The Senate

Standing Committee on Community Affairs

Aged Care Amendment (2008 Measures No. 2) Bill 2008 [Provisions]

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The Aged Care Amendment (2008 Measures No. 2) Bill 2008

1.1 On 16 October 2008 the Senate, on the recommendation of the Selection of Bills Committee, referred the provisions of the Aged Care Amendment (2008 Measures No. 2) Bill 2008 (hereafter 'the bill') to the Community Affairs Committee for inquiry and report by 20 November 2008.

1.2 The inquiry was advertised in *The Australian* and through the Internet. The committee wrote to interested individuals and groups inviting submissions. The committee received submissions from 16 individuals and organisations, and these are listed at Appendix 1. The committee held a public hearing in Canberra on 14 November 2008. Details of the public hearing are referred to in Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the committee's website at http://www.aph.gov.au/senate_ca.

1.3 The committee notes that the Senate's Finance and Public Administration committee is currently holding a broader inquiry into residential and community aged care in Australia, and has sought not to traverse any such broader issues in discussing the bill before the committee.

Residential aged care

1.4 Many older Australians receive care in residential aged care facilities, and there are now around a thousand organisations providing approved care.[1] Residential aged care comprises a range of supported accommodation services for older people who are unable to continue living independently in their own homes. It includes high level and low level care, depending on the amount of assistance the resident requires. There are also programs that support care in the home or home-like environments, including Community Aged Care Packages and Extended Aged Care at Home.[2]

1.5 Residential aged care is governed by the Commonwealth's *Aged Care Act 1997* (hereafter 'the Act') and the User Rights Principles. The legislation, administered by the Department of Health and Ageing (DOHA), does two things. First, it sets out objectives for the aged care sector. These are:

> to promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals;
>
> to protect the health and well−being of the recipients of aged care services;

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1 Explanatory Memorandum, p. 1.

2 Greg McIntosh and Thomas John, 'Aged Care Amendment (Residential Care) Bill 2006 – Bills Digest', *Bills Digest* No. 129, 2006–07, p. 3.

> to ensure that aged care services are targeted towards the people with the greatest needs for those services;
>
> to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location;
>
> to provide respite for families, and others, who care for older people;
>
> to encourage services that are diverse, flexible and responsive to individual needs;
>
> to help those recipients to enjoy the same rights as all other people in Australia;
>
> to plan effectively for the delivery of aged care services
>
> to promote ageing in place through the linking of care and support services to the places where older people prefer to live[3]

1.6 Second, the Act underpins Commonwealth funding of aged care. It establishes principles for funding, stating that it will take account of quality, type and level of care; the accessibility of care; the outcomes achieved by service providers; and the need for accountability, both for funding and for care outcomes.[4]

1.7 The Commonwealth's residential aged care program provides funding for aged care services. The program is characterised by 'funding, user charging, and regulatory arrangements that apply across the whole Australian Government funded residential aged care sector'.[5]

1.8 A 2006 paper summarised funding arrangements for aged care:

> [T]he Commonwealth provides approximately three-quarters of the total funds available (mainly via residential care subsidies and capital grants to providers). The remaining funding comes from permanent residents in aged care facilities paying accommodation and daily living charges. Most of the funding comes via the Commonwealth Department of Health and Aged Care but there is also specific residential aged care funding via the Department of Veterans' Affairs for aged veterans.[6]

1.9 The majority of aged care services continue to be provided by not-for-profit organisations,[7] with Catholic Health Australia for example being the 'largest non-government provider grouping of aged care services'.[8]

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3 Adapted from *Aged Care Act 1997*, Division 2.

4 Adapted from *Aged Care Act 1997*, Division 2.

5 Department of Health and Ageing, *The Residential Care Manual*, April 2005.

6 Greg McIntosh and Thomas John, 'Aged Care Amendment (Residential Care) Bill 2006 – Bills Digest', *Bills Digest* No. 129, 2006–07, p. 4.

7 Aged and Community Services Australia (ACSA), *Submission* 6, p. 1.

8 Catholic Health Australia (CHA), *Submission* 11, p. 1.

Approved providers

1.10 In order to receive Commonwealth funding for aged care, the service provider must be an **approved provider**.[9] Approval as a provider of aged care is granted upon application to the Secretary of the Department of Health and Ageing, provided the service provider meets certain conditions.[10] These conditions include that the applicant:

> has shown that specific criteria have been met: the capacity to deliver appropriate standards of care, managerial and financial skills, and that key personnel are not 'disqualified individuals'.[11]

1.11 'Key personnel' is a term defined in the Act, and, in respect of applicants for approved provider status, means:

> (a) a member of the group of people who are responsible for the executive decisions of the applicant;
>
> (b) any other person who is concerned in, or takes part in, the management of the applicant;
>
> (c) any person who is responsible for the nursing services provided, or to be provided, by the aged care service conducted, or to be conducted, by the applicant;
>
> (d) any person who is responsible for the day‑to‑day operations of an aged care service conducted by the applicant, whether or not the person is employed by the applicant;
>
> (e) any person who is likely to be responsible for the day‑to‑day operations of an aged care service that the applicant proposes to conduct, whether or not the person is employed by the applicant.[12]

1.12 'Disqualified individual' also has a particular meaning under the Act, and refers to situations where:

> (a) the individual has been convicted of an indictable offence; or
>
> (b) the individual is an insolvent under administration; or
>
> (c) the individual is of unsound mind.[13]

1.13 An approved provider may be a corporation, a state or territory government, or a local government authority.[14]

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9 *Aged Care Act 1997*, s. 6-1.

10 *Aged Care Act 1997*, s. 8-1.

11 Department of Health and Ageing, *Review of Pricing Arrangements in Residential Aged Care: The Commonwealth Legislative Framework*, Background Paper No. 2, 2003, p. v.

12 *Aged Care Act 1997*, s. 8-3.

13 *Aged Care Act 1997*, s. 10A-1.

Aged Care Assessment Teams

1.14 While the secretary of DOHA makes assessments of care providers to see whether they qualify to be approved providers, there is also an assessment process of the individuals seeking care, to determine whether they are eligible for subsidy, and what sort of care they require.[15] These assessments are made by an Aged Care Assessment Team (ACAT).[16] ACATs are generally multidisciplinary teams of health professionals, funded by the Commonwealth through the states and territories,[17] as the operational arm of the Commonwealth's Aged Care Assessment Program.[18]

1.15 In 2006, the Council of Australian Governments (COAG) agreed to reform aspects of aged care delivery, including 'that there be more timely and consistent assessments for frail older people by Aged Care Assessment Teams and simplified entry and assessment processes for the Home and Community Care Program'.[19] This resulted in a review of the operation of ACAT teams that, while positive about their role and professionalism, identified issues with consistency of assessment approach, capacity and timeliness, as well as complexity, particularly from the point of view of clients and carers.[20] The Review noted that there may be some unnecessary re-assessments of care needs, stretching resources that are already in heavy demand.[21]

Accommodation bonds

1.16 One of the key elements of the funding arrangements, relevant to the bill before the committee, is accommodation bonds. Accommodation bonds are charges levied on a person when they enter low level approved residential care.[22] Not all low

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14 Department of Health and Ageing, *Review of Pricing Arrangements in Residential Aged Care: The Commonwealth Legislative Framework*, Background Paper No. 2, 2003, p. v.

15 Department of Health and Ageing, *The Residential Care Manual*, April 2005, p. 4:2.

16 Department of Health and Ageing, *Review of Pricing Arrangements in Residential Aged Care: The Commonwealth Legislative Framework*, Background Paper No. 2, 2003, p. viii.

17 Department of Health and Ageing, *Ageing and Aged Care in Australia*, July 2008, p. 17.

18 Communio, for Department of Health and Ageing, *National ACAT Review Final Report*, November 2007, pp 22, 24, 60–61.

19 COAG, *Communique*, 10 February 2006, p. 11, http://www.coag.gov.au/coag_meeting_outcomes/2006-02-10/docs/coag100206.pdf (accessed 31 October 2008).

20 Communio, for Department of Health and Ageing, *National ACAT Review Final Report*, November 2007, pp 9–17.

21 Communio, for Department of Health and Ageing, *National ACAT Review Final Report*, November 2007, p. 50.

22 *Aged Care Act 1997*, ss 57-2, 57A-2.

level care recipients pay these bonds: there is an assets test.[23] The bonds are held by aged care providers for as long as the person is in care. The service provider is allowed to draw on the investment income from the bonds to help fund capital works, debt retirement or, in limited circumstances, to improve the quality and range of care services.[24] Unlike accommodation charges, bonds must be refunded (apart from some allowable deductions)[25] when the person leaves low level care.[26]

1.17 Accommodation bonds represent a major asset base within the aged care sector. At 30 June 2007, bonds held by aged care service providers were worth $6.3 billion.[27]

1.18 The Commonwealth's *Aged Care (Bond Security) Act 2006* provides, in certain circumstances, a Commonwealth guarantee underpinning aged care accommodation bonds in the event that an approved aged care service provider becomes insolvent.[28]

The bill

1.19 The bill seeks to amend the Act, and the *Aged Care (Bond Security) Act 2006*, 'to address current legislative inadequacies and maintain effective regulatory safeguards for ensuring high quality care for older Australians'.[29] It reflects the fact that the legislation is over ten years old, and in that time the aged care sector has evolved and changed substantially. In particular,

> a different model of aged care has emerged, one in which the owner and operator of a facility have distinct roles and responsibilities and may function quite separately. The last decade has also seen a significant increase in the level of investment in the sector from large corporate entities. The regulatory framework has not kept pace with this shift in business practice.[30]

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23 In summary, an accommodation bond is charged only when the person receiving care has assets greater than 2.5 times the basic age pension, at the time they enter care. See *Aged Care Act 1997*, s. 57.12. In 2008, this amount is $34 500. See Department of Health and Ageing, Aged care Australia website, Help with aged care homes: accommodation bond, http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Accommodation+bond-1 (accessed 31 October 2008).

24 *Aged Care Act 1997*, s. 57-2.

25 *Aged Care Act 1997*, ss 57-8, 57.20.

26 *Aged Care Act 1997*, s. 57-21.

27 Explanatory Memorandum, p. 1.

28 *Aged Care (Bond Security) Act 2006*, ss 6, 12, 13.

29 Explanatory Memorandum, p. 1.

30 Explanatory Memorandum, p. 1.

1.20 The government has indicated that the bill makes changes to aged care regulation in three areas: the regulation of approved providers; the framework for assessments made by Aged Care Assessment Teams; and the protection of residents' accommodation bonds.[31]

1.21 The regulation of approved providers is to be improved in several ways:

- The bill will link approved provider status to the actual allocation of aged care places, so that a provider will only be 'approved' once it actually has aged care places allocated to it, and will only be an 'approved' provider for those services to which funded places have been allocated.[32]
- The bill will ensure that the regulatory approach to the sector reflects the realities of the structure of aged care service providers. This will include allowing the Secretary of the Department to examine related business entities when making decisions under the Act.[33] This will also address the possibility that businesses will establish structures to deliberately limit the transparency of their suitability to provide aged care, taking advantage of the current structure of the Act.[34]
- The bill will introduce a broader definition of 'key personnel' for the purposes of regulatory scrutiny, ensuring consideration of the suitability of everyone who has 'authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the applicant / approved provider',[35] regardless of the structure of the aged care service provider's business.[36]

1.22 The bill will reduce the number of ACAT assessments needed to ensure that people receiving high level care, respite care or flexible care may continue to be eligible for that care. Currently, older Australians requiring these categories of care are generally assessed every twelve months.[37] The bill will remove this requirement, though 'reassessment should occur at any stage if there has been a change in the care recipient's care needs'.[38]

1.23 The bill amends both the Act and the Aged Care (Bond Security) Act to improve the security of accommodation bonds:

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31 Explanatory Memorandum, pp 3–4.

32 Explanatory Memorandum, p. 3.

33 Explanatory Memorandum, p. 21.

34 Mr Andrew Stuart, First Assistant Secretary, Ageing and Aged Care Division, DOHA, *Proof Committee Hansard*, 14 November 2008.

35 Explanatory Memorandum, p. 23.

36 Explanatory Memorandum, pp 1, 23–24.

37 See the Act, s. 23-3 (1).

38 Explanatory Memorandum, p. 41.

> Experience with the operation of the Aged Care (Bond Security) Act 2006 has highlighted that the Guarantee Scheme only operates in regards to current approved providers and does not protect bonds when the approved provider status has lapsed or been revoked before the refund declarations have been made.[39]

1.24 The bill extends the application of the bond scheme's rules (such as time frames for bond refunds), and also extends the reach of the government's Guarantee Scheme.[40]

1.25 In addition to these changes, there are a range of other more minor amendments, such as the introduction of an additional mechanism for transferring provisionally allocated aged care places in exceptional circumstances.[41]

Departmental consultations

1.26 The Department advised the committee that the bill had been

> the subject of extensive consultation with the aged care sector through the Aged Care Assessment Program officials and the Ageing Consultative Committee which comprises peak industry, professional and consumer bodies.[42]

1.27 The Department indicated that some changes were made to proposed amendments as a result of these consultations. Officials at the hearing emphasised that the Consultative Committee is very representative of the industry.[43] However, in response to committee concern raised during the hearing, DOHA undertook to write to stakeholders regarding some of the matters raised during this inquiry.[44]

1.28 DOHA also indicated that two matters have been raised with them since the introduction of the bill. It had discussed these issues directly with concerned stakeholders, but also drew these matters to the attention of the Committee. The first concerned introducing deterrence as a factor in determining sanctions against non-complying service providers. The Department indicated that concerns were raised that 'this amounts to punishment and is inappropriate'. The Department indicated that the purpose of the amendment was to ensure that action can be taken against non-

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39 Explanatory Memorandum, p. 47.

40 Explanatory Memorandum, pp 47, 56.

41 Proposed new subdivision 16-B: Explanatory Memorandum pp 35–40.

42 DOHA, *Submission* 1.

43 Mr Andrew Stuart, First Assistant Secretary, Ageing and Aged Care Division, DOHA, *Proof Committee Hansard*, 14 November 2008.

44 Mr Andrew Stuart, First Assistant Secretary, Ageing and Aged Care Division, DOHA, *Proof Committee Hansard*, 14 November 2008.

compliance 'even where there may be no immediate impact on the health, safety or well-being of care recipients'.[45] This matter is discussed further below.

1.29 The Department indicated that clarifying material regarding the reforms would be made publicly available in November 2008.[46] Clarification in relation to police check provisions and some other matters was provided to the committee in its supplementary submission to this inquiry.[47]

1.30 Several submitters raised concerns about the public consultations and how DOHA presented them. Some indicated that they had indeed been consulted, but wanted to emphasise that they had not, and did not, agree with some of the proposals they were consulted upon.[48] Others indicated they had not been a part of consultation processes, and hoped that the reform process would be delayed to conduct more extensive discussion and education with the sector.[49]

Support for the bill

1.31 There was support for the measures in the bill. The aged care lobby group were 'pleased to see that amendments are being made' to the Act.[50] The Australian Medical Association (AMA) 'supports the measures in the Bill to reduce the number of unnecessary reassessments for residential respite care and high level residential care'.[51] The NSW Nurses' Association believed that the bill 'offers changes that will benefit care recipients, providers of aged care services and the government'.[52] The Combined Pensioners and Superannuants Association (CPSA) of NSW welcomed the changes to the definition of 'key personnel', changes to the operation of ACAT teams, and new measures to protect residents' bonds.[53] Aged Care Crisis Team also supported the bill.[54] Aged and Community Services Australia (ACSA) indicated that changes to ACAT team operations will be a valuable step forward.[55]

1.32 ACSA also supported some other aspects of the legislation, such as the linking of approved provider status to the allocation of funded places. ECH Inc supported the legislation, 'but believes that several aspects of the amendments require

45 DOHA, *Submission* 1.

46 DOHA, *Submission* 1.

47 DOHA, *Submission* 1A.

48 Mr Greg Mundy, CEO, ACSA, *Proof Committee Hansard*, 14 November 2008.

49 Mr Jim Toohey, CEO, TriCare, *Proof Committee Hansard*, 14 November 2008.

50 aged care lobby group, *Submission* 2.

51 AMA, *Submission* 4.

52 NSW Nurses' Association, *Submission* 13, p. 1.

53 CPSA, *Submission* 12, pp 3–6.

54 Aged Care Crisis Team, *Submission* 7.

55 Mr Greg Mundy, *Proof Committee Hansard*, 14 November 2008.

clarification'.[56] Catholic Health Australia (CHA) provided 'broad support' for the bill, but had concerns in particular areas.[57]

Issues with the bill

1.33 A number of stakeholders were critical of elements of the bill. ACSA stated that, while consultation had taken place, 'there was no unanimity between the Government and other stakeholders on some key points', and there are areas where they and other stakeholders 'did not support the final version of the measures proposed in the bill'.[58] The Aged Care Alliance (TACA) is a Queensland-based industry organisation that was sharply critical of the legislation.[59] TACA stated that:

> [t]he amendments will impose additional compliance costs upon a highly regulated sector and will have the effect of further increasing the level of regulatory complexity and inefficiency. We submit that the rationale for those particular amendments is flawed and that they represent poor public policy.[60]

1.34 The main areas in which industry stakeholders had concerns were:

- Increased regulation and red tape generally;
- The effects of an expanded definition of "key personnel";
- Fears about the expanded and potentially more 'punitive' role of the Secretary of the Department, such as in respect of imposing sanctions on providers and in the setting of maximum accommodation bond payments;
- Criteria for, and processes associated with, sanctions and deterrence functions.

The definition, and consideration of the suitability, of 'key personnel'

1.35 The current legislation requires the Secretary to consider whether an applicant for approved aged care places is suitable for the task.[61] In broad terms, that consideration includes whether the applicant can provide quality care, whether the applicant can implement sound financial management, and whether the applicant's 'key personnel' are suitable and experienced.

1.36 'Key personnel' has a particular meaning under the Act. It currently states that such personnel include:

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56 ECH Inc, *Submission* 9.

57 CHA, *Submission* 11.

58 ACSA, *Submission* 6.

59 TACA, *Submission* 3; also Sundale, *Submission* 5.

60 TACA, *Submission* 3, p. 4.

61 *Aged Care Act 1997*, s.8-3.

> (a) a member of the group of people who are responsible for the executive decisions of the applicant;
>
> (b) any other person who is concerned in, or takes part in, the management of the applicant;
>
> (c) any person who is responsible for the nursing services provided, or to be provided, by the aged care service conducted, or to be conducted, by the applicant;
>
> (d) any person who is responsible for the day‑to‑day operations of an aged care service conducted by the applicant, whether or not the person is employed by the applicant;
>
> (e) any person who is likely to be responsible for the day‑to‑day operations of an aged care service that the applicant proposes to conduct, whether or not the person is employed by the applicant.
>
> (4) A person referred to in paragraph (3)(c) must hold a recognised qualification in nursing.

The bill proposes to change these arrangements in three respects.

1.37 First, it would allow the Secretary to consider not only the record of the applicant seeking to become an approved provider, but also the record of related approved providers who share key personnel with the applicant.

1.38 Second, it would amend the definition of key personnel. Clause (b), which refers to 'any other person who is concerned in, or takes part in, the management of the applicant' would be replaced with 'any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the entity at that time'.[62] The intention behind this amendment is to keep pace with changes to business structures occurring amongst some providers in the sector. The Explanatory Memorandum states:

> As business structures have changed it has become more likely that control may be exercised over an approved provider by a variety of individuals and organisations that may be outside the immediate entity that constitutes the approved provider. For example, an approved provider entity may form part of a collection of companies managed by another company.[63]

1.39 The government is proposing to amend the legislation to ensure that those directing or controlling the approved provider, whether or not they might be considered to be directly managing its operations, are recognised as key personnel whose decisions may have a bearing on 'the quality of care and the financial viability of the provider'.[64]

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62 The bill, schedule 1, item 7 (proposed new clause 8-3A(1)(b)).

