
# AGED CARE REFORM CONSULTATION PAPERS

# COUNSEL ASSISTING'S DRAFT ROYAL COMMISSION RECOMMENDATIONS

1. A Reformed Aged Care System – Overview
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## A REFORMED AGED CARE SYSTEM – THE ROYAL COMMISSION'S EMERGING VISION

## OVERVIEW

The following summarises the key features of a reformed aged care system as envisaged by Counsel Assisting's draft recommendations presented at the Final Hearings on 22-23 October 2020.

A timeline of the key implementation stages is at Attachment A.

1. A **new Aged Care Act and statutory framework** that would enshrine and protect the rights of older people to high quality, safe and timely support and care to assist them to live active, self-determined and meaningful lives.

    - The statutory framework would be administered and regulated chiefly by an independent **Australian Aged Care Commission** with a distributed network of offices, and a head office outside Canberra

        - An Implementation Unit would be established in the Department of Prime Minister and Cabinet to progress the reforms pending the establishment of the Commission

    - Pricing and standards setting would be undertaken by bodies removed from and independent of the Aged Care Commission and Government – an independent **Aged Care Pricing Authority** and the **Australian Commission on Safety and Quality in Health and Aged Care** respectively

    - An independent **Inspector-General of Aged Care** would review and report annually on the performance of the Aged Care Commission

    - The current Aged Care Industry Workforce Council would be re-constituted as the **Aged Care Workforce Council**, chaired by Aged Care Commission rather than industry

2. The focus of aged care would be maintenance of **independence, autonomy and choice**

    - There would be **no planning limits or rationing of entitlements** to receive aged care. Funding of aged care would be driven by individual care needs, independently assessed in a timely manner through an integrated and scalable assessment process which provides access to all aged care services a person might need

    - People receiving aged care would have access to **locally based care finders** to assist with accessing aged care and other systems in accordance with their individual needs and preferences

3. **Prices** would be set independently at a level to enable provision of high quality care ie to meet the reasonable and efficient costs of delivering aged care services

- **Means tested care contributions** would no longer apply in residential or home care. People would be subject to means tested fees for residential daily living and accommodation costs, and nominal payments would apply for home-based support services such as domestic assistance

4. **Support and care in the home** would be the norm for aged care, through to the end of life.

    - **Residential aged care** would chiefly provide aged care services for older people with the most complex, acute and special needs, including those needing advanced sub-acute care, advanced palliative care, and advanced dementia care.

    - Greater numbers of **smaller congregate living arrangements** would be available for people living in residential aged care

5. There would be a **larger, better-trained, valued and regulated aged care workforce**. Residential aged care providers would have to meet minimum staffing standards taking into account their casemix of residents, including some flexibility concerning staffing skill mix for innovative service models. Providers would be funded accordingly

    - **Personal care workers** would have mandatory minimum qualifications and undertake ongoing training and professional development activities. All staff would receive better training in dementia care and infection control

    - There would be improved access to **allied health** in accordance with assessed need

    - People receiving aged care would have better **access to general practitioners, specialists, dentists and pharmacists** at their place of residence, whether that be at home in the community or in residential aged care

    - **Outreach services** would deliver health care to people who are unable to travel to visit health professionals

6. There would be **system and data interoperability of information systems** used by providers and the health care system to facilitate continuity of care

7. **People with disability** receiving aged care would have access to services that would otherwise be available to a person with similar conditions under the National Disability Insurance Scheme

8. The Aged Care Commission would have **more regulatory powