged care is not currently fit for purpose and requires fundamental reform to make sure that it can meet contemporary needs.

It recommended that all approved providers of residential aged care should report, on a quarterly basis, the total direct care staffing hours provided each day at each facility they conduct. This includes specifying the different employment categories, including personal care workers, enrolled nurses, registered nurses, and allied healthcare professionals.[xxxi] **The Aged Care Legislation Amendment (Financial Transparency) Bill 2020 supports this.**

It is disappointing that the Royal Commission into Aged Care Quality and Safety did not publish submissions made in regards to the hearings examining the provision of mental health care, oral health care and allied health care to people receiving aged care services.[xxxii] This has created the impression that this isn't important in aged care. The submissions could have provided details that relate to the Bill.

Concluding Comments

As I have stated in my prior submission now is the opportunity to take the step to ensure transparency and leadership in aged care as the community is crying out for it.

Sadly the Commissioners (Royal Commission into Aged Care Quality and Safety) could not agree on recommendations jointly and so this does not give me any confidence that the right changes will be made to improve the aged care system. **Passing the Bill will help build confidence in the system.**

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[i] Aged Care Legislation Amendment (Financial Transparency) Bill 2020 – Submission 12: https://bit.ly/3xks1XU
[ii] Quality of Care Principles 2014: https://www.legislation.gov.au/Details/F2021C00292
[iii] The Aged Care Quality Standards: https://www.agedcarequality.gov.au/providers/standards
[iv] Royal Commission into Aged Care Quality and Safety Draft Proposition – Allied Health: https://bit.ly/3tXqzZp
[v] Royal Commission into Aged Care Quality and Safety - Supplementary Submission – Hearing 5, Draft Propositions (May 2020): https://agedcare.royalcommission.gov.au/system/files/2020-07/RCD.9999.0325.0001.pdf
[vi] Position Paper: Food, Nutrition and Mealtime Experience in Aged Care: https://bit.ly/3tTZeYg
[vii] Allied Health Professionals Royal Commission into Aged Care Quality and Safety Supplementary Submission - Hearing 3 Workforce March 2020: https://bit.ly/3sRCkzf
[viii] Australian Podiatry Association Submission to the Royal Commission into Aged Care Quality and Safety (Feb 2020) https://www.podiatry.org.au/documents/item/2133
[ix] Submission made to the Royal Commission into Aged Care Quality and Safety (AWF.001.05470): https://bit.ly/3aESd64
[x] Occupational Therapy Australia - Aged Care: http://aboutoccupationaltherapy.com.au/aged-care/
[xi] Royal Commission into Aged Care Quality and Safety OTA Submission (Sep 2019): https://bit.ly/3xtjXEk
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