63 Explanatory Memorandum, p. 23.

64 Explanatory Memorandum, p. 23.

1.40 Third, the bill would provide some guidance as to who are the people responsible for 'executive decisions' under the first clause of the definition. The bill indicates that these would include directors of a body corporate if the applicant is an incorporated entity, and a 'member of the entity's governing body' in all other cases.[65] This provision is intended to clarify the application of the 'key personnel' definition, but not to change it.

1.41 TACA was critical of the proposal to require the Secretary to consider the record of key personnel in related entities when considering the suitability of an applicant for approved provider status. TACA stated:

> The proposal ignores the existing criteria under the Aged Care Act 1997 for applications where there are adequate criteria for establishing the responsibilities of key personnel. It is usual in commercial and service organisations for the owners to place responsibility on management to meet the requirements of regulation and compliance.[66]

1.42 TACA was also concerned that the inclusion of 'any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the entity at that time' was too broad. TACA suggested this would capture 'all decision-making within the commercial [entity], including, for example, financiers whose influence, while essential, would traditionally fall outside what was considered relevant and operational'.[67] A number of submitters likewise argued the effect of this section would be unclear, in particular in respect of its possible extension to members of church councils in the case of providers that are operational arms of a church organisation.[68]

1.43 CHA pinpointed the use of the expression 'having significant influence over' planning, directing or controlling the aged care provider as a particular issue.[69] They noted that DOHA was indicating that the measure 'is not designed to include those sporadically involved in decision making or all leaders within the organisation, unless they are actively involved in making financial or managerial decisions which affect the aged care service (eg. Church leaders who do not involve themselves in the executive decisions of the aged care service'.[70] They nevertheless were not reassured, arguing that whatever DOHA might indicate was the intention behind the bill, it will not alter the legal effect of the provision, which was potentially very broad.[71]

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65 The bill, schedule 1, item 7 (proposed new clause 8-3A(2)).

66 TACA, *Submission* 3, p. 8.

67 TACA, *Submission* 3, pp 8–9.

68 TACA, *Submission* 3, p. 14; Resthaven Incorporated, *Submission* 8; ECH, *Submission* 9.

69 Mr Martin Laverty, CEO, CHA, *Proof Committee Hansard*, 14 November 2008.

70 DOHA, *Submission* 1A.

71 Mr Martin Laverty, CEO, CHA, *Proof Committee Hansard*, 14 November 2008.

1.44 DOHA indicated that the general wording of this part of the definition 'is based on the accounting standard AASB124: Related Party Disclosures'.[72] That standard provides a definition of 'significant influence':

> The power to participate in the financial and operating policy decisions of an entity, but is not control over those policies. Significant influence may be gained by share ownership, statute or agreement.[73]

1.45 The committee believes that some of the industry's concerns are based on misunderstandings. TACA's first criticism implies that the purpose of this amendment is to deal with the responsibilities of key personnel. TACA argue, for example, that 'Serious non compliance by "common key personnel"' should be rectified by the applicant.[74] That may well be the case, and is indeed the assumption underlying the existing non-compliance provisions of the legislation. However, that is an issue unrelated to the purpose of section 8 of the Act (and bill). This section is about what the Secretary should consider when determining an applicant's suitability, not how the entity should be managed, nor how breaches should be rectified. The committee believes it is appropriate that the Secretary be able to consider the skills, experience and track record of closely related entities in the manner envisaged by the bill.

1.46 TACA's second criticism was that revisions to the definition of key personnel would cast too wide a net. The new definition does potentially broaden the range of key personnel, but it must be kept in perspective by remembering the purpose of the clause. These personnel are only being considered in relation to their suitability and experience as it is relevant to an application to become an approved provider. If the role of the financiers, for example, was not 'relevant and operational', then it would not present a problem for securing approval under the Act. The amendments ensure, however, that players with the potential to have a significant bearing on the quality or financial management of aged care do not escape scrutiny altogether merely because of the nature of providers' business structures.

Missing residents

1.47 ACSA stated that during consultations prior to the introduction of the bill, both service providers and consumers did not support changes concerning the reporting to DOHA of unexplained absences of residents from aged care facilities.[75] ACSA argued:

> There is a risk that in seeking to protect potentially vulnerable older people we deny them the freedom to take risks available to other members of the community. We should be very wary of restricting people's liberty in order to avoid bureaucratic or political embarrassment. We should take pains not

72 DOHA, *Submission* 1A.

73 AASB124 Related Party Disclosures December 2005, s.9.

74 TACA, *Submission* 3, p. 8.

75 ACSA, *Submission* 6, p. 2; Explanatory Memorandum, p. 51.

> to inadvertently compound the institutional character of residential aged care by denying residents the same rights that would be afforded to other members of the community. While this measure specifically is not part of the Bill it should nonetheless be opposed and the changes proposed at Item 112 deleted.
>
> Reporting missing persons to the police (and notifying their relatives, with prior consent) should be sufficient.[76]

1.48 The committee understands that the changes to the Act will make such reporting possible, and that it is proposed to make changes to the Principles that will require such notification of DOHA to take place within 24 hours, adopting the same time frame as used for the reporting of assaults.[77] The committee believes that it might be desirable in certain circumstances for DOHA to be aware of absences reported to police, to assist it in monitoring the operation of aged care homes. It does however accept the concerns of both industry and consumers, that the rights and freedoms of aged care residents should not be curtailed, and that these reporting arrangements should not progress further into unwarranted restrictions on freedom of movement.

Sanctions and deterrence

1.49 The bill contains a number of new provisions relating to sanctions and deterrence. Currently section 65-2 of the Act sets out conditions for the Secretary to consider the appropriateness of imposing sanctions for non-compliance. It currently states:

> In deciding whether it is appropriate to impose sanctions on an approved provider for non‑compliance with one or more of its responsibilities under Part 4.1, 4.2 or 4.3, the Secretary must consider the following:
>
> (a) whether the non‑compliance is of a minor or serious nature;
>
> (b) whether the non‑compliance has occurred before and, if so, how often;
>
> (c) whether the non‑compliance threatens the health, welfare or interests of care recipients;
>
> (d) whether the approved provider has failed to comply with any undertaking to remedy the non‑compliance;
>
> (e) any other matters specified in the Sanctions Principles.

1.50 The bill proposes three changes to this section. It proposed to add two new matters for the Secretary to consider when determining whether sanctions should be imposed:

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76 ACSA, *Submission* 6, p. 3.

