The
Aged Care Alliance

Committee Secretary
Community Affairs Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Via e-Mail to: community.affairs.sen@aph.gov.au

4 November 2008

To the Committee Secretary:

The Aged Care Alliance is pleased to provide the attached submission to the Community Affairs Committee in relation to the amendments to the Aged Care Act 1997 and Bond Security Act 2006.

Representatives of the Alliance would be available to discuss our submission with the Committee. We would appreciate your advice in relation to hearings scheduled regarding this Inquiry.

Please do not hesitate to contact me for further information.

Yours Sincerely,

Jillian Jeffery
Coordinator

The

Aged Care Alliance

Submission to the Senate Community Affairs Committee
in relation to Amendments to the *Aged Care Act 1997*
and *Bond Security Act 2006*

4th November, 2008

Submission Inquiries:
The Aged Care Alliance Coordinator
Jillian Jeffery
Tel: (07) 3360 9038 / 0407 133 066
Fax: (07) 3360 9100
Email: Jillian.Jeffery@tricare.com.au

Submission researched and written by Jillian Jeffery and Denis Jones (TriCare).

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Part 1 - Introduction

The members of the Alliance who are Chief Executive Officers of provider and membership organisations respond to community needs and manage the organisational delivery of services across the spectrum of residential and community service delivery. Their respective organisations are long-term providers and include private for-profit, church and community organisations that operate in metropolitan, regional and rural areas.

The view of the Alliance is that the 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. The proposed amendments do not provide an estimate of the actual costs of new compliance, and to that extent are inconsistent with the regulatory reform goals of the Rudd Government.

It is important to note that the amending legislation also makes reference to anticipated changes to the Aged Care Principles. We are not, at this stage, aware of those changes. This is significant as while the Principles are subordinate legislation, they do carry the burden of providing the detail of how the act is to operate and are therefore critical to the day to day regulation of the provision of aged care within a facility. The full effect of the impact of the amendments which the Alliance addresses in its submission may be further extended by the Principles.

The aged care sector is highly regulated. The Aged Care Act 1997 and the Aged Care Principles plus supporting regulation, determine the following;

- the nursing, personal care and hotel services aged care providers must deliver;
- the numbers of residents these services can be provided to;
- the type of buildings the services must be provided within;

- the region in which the service must be provided;
- the nature and content of the contract entered into between provider and resident;
- the price providers can charge for these services;
- the type of staff who must deliver these services;
- the type of records providers must maintain; &
- the level of services individual residents require.

Commonwealth, State and Local Governments all have an involvement in the regulation of residential and community care services.

Since the introduction of the Aged Care Act in 1997 significant amendments have been introduced in respect to regulation and compliance regarding provider status, the operation of providers and the importance of a system of quality standards and accreditation. These new amendments widen the scope of regulation and have not been measured for the additional complexity and compliance costs that will result. The effect of new regulation should be measured against identifiable benefits for the community and residents.

The Alliance is sensitive to increased compliance costs. The effect of new compliance directly affects the operating costs and the efficient use of limited staff in facilities. These amendments have the potential to increase compliance and operating costs where such costs have not been factored into the subsidy regime. The justification for new compliance is not evident in the explanatory memorandum.

This submission deals with amendments as they are presented in the Bill.

Part 2 - Amendment 1

Section 7-1

The intent under the current Act, but more specifically under the Principles, enables the Department of Health and Ageing to regulate major aspects of the relationship between a consumer and service provider. The amendment changes the current status of approved to operate to a conditional approval dependent on subsequent allocation.

The current section 7-1 grants approved status and that approval only has effect with the acquisition of residential and community places which entitles the provider to claim care subsidies.

Current legislation approves new applicants who then apply in the ACAR rounds for allocations or newly approved providers who can purchase existing allocations from other providers. The amendment proposes that future approved provider status would be made conditional on the acquisition of residential places.

The underlying intent of the legislative amendments appears to seek to go beyond the existing relationship between the government on one hand, and the approved provider. This proposed legislative amendment would give the Department of Health and Ageing (the Secretary designate in effect) the right to assess the capacity of each director. The Corporations Act already establishes the duties of directors. The proposed amendments duplicates existing obligations that now apply to private sector providers.

Part 3 - Amendment 2

Sub-Sections 8-1(2) and (3)

The Alliance submits that the amendment is an unnecessary one as there are substantial and adequate criteria for determining the suitability of applicants for provider status in the current Act. Those criteria in the current Act are extensive in nature and are designed to establish the integrity of applicants to operate

within current regulatory parameters. The suggestion that approved providers who do not have an allocation would purport to provide high or low care services lacks substance for this amendment which introduces further compliance.

The amendment introduces a further barrier to new service providers and the potential for choice and competition. The amendment of conditional provider status fails to take into account the initial costs and investment that prospective entrants would undertake in setting up corporate structures and investing in land and technology in preparation for making application for residential places.

Another effect of conditional provider status would be to create an artificial market because a provider with conditional status will have the option of losing their initial investment if unsuccessful in the allocation rounds and would be obliged to purchase existing licenses from other providers to preserve their investment. One effect of an artificial market created by regulatory change will be to place further pressure on operating costs and service delivery in a sector where the adequacy of care subsidies and related funding are a point of contention between the sector and the government.

Part 4 - Amendment 3

Paragraph 8-3 (1) (g) is part of a wider change related to the governance of providers and changes to key personnel.

This amendment will insert a new paragraph 8-3 (1) (ga). The assertion is that a ‘common link’ between key personnel represents a risk to the delivery of care unless that link is explicitly stated. The explanatory memorandum offers no evidence that existing corporate structures in the sector have had a direct effect on providers not meeting their compliance obligations. The governance and management of individual providers reflects similar structures in other publicly funded sectors.

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. Corporate governance typically seeks a close alignment between the governing body and its management in respect of the boards' policy and regulatory obligations. Serious non compliance by 'common key personnel' should rely on rectification by the applicant (the owner).

The proposed section 8-3A is to supplement the existing section 8-3 by broadening the class of *key personnel* to include:

(a) any other person who has authority or a responsibility for (or significant influence over) planning, directing or controlling the activities of the entity[1];

(b) persons likely to be responsible for the nursing services or day-to-day operations of the services whether employed by the operator or not[2].

Further, the term 'Key Personnel' is expanded to operate at 'particular times' therefore including those people who have intermittent or transient impact on the executive decisions of the entity or have authority or responsibility for (or a significant influence over) planning, directing or controlling the activities of the entity.

The intention of the Government in broadening the definition is to capture influences beyond the approved provider[3]. The proposed section does however move well beyond this by capturing all decision-making within the commercial

[1] Proposed section 8-3A(1)(b) *Aged Care Amendment (2008 Measures No.2) Bill 2008*
[2] Proposed section 8-3A(1)(c)(i) and (ii) respectively *Aged Care Amendment (2008 Measures No.2) Bill 2008*
[3] See second Reading Speech by the Honourable Justine Elliot, *Aged Care Amendment (2008 Measures No.2) Bill 2008 pp2 -3*

change, including, for example, financiers whose influence, while essential, would traditionally fall outside what was considered relevant and operational.

The proposed legislation also focuses on discrete decision-making 'at a particular time'. Whether a particular person held significant influence over planning, directing or controlling an activity at a particular time is an analysis which will even for routine commercial decision-making be enormously complex and often only able to be determined in retrospect.

The broadening of the definition in this way also leads to difficulty in application of section 9.1 where the approved provider is obliged, on the standard of strict liability[4], to notify a change of circumstances or a change of any of the provider's key personnel[5]. Amendment number 14 repeals Subsection 9-1 (2) and (3). The amendment in particular inserts a new paragraph (3) (b) (ii) which provides a new requirement in this form: 'any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the approved provider.'[6] The Alliance submits that this particular amendment is vague in its application and provides insufficient guidance to providers, in terms of adequate compliance.

This amendment suggests that the normal corporate governance structures that now apply in respect of policy and decision making to church organisations, community organisations and for-profit providers are inadequate.

By broadening the definition of key personnel to include those who are sporadically involved in decision-making, makes notification of change to these personnel practically extremely difficult. The amendment will further increase the compliance and cost burden on the non-government sector.

Further, the extension of the definition under proposed section 8-3A (1) (d) to persons who are 'likely to be responsible' for nursing services or day-to-day

[4] Section 9-1(5) *Aged Care Act 1997*
[5] Section 9-1(1)(b) *Aged Care Act 1997*
[6] Proposed Section 9 -1 (2) and (3*) Aged Care Amendment* (2008 Measures no2), page 8 *Bill 2008*.

operations means that, in effect, an operator must (on the standard of strict liability) notify of a change of personnel who are not yet placed in the job or who might be required as a matter of succession planning be required to fulfil the role at some time for whatever reason.

The proposed amendments imply that any licensed nurse on the roster would be required to be designated as key personnel. If the effect of the amendment introduces a compliance requirement to advise the Department of Health and Ageing of all roster changes, it would be administratively unwieldy. This extension of the definition imposes duties on providers for no practical result.

A further fundamental difficulty which arises on the proposed legislation is that it imposes on the Secretary of the Department of Health and Aging, an extraordinarily high level of scrutiny which the legislation obliges the Secretary perform before determining whether an entity is suitable for the provision of aged care.

In section 8-3(1), the Secretary must (not *may*) consider the suitability and experience of the applicant's key personnel. As the proposed changes significantly expand this definition, the Secretary will be obliged to identify and scrutinise:

(c) those who were traditionally considered key personnel[7];

(d) those who fall within the expanded definition as having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the entity[8];

(e) those who are sporadically involved in the decision-making process[9]; and

(f) those who may be involved in nursing services or day-to-day operations of the service[10].

[7] See section 8-3(1)(a) of the Aged Care Act
[8] Proposed section 8-3A(1)(b) *Aged Care Amendment (2008 Measures No.2) Bill 2008*
[9] Proposed section 8-3A(1)(a) and (b) *Aged Care Amendment (2008 Measures No.2) Bill 2008*
[10] Proposed section 8-3A(1)(c)(i) and (ii) respectively *Aged Care Amendment (2008 Measures No.2) Bill 2008*

The Act precludes States, Territories and Local Government from the requirement that they establish themselves as approved providers, as they are deemed to be so under section 8.6. However, under section 10.3, a State, Territory or Local Government must have approval revoked in circumstances where they cease to be suitable for approval. It is difficult to reconcile that State Government facilities will be excluded from the proposed amendments when at least one is currently under sanction.

The difficulty, both in terms of logistics and cost in maintaining compliance with the notification section, is acknowledged in proposed section 14(3) (a) where government controlled entities are excluded.

The rationale for the exclusion of States, Territories and Local Government providers is not explained. Presumably the objective of quality of care which according to this proposed legislation will be improved by an increased level of scrutiny must logically apply to all aged care facilities, not just non-government facilities. Minister Elliot's second reading[11] speech on October 16th, 2008, designated that 'these amendments would be applied equally to all approved providers regardless of their corporate structure.'

If the intention of the Act is to establish responsibility for deficiencies in the delivery of care and services to residents, then State, Territory and Local Government decision making structures should be identified. The amendments impose further regulation upon the non-Government sector where there is identifiable corporate governance structures in place but it assumes that similar levels of authority and responsibility apply in the case of Government responsibly equally.

There is significant problem which arises from the broadening of these sections and the current Act is their practical application to the aged care sector. The broadening of the definition creates a level of scrutiny beyond that which is expressed in the Minister's second reading speech. The rationale for extending

[11] Minister Elliot, House of Representatives, Hansard, Thursday 16th October, 2008 p 4.

the scope of key personnel to private providers is to identify those 'pulling the financial strings'. It is difficult to follow the logic that a distinction can be made based on that rationale and a conventional and current governance structures which now operate under the current Act.

A more meaningful amendment would be to preclude key personnel who are 'likely' to manage nursing or day-to-day services and those who realistically have no role to play in the proper management of an aged care facility.

Part 5 - Amendment 11

Section 8-5

This amendment directly refers under item 11 in the explanatory memorandum to the current business practice of a number of approved providers to engage a management company to manage the deliver of care services. The amendment contemplates future applicants for approved provider status relying upon a management company to demonstrate suitability as an applicant. The explanatory memorandum asserts and assumes that a change in a management company could have a significant impact on an organisation's capacity to provide aged care and in some circumstances that may pose risks to care recipients.

The explanatory memorandum states that owners may use a separate and unrelated management company to deliver care. The current Act requires the approved provider to comply with the key personnel provision and other existing criteria in the Act. Owners who use management companies remain responsible for compliance under the Act and not the management company. The use of a management company is a commercial decision made by the approved provider and such a provider would establish both control and the capacity to sever the contract in the event of a breach of the Act by the management company.

The amendment, Sections 8-5(3) and (4) grant the Secretary wide powers under the phrase '*any circumstance that the Secretary is satisfied materially affects suitability to provide care'.* 8-5 (4) restricts the operation of the business,

removes the owners discretion and overrides the compliance function of the Accreditation Agency.

The effect is to reduce the rights of the approved provider to select or change their management company without the approval of the Department without any regard to the commercial priorities of the provider. Public hospitals are responsible for the majority of taxpayer expenditure on health care but are not subject to the same control over operational decisions.

Management decisions are made every day through rosters and other resource allocation determinations that influence the operation of the business. The approved provider carries the responsibility for every such decision. The outcome of these amendments is that the Secretary now seeks to have implicit oversight of these decision making processes.

This amendment will insert new scope for the examination of suitability for provider status; particularly it specifies any circumstance that the Secretary is satisfied materially affects the applicant's suitability to provide aged care. This amendment creates the additional capacity for the Secretary to provide conditional approved provider status. Unlike a refusal of the grant of approved provider status, under section 8(1)-1 of the Aged Care Act 1997 a condition imposed by the Secretary cannot be the subject of a review under section 85-1 of the Aged Care Act.

An applicant who does not meet the criteria in the Secretary's view to achieve Approved Provider status is entitled to a review of the decision. But an applicant who achieves conditional Approved Provider status cannot seek to have the conditions imposed upon them reviewed. This is inequitable and illogical.

The amendment stipulates changes to Section 8-3 and inserts a new provision requiring identification of directors in corporations and in non- corporate bodies, i.e., Church boards, Community boards and charitable organisations. The amendment seeks to define executive functions widely beyond the current

specific responsibility for nursing care or compliance at the point of service delivery that are now established under the Accreditation Principles and the Act.

The impact on Queensland Baptist Care (QBC) illustrates the lack of understanding demonstrated by the proposed amendment of how many church governance structures operate. In the case of QBC, the governance structure is as follows:
The Baptist Union of Queensland is governed by an annual assembly of the church at which in excess of 300 delegates attend. It is the governing body of QBC. Those delegates appoint the members of the church board which is the corporate entity. That church board is responsible for the entire scope of Baptist church activities in Queensland which extend well beyond residential aged care. QBC is a service division responsible to the church board which makes church policy and strategic decisions. QBC has its own board which is subordinate to the church board. QBC board has direct responsibility for the delivery of residential and aged care services and the Chief Executive of QBC, Peter Lindsay reports to that board.

The effect of the new amendments would be to require all members of the church board to be nominated as key personnel, and vetted as suitable individuals and possibly delegates to the annual assembly as well as those two bodies exert control over QBC. Peter Lindsay would assert that those governing bodies have no direct involvement in the delivery of care services and are not in a position to exert influence over compliance with the accreditation standards or other regulatory obligations which now apply.

It is a structure that has similarities in most church organisations in Australia which comprise a major component of the provider cohort which will be directly affected by this amendment.

The Accreditation Principles already establish responsibility for compliance and quality of care by key personnel who carry responsibility on behalf of the owner.

The existing sanctions provisions have a direct impact on serious non-compliance and are explicitly designed to protect residents.

The explanatory memorandum suggests that further examination of ownership structures and governance is required to maintain quality and requisite compliance even though the Prudential Standards (Section 57.4) relate specifically to sound financial management, corporate governance, financial reporting, liquidity requirements, and capital adequacy.

These are adequate requirements to meet typical commercial financial management standards and the Department has adequate regulatory capacity to scrutinise providers under the existing provisions and mechanisms available to them.

Part 6 - Amendment 118

Section 65-2 of the Act

The new amendment 65-2 (2) to the sanctions provision introduces new criteria which specifies that *paramount consideration* be given to whether non-compliance threatens or would threaten the health, welfare or interests of current or future care recipients. It brings into question the purpose of sanctions and how that determination is arrived at by the Secretary.

A new subsection 65-2 (2) will require that the Secretary give paramount consideration to whether non-compliance threatens or would threaten the health, welfare or interests of current and future care recipients. The current provisions of the Act are clear and specific. The proposed amendment ignores the primary role of the Aged Care and Accreditation Agency which will conduct the audit against the applicable Standards and would recommend sanctions to the Secretary. There is no evidence of the Agency failing to meet it statutory obligations.

The amendment imposes no explicit obligation on the Department to consult residents, their families or the resident's treating Doctor in a structured manner. The amendment despite its extension of the Secretary's powers also does not contemplate consultation with the approved provider to establish that the provider is unable to rectify severe risk and the reasons for that inability. The amendment lacks a transparent mechanism of consultation and a requirement that the Department is to properly consult the owner of the approved provider over rectification and to an establish inability to comply.

The Department of Health and Ageing conducted consultations with the national peak organisations in their role as stakeholder groups with an interest in this sector. Residential and community care is a major area of public policy because of the nature of the recipients of federally funded services. In such an important area a reasonable expectation would be that the purpose of new regulation is to establish a balance between care recipients and the responsibilities of providers.