77 DOHA, *Submission* 1, p. 4; *Submission* 1A.

- A proposed new section 65-2(ca), that would add 'whether the non-compliance would threaten the health, welfare or interests of future care recipients' as an additional factor the Secretary can consider.[78]
- a proposed new section 65-2(da), that would add 'the desirability of deterring future non-compliance' as an additional factor the Secretary can consider.[79]

1.51 The bill also proposes to indicate that, when weighing up the factors listed in section 65-2, 'whether the non-compliance threatens or would threaten the health, welfare or interests of current and future care recipients is to be the Secretary's paramount consideration'.[80] The Explanatory Memorandum states that the purpose of this change is to make it clear that '[t]he interests of any other party, insofar as they are taken to be a relevant consideration, must be given less weight than the health, welfare or interests of current and future care recipients'.[81]

1.52 CHA argued that the focus should be on assisting industry compliance through 'enabling and incentivising' measures, rather than on clarifying the criteria for imposing sanctions. It suggested the new provisions 'could have the effect of resulting in punitive action being taken against operators who may otherwise be unaware of their new obligations'.[82]

1.53 Concerns were also raised by industry stakeholders about the proposal to give paramount consideration to particular factors. ACSA believed that this point indicates 'that the Department need not take the business interests of the provider, the continuing employment of current staff, or other factors, into account when considering sanctions'.[83] It believed that there should be amendment or clarification that would ensure that the Secretary 'must continue to take a balanced view of all factors into account'.[84] TACA made similar observations.[85]

1.54 The committee is aware of some litigation history associated with this section.[86] The Department also acknowledged that concerns had been raised during the consultation process. DOHA stated:

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78 *Aged Care Act 1997*, s.65-2; the bill, item 116.

79 *Aged Care Act 1997*, s.65-2; the bill, schedule 1, item 117.

80 The bill, schedule 1, item 118.

81 Explanatory Memorandum, p. 53.

82 CHA, *Submission* 11, p. 4.

83 ACSA, *Submission* 6, p. 4.

84 ACSA, *Submission* 6, p. 4.

85 TACA, *Submission* 3, p. 15.

86 Eg. Marnotta Pty Ltd (Receivers and Managers Appointed) and Secretary, Health and Ageing [2005] *AATA* 426 (12 May 2005); Secretary, Dept of Health & Ageing v Marnotta Pty Ltd (Receivers & Managers Appointed) with corrigendum 3 Oct [2005] *FCA* 1395 (29 September 2005).

> If passed, the legislation would require the Secretary to the Department of Health and Ageing to consider the desirability of deterring future non-compliance when imposing sanctions on an aged care service… For example, the Department may decide it is appropriate to impose sanctions on an approved provider who fails to refund accommodation bonds, where the refund amounts have already been paid to former care recipients through the Government's Accommodation Bond Guarantee Scheme…The amendments to the Act put beyond doubt the appropriateness of imposing a sanction in such cases in order to deter future non-compliance either by the sanctioned provider or others.[87]

1.55 Responding to submissions to the current inquiry, DOHA made further comment on this issue. DOHA highlighted that the objects of the Act are concerned primarily with 'the protection of the interests of care recipients', and the changes to section 65 of the Act are designed to make sure that it is put beyond doubt that this should be the guiding concern in assessing the appropriateness of sanctions.[88]

1.56 The committee recognises that the use of sanctions or punitive measures to ensure compliance should be a last resort. It did not receive any evidence that sanctions or similar measures were over-used. It also notes that there are other procedures that would be followed before the stage of applying sanctions is reached. In most cases, an approved provider would receive a notice of non-compliance, and be given an opportunity to both address compliance issues, and to make a submission to the Secretary in response to the concerns identified in such a notice.[89] If that did not achieve the desired result, a notice of intention to impose sanctions would be issued and, again, the provider would have an opportunity to respond.[90] If there was still no satisfactory action taken by the provider, only then would sanctions be implemented. Furthermore, providers have avenues of review and appeal against this step in the process.[91]

1.57 In addition, the committee understands that the Aged Care Standards and Accreditation Agency provides support to the sector in 'identifying best practice, and providing information, education and training'.[92]

1.58 The proposed changes to section 65-2 do not alter the reasons that sanctions may be imposed, they merely modify the way the appropriateness of sanctions is considered. This fact, together with the existing staged process by which sanctions are

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87 DOHA, *Submission* 1.

88 DOHA, *Submission* 1A.

89 *Aged Care Act 1997*, s. 67-2.

90 *Aged Care Act 1997*, s. 67-3.

91 *Aged Care Act 1997*, ss. 68, 85.

92 Aged Care Standards and Accreditation Agency, 'About the Agency', http://www.accreditation.org.au/AboutTheAgency (accessed 14 November 2008).

threatened, described above, means that there should be no risk (as suggested by CHA) that approved providers could possibly be unaware of their obligations.

1.59 The committee endorses the view that the health, welfare and interests of current and future care recipients should be the over-riding concern in determining whether sanctions are to be applied against an approved provider. It believes the additional factors are relevant and appropriate, and the checks and balances in the legislation are already extensive.

1.60 CHA raised a specific concern in relation to the possible effects of an approved provider having all of their places revoked as a sanction under the Act. The Act contains mechanisms by which an approved provider can seek a review of a decision to implement sanctions against them, including if the sanction is the revocation of their approved provider places.

1.61 The Act also, in section 10-2(1), states in part that 'If an approved provider does not provide any aged care during a continuous period of 6 months, the approval lapses on the day after the end of that period'.

1.62 In 2005, the Administrative Appeals Tribunal upheld a complaint by an aged care provider against the revocation by the Secretary of their approved places. The Secretary of DOHA successfully appealed that decision to the Federal Court. The Federal Court accepted the Secretary's argument that the provider's:

> only purpose in bringing the review was to have its approval as a provider and allocations of places restored to it. This result could not be achieved because s 10-2(1) of the Act caused the approval to lapse[93]

and therefore their appeal against the Secretary's decision could not succeed. Because the Secretary's appeal under s.10-2 was successful, the Federal Court did not examine any other aspect of the AAT's original decision.

1.63 CHA noted that the bill seeks to amend 10-2 in such a way that

> as soon as an approved provider with one approved service has all their approved places revoked, their approval as a provider would lapse.[94]

This raised the possibility that providers would effectively lose some of their rights of appeal to the AAT because, even if they had a substantive case, there was no remedy available, as their approved provider status would have lapsed.

1.64 DOHA indicated that there were legal mechanisms to ensure the appeal rights would be preserved. It was pointed out that the provider could go to the AAT and seek

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93 Secretary, Dept of Health & Ageing v Marnotta Pty Ltd (Receivers & Managers Appointed) with corrigendum 3 Oct [2005] *FCA* 1395 (29 September 2005) at 18.

94 CHA, *Submission* 11, p. 2.

a stay of the sanction decision.[95] If the AAT agreed to this stay, then the provider would be able to seek a review of the decision and, if successful, could have their places returned to them. Neither the original, nor the proposed new construction of, section 10-2 will prevent providers getting meaningful review through the AAT, provided they first seek a stay of the original decision – something the committee understands the provider involved in the 2005 case did not do.[96]

Police checks

1.65 Submitters raised concerns about possible modifications to the existing arrangements for police checks of staff working in aged care facilities.[97] Industry representatives were concerned about both increased costs, as they must pay for police checks, as well as possible impediments it might create to bringing in contractors (such as tradespeople) at short notice.[98]

1.66 The committee notes that the details of these changes will be the subject of regulations that neither the committee nor stakeholders have yet seen. However, in a supplementary submission, DOHA clarified that 'trades people who perform work otherwise than under the control of the approved provider (as independent contractors) will not be required to obtain a police check'.[99]

Other issues

1.67 The AMA had one particular suggestion, which was that GPs be included in the ACAT assessment process. The committee acknowledges that this may be desirable, but does not think this is a matter for the Commonwealth's legislation.

1.68 ACAA were disappointed that there had not been revision of the provisions associated with subsidy payments following Aged Care Assessment Team re-assessments of resident care needs.[100] DOHA acknowledged there were still issues in relation to ACAT administration. It indicated that the Department is continuing to work on this area, and in particular that it 'will also review the implementation of the Aged Care Funding Instrument after 18 months'.[101]

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95 Ms Marlene Hall, Principal Legal Adviser, DOHA, *Proof Committee Hansard*, 14 November 2008.

96 Secretary, Dept of Health & Ageing v Marnotta Pty Ltd (Receivers & Managers Appointed) with corrigendum 3 Oct [2005] *FCA* 1395 (29 September 2005) at 41.

97 ACSA, *Submission* 6, p. 3; Sundale Garden Village, *Submission* 5, p. 12; Resthaven Incorporated, *Submission* 8; Mr Greg Mundy, CEO, ACSA, *Proof Committee Hansard*, 14 November 2008.

98 Mr Greg Mundy, CEO, ACSA, *Proof Committee Hansard*, 14 November 2008.

99 DOHA, *Submission* 1A.

100 ACAA, *Submission* 10, covering letter.

101 DOHA, *Submission* 1A.

Conclusion

1.69 The committee notes DOHA's explanation of a number of reasons why it is desirable for the bill to be passed as soon as possible:

> First, in response to the joint Commonwealth-State National Review of Aged Care Assessment Teams, the Minister for Ageing undertook to make amendments to the Aged Care Act 1997 to remove unnecessary assessments by Aged Care Assessment Teams (ACATs). In return the Minister intends to seek improved timeliness of assessments by ACATs. The Australian Government needs to commence negotiations with State and Territory Governments on the performance indicators for improved timeliness early next year ahead of the next funding agreement with the jurisdictions which is due to be agreed by all Governments by the end of June 2009. States and Territories will not be prepared to agree to improved performance in the absence of the legislative changes being passed by the Parliament.
>
> Secondly, the Department has commenced the 2008-09 Aged Care Approvals Round and will, early in the new year, be assessing the applications received. The legislation as currently written does not allow the Department to take into consideration the conduct of related entities when making decisions on the allocation of aged care places. Given that there are a number of large organisations that have established multiple approved provider entities under their management banner, but essentially operate as the one entity with the parent organisation pulling the strings, the Department should be able to consider any issues, particularly serious compliance problems, that have occurred within the whole group when assessing applications. Legislative amendments in the Bill are required to allow this.
>
> Thirdly, it came to light through experience in the first operation of the bond guarantee scheme that the scheme does not cover bonds held by former approved providers. As providers may hand back their approval at any time, or it there is a very serious issue the Department should revoke approved provider status, there is potentially a situation where accommodation bonds are no longer covered by the scheme and this could arise at any time. This needs to be remedied as soon as possible.[102]

1.70 The committee believes that, as the aged care services sector grows and evolves, this legislation is a valuable step to ensure that legislation and regulation designed to protect residents will keep pace with that evolution.

1.71 The committee does however wish to emphasise the concerns of both industry and consumers, that the rights and freedoms of aged care residents should not be curtailed, and that the reporting arrangements envisaged under the legislation, regarding missing persons, should not progress further into unwarranted restrictions on freedom of movement.

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102 DOHA, Correspondence to the committee, 14 November 2008.

Recommendation 1

1.72 The committee recommends that the bill be passed.

Senator Claire Moore

Chair
November 2008

Additional comments by Coalition Senators

1. Introduction

1. 1 The Coalition Senators do not oppose the Bill and commend the ongoing commitment of the Department of Health and Ageing and of the various providers of high-standard care to the aged members of our community.

1. 2 The Aged Care Act, introduced by the Coalition Government in 1997, created the legislative support necessary for ensuring the rights of our older citizens to live with dignity and respect in appropriate facilities. Currently, the aged care industry is well regulated, but after ten years of operation, evolving business practices, and changed community standards and expectations, Coalition Senators acknowledge and support the need for enhancement of the act to ensure the protection of our older and more vulnerable citizens.

1. 3 Although we support the mainly non controversial amendments of the Bill in principle, we note several areas of concern raised, by providers in particular, that should be addressed.

2 Points of Concern

2.1 Several submissions raised concerns about the standard of consultation by the Department of Health and Ageing (DoHA) on the bill and the lack of opportunity to view the proposed guidelines or amended Aged Care Principles. There was concern expressed that, contrary to the view of some peak bodies, the Department promulgated the view that all sectors of the industry were supportive of the proposed amendments. One witness at the public hearing[1] indicated that:

> '…it is certainly true that there was consultation with the aged-care sector on the detail of the material that was in the bill. What is not recorded in the explanatory memorandum is that we did not agree with all of it. We were spoken to, but there were a couple of issues—and one issue in particular that I have highlighted in this submission—where, from my recollection, no-one agreed with the proposition. I thought it was worthwhile making that point because silence is sometimes taken as assent, and we did not assent.'

Whilst the Aged Care Principles will be a legislative instruments, witnesses stated their ongoing frustration, with one witness [2] commenting:

> 'It is extremely frustrating. We have on not infrequent occasions in the past come to this committee and others to give evidence; you are dealing with a bill but you do not know the details of the principles that are going to sit behind that. Then you have a secondary issue with the department which is an administrative instrument that sometimes you can reach agreement on but many times you cannot.'

The concern of the various bodies in relation to the guidelines and Principles was addressed in a supplementary submission from DoHA [3] stating that:

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[1] Mr G Mundy, CEO, Aged and Community Services Australia. *Proof Committee Hansard*, 14 November 2008.

[2] Mr R Young CEO, Aged Care Association Australia. *Proof Committee Hansard*, 14 November 2008.

[3] A Stuart First Assistant Secretary, DoHA. 14 November 2008.

> 'The Department is preparing a comprehensive Guide to the new arrangements, which, subject to the Bill's passage through Parliament, will be sent to approved providers.'

But this ongoing concern regarding timeliness should be addressed.

The legislation is now about 1,000 pages long with more than a dozen subsets of regulations. It is now an extraordinarily complex regulatory environment that directors of nursing, managers and CEOs are expected to understand, and this complexity is further exacerbated by the unknown content of guidelines and regulations.

2. 3 Concern was raised in regard to broadening the current section 8-3 of the Act by adding proposed section 8-3A in respect of "common key personnel who have 'significant influence' planning, directing, or controlling the activities of the entity"[4]. This is of particular concern to church based organisations, many of which have an overarching body which delegates authority to the particular undertaking. Whilst it is acknowledged that transparency is an issue in some management arrangements, further clarification, not covered in the amended submission of the department[5], should be urgently provided to those concerned.

2.4 Despite comments in the Explanatory Memorandum that there would be no additional costs imposed on the providers, evidence suggests this will not be the case. This point was specifically raised during the public hearings in relation to the additional police checks required by the amendments. Witnesses indicated that checks undertaken in compliance with the current requirements had cost the industry around $30 million.[6] Because of the difficulty in attracting staff and the salaries paid, employers generally meet the costs of these police checks. The industry generally works on a per capita cost of $100 including a printout from CrimTrac costing $50-$60[7] and other administrative and record-keeping costs. Whilst all sectors of the industry acknowledge the need to ensure the safety and privacy of vulnerable residents, providing such checks for staff that may not necessarily come into contact with residents is likely to result in substantial further costs to operators.

2.5 The issue of police checks for tradespersons called upon by approved providers in emergency situations was noted as a concern. However, it is noted that, in the departmental supplementary submission[8], independent contractors who are not under the control of the approved provider will not be required to obtain a police check.

2.6 Concerns have also been raised regarding the sanctions proposal and the resultant increased power of the Departmental Secretary. Issues raised in this particular context included the new amendment 65-2(2). The amendment will require the Secretary to give *paramount consideration* to the effect of non-compliance that threatens or would threaten the health, welfare or future care of recipients. As indicated in the submission of the Aged Care Alliance this amendment raises the 'question of the purpose of sanctions and how that determination is to be arrived at.' [9] The power to impose sanctions as a deterrent against future non-compliance introduces ambiguity and complexity into the legislation. Further questions also arise as to whether the Department should be

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[4] Proposed s8-3A(1)(b) *Aged Care Amendment (20008 Measures No 2) Bill 2008*

[5] Supra

[6] Mr G Mundy, CEO, Aged and Community Services Australia. *Proof Committee Hansard*, 14 November 2008

[7] Supra.

[8] A Stuart First Assistant Secretary, DoHA Supplementary submission. 14 November 2008

[9] Submission. Aged Care Alliance 4 November 2008. P16

required to consult the family of residents or others in relation to problems with approved providers before deciding on sanctions.

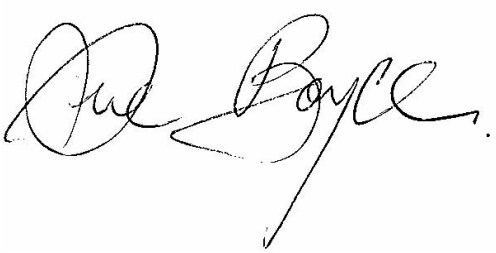
2.7 The reporting requirements in relation to 'missing' residents are also of concern to many approved providers, with providers suggesting that there had been unanimous disapproval for this measure during consultations.[10] Whilst all supported the need to provide safe and consistent care for residents, the need to separately advise the department in addition to the police is questioned. The operators were concerned that enquires by the department may lead to unacceptable limitations on the freedom of movement enjoyed by residents.

2.8 An important issue raised by various witnesses related to ACAT assessments. Most approved providers welcomed the amendment relating to unnecessary assessments. However, the issue of most concern to approved providers related to the default payment of $44.14 per day when an ACAT assessment rates the new resident as low care, but in reality the resident requires (and receives) high care that normally attracts a subsidy of $135.00 per day. There is sometimes a delay of up to 12 weeks[11] before an ACAT re-assessment is made, but there is no backdating of the subsidy to the higher care rate. This has resulted in lost subsidies of up to $50,000 for some approved providers. [12] Any delays in rectifying this matter are unacceptable given the already threatened viability of the industry and the Coalition senators urge the Minister to act promptly in this matter.

3. Conclusion

3.1 The Coalition Senators do not oppose passage of the Bill as the overall thrust is to provide greater surety and safety for current and prospective aged care residents and their families, but recommends that the Department and the Minister provide further clarification on the issues raised in these additional comments to approved providers and, where appropriate, seek further consultation with the various sectors of the aged care industry.

Senator Gary Humphries **Senator Judith Adams**



Senator Sue Boyce

[10] Mr G Mundy, CEO, Aged and Community Services Australia. *Proof Committee Hansard*, 14 November 2008.

[11] Mr R Young CEO Aged Care Association Australia Ltd. Submission of 4 November 2008 p2 (letter).

[12] Supra.

Additional Comments by the Australian Greens

The Aged Care Amendment (2008 Measures No. 2) Bill 2008

The Australian Greens support measures to ensure high standards in aged care and appreciate that the intent of the proposed amendments in this Bill is to improve standards. However, we are concerned that there are issues with the provisions of this Bill that are creating uncertainties for the sector and require further clarification.

Defining key personnel

On the widened definition of key personnel, the Australian Greens are concerned that in the case of not for profit providers, a large number of voluntary board members would be encompassed within the definition of key personnel. As the Bill is currently stands, there is ambiguity. The legislation should clearly define what groups of people are to be included **and** excluded from the definition of key personnel.

> **Recommendation: That the legislation provide a clear exclusion principle on the definition of key personnel.**

ACAT assessments

The resource shortfall affecting ACAT teams was noted in several submissions to the inquiry. Although many of the concerns raised were beyond the scope of this legislation and this inquiry, they clearly require further investigation.

The Australian Greens concur with the move to reduce unnecessary ACAT assessments. In their evidence to the inquiry, aged care providers indicated that there are often disagreements between ACAT and ACFI assessments on the level of care needed by incoming residents. When this occurs, ACAT is required to return to the facility to re-assess the resident. The delay can be a lengthy one. Therefore, it has been argued that when the ACAT reassessment concurs with the ACFI assessment, the level of subsidy funding should be back dated to the date of admission as this reflects the level of care that the resident has received.

> **Recommendation: The higher level of subsidy should be paid from the date of admission rather than the date of the second ACAT assessment.**

The reporting of missing residents to DOHA

In the case of a resident going missing, it is not clear what benefit is to be gained from the proposed requirement that DOHA be notified. Nor is it clear what action DOHA will be expected to take once

they have been notified that a person is missing. The Australian Greens note the concerns about the potential for the infantilising of residents of aged care facilities. As the Catholic Health Australia evidence highlighted, there may be an increased pressure placed on providers to increasingly restrict the movement of residents in the effort to avoid sanctions that might be imposed should a resident go missing.

In their initial evidence to the inquiry, the Department was unable to provide an assessment of the extra workload and operational procedures necessary to administer this requirement. The Australian Greens are concerned that this amendment will create a greater impost on the Department than has been planned for yet without necessarily adding any benefit to the well being of residents.

Recommendation: That this amendment be deleted or further clarified.

Overall comment on administrative burdens

Given the additional administrative burden arising from the amendments to the Bill, the Australian Greens concur with the evidence presented by aged care providers who have requested that, wherever possible, electronic communications be made available for providing up dated information to the Department of Health and Ageing.

Recommendation: That administrative reporting requirements be facilitated in the most cost efficient manner.

Consultation Processes

There is disagreement between the views of the Department of Health and Ageing and a number of aged care providers who gave evidence to the inquiry about the nature and extent of the consultative process surrounding these amendments. Several aged care providers commented that while some formal meetings took place whereby DOHA advised providers of proposed changes, there was no opportunity for providers to view the proposed amendments. Even now, in the absence of the aged care principles, some providers are still unsure as to the full operational requirements and impact of the proposed amendments.

Recommendation: That the Department of Health and Ageing improve their consultative processes.

Sanctions

It was clear from a number of submissions that aged care providers are concerned that sanctions are increasingly viewed by the Department as the means through which to address any problems in the sector. This was contrasted with the preferred approach whereby consultations take place between providers and the Department with a view to making improvements that benefit residents. Of

particular concern are the broadened powers of the Department to take into account the needs of future residents and future incidents of non compliance.

The Australian Greens remain concerned that provisions relating to possible future compliance remain vague and ambiguous and are thus open to subjective interpretation and likely to result in uneven application. It is not at all clear how the Secretary can make decisions and impose sanctions based on an event that has not yet occurred. We do not consider that an emphasis on a punitive approach, particularly where it is somehow intended to deter events that have not yet occurred, is likely to be productive, and suggest that a cooperative approach geared towards enabling and incentivising service delivery would be more conducive to improved outcomes.

The example given by the Department for the need for this amendment was to protect bonds in the future. We believe that rather than taking this broad, ill-defined approach, a more specific amendment that specifically deals with bonds would be better.

> **Recommendation: That compliance measures intended to address future non-compliance be abandoned and amendments for bond protection be developed.**

Conclusion

These amendments seek to improve standards and compliance in aged care under the current model. Many submissions raised the need for broader reform in the aged care sector to address the long term sustainability issues of the sector. This is also reflected in recent report by the Productivity Commission[1] and the Grant Thornton Survey.[2] The Greens look forward to the inquiry by the Standing Committee of Finance and Public Administration into the aged care sector.

Senator Rachel Siewert

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[1] Productivity Commission 2008, *Trends in Aged Care Services: Some implications*, Productivity Commission Research Paper, Canberra.

[2] Grant Thornton 2008, *Aged Care Survey 2008: Summary findings, October 2008*, available at www.grantthornton.com.au

APPENDIX 1

Submissions received by the Committee

1 Department of Health and Ageing (ACT)

Supplementary information

- Additional information dated 14.11.08
- Additional information provided following hearing 14.11.08, received 19.11.08

2 Aged Care Lobby Group (SA)

3 Aged Care Alliance (QLD)

Supplementary information

Tabled at hearing 14.11.08

- Organisation flow chart of Queensland Baptist Care
- Copy of Queensland Baptist Care Charter

Provided following hearing

- Supplementary submission received 17.11.08

4 Australian Medical Association Limited (ACT)

5 Sundale Garden Village (QLD)

6 Aged and Community Services Australia (VIC)

Supplementary information

- Aged and Community Services Australia Research Report, *Where would we be with out them?* Research findings on the Aged and Community Care Industry Image Project received 17.11.08

7 Aged Care Crisis Team (VIC)

8 Resthaven Incorporated (SA)

9 ECH Inc (SA)

10 Aged Care Association Australia (ACT)

11 Catholic Health Australia (ACT)

Supplementary information

Tabled at hearing 14.11.08

- Copy of 'Notification of Changes to Key Personnel' Form by the Department of Health and Ageing
- *Aged Care Policy Blueprint for 2020,* by Catholic Health Australia, November 2008

12 Combined Pensioners & Superannuants Association of NSW (CPSA) (NSW)

13 NSW Nurses' Association (NSW)

14 Dels Rama, Ms Marie; Edward, Ms Melissa and Dalton, Ms Bronwen (NSW)

15 Vassiliou, Mr George

16 Wynne, Dr J M

APPENDIX 2

Public Hearing

Friday, 14 November 2008
Parliament House, Canberra

Committee Members in attendance

Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Judith Adams
Senator Sue Boyce
Senator Carol Brown
Senator Mark Furner
Senator Gary Humphries

Witnesses

Aged and Community Services Australia
Mr Greg Mundy, Chief Executive Officer

Aged Care Association Australia
Mr Rod Young, Chief Executive Officer

Aged Care Alliance
Mr Jim Toohey, Alliance member, Chief Executive Officer, TriCare Ltd
Ms Jillian Jeffery, Manager, Strategic Development, TriCare Ltd
Mr Peter Lindsay, Alliance member, Chief Executive Officer, Queensland Baptist Care

Catholic Health Australia
Mr Martin Laverty, Chief Executive Officer
Mr Richard Gray, Director, Aged Care Services

Department of Health and Ageing
Ms Carolyn Smith, First Assistant Secretary, Office for Aged Care Quality and Compliance
Mr Andrew Stuart, First Assistant Secretary, Ageing and Aged Care Division
Ms Allison Rosevear, Assistant Secretary, Residential Program Management Branch
Mr Iain Scott, Assistant Secretary, Prudential Regulation Branch
Ms Marlene Hall, Principal Legal Adviser