This amendment instead confirms a bias against providers. That bias is described in the Departmental briefing paper distributed in July 2008 to national stakeholder organisations wherein it states *"In deciding whether to impose sanctions, the paramount consideration of the Department must be the health, safety and wellbeing of the care recipients and any future care recipients. However, this priority could be more clearly articulated in the legislation to prevent the drawing of any conclusion that the business interests of the approved provider must be taken into account."*[12]

The amendment suggests that past practice by the Department has been restricted by concern for the effects on the provider. No evidence for that concern exists and the Department is obliged to act upon the findings of the Agency

The amendment is a major change in the criteria for sanctions and implicitly excludes any obligation to explore viable solutions with the approved provider.

[12] Australian Government. Department of Health and Ageing. Consultation Paper. *Proposed Reform of the Regulatory Framework for Aged Care, July 2008.*

The degree of the effect of non compliance is redefined as a very wide set of qualitative criteria and the grounds for appeal are implicitly reduced by the term *paramount, w*hile the change ignores corrective action and establishes the basis for precipitous closure or transfer of residents.

The circumstances' concerning sanctions and the relocation of care recipients from Rosden Nursing Home in Victoria in October, 2008 demonstrates the potential for the interests of residents and relatives to be minimized. Media reports associated with Rosden Nursing Home, indicated that relatives and families of the residents were not consulted in an adequate way regarding the decision to relocate care recipients.

The amendment does not consider the preferences of residents, their families or the commercial viability of the provider. These amendments however will increases the moral hazard to the government where intervention by the Department sets aside the tenure rights of residents before a fair opportunity by the provider to appeal against the decision or to rectify the matters which are the cause to service deficiencies.

Part 7 - Amendment 116 and 117

Section 65-2

Proposed Section 65-2 (2) permits the Secretary to impose sanctions on the basis of a potential non-compliance concerning future residents. The proposed amendment provides that threats to the health, welfare or interests of care recipients can constitute grounds under section 65(2) for the secretary to impose sanctions.[13]

As the distinction is made in the amendments[14] future care recipients do not through the operation of the proposed amendment include existing residents.

[13] Section 65-1(b)
[14] See proposed section 65-2(ca) refers exclusively to 'future care recipients compared with section 65(c) which refers only to 'care recipients'

This amendment introduces new sanctions for hypothetical residents. This is an extraordinary presumption that the future behaviour of the provider will continue to be the same of that which led to the sanction. The effect of the section is that the approved provider would have to provide evidence to challenge a hypothetical non-compliance. That is, there could be circumstances where there was no actual or perceived threat to existing residents but rather what could only be a perceived threat to future residents.

This creates an increasingly arbitrary standard of regulation and compliance.

Further, the amendment at subsection 2 to section 65-2 creates the potential for conflict. Where previously this Division in the Aged Care Act focused on the risks to care recipients, the requirement that the secretary must (again, not may) consider the interests of future care recipients can only dilute the duty towards existing residents in circumstances where the two duties are not aligned.

As a practical example, a sanction causing the approved provider to relocate residents because it was the best result for future residents may not be the best result for existing residents. It is impossible in these circumstances to determine that both classes of residents can be of 'paramount' consideration.

Future non compliance is inserted as a deterrent and relevant consideration for the Secretary where the amendment states *'The desirability of deterring future non - compliance'* is a further aspect of imposing sanctions. This new aspect of the rationale for imposing sanctions effectively implies that should a provider effectively rectify the causes of current sanctions the Department can make a presumption that future non compliance is likely and therefore deterrence is necessary.

The first deficiency in the extension of the sanctions power is that there is no specific obligation imposed upon the Secretary or the Accreditation Agency to consider in a verifiable manner that the provider is unable to effectively rectify the identified deficiencies.

The second deficiency is that the Department is not explicitly required to consult resident, and their families and the resident's General Practitioner on the effect of sanctions and the transfer of the residents to alternative care and accommodation.

Part 8 - Amendment 119

Section 66-1(c)

This amendment seeks the same rights to scrutiny of residents by the Complaints Investigations Scheme where a provider continues to admit residents while under sanction. This amendment is not qualified as the provider may be implementing improvements and the provider is denied revenue even though the resident and relatives make a deliberate decision to use the facility. The amendment has no limitation on how long the embargo lasts.

Part 9 - Recommendation:

At the end of Section 65-2, add:

(3) and the Secretary must consider the interests of residents, the clinical advice of the resident's General Practitioner and the response of the provider in conjunction with Section 65 (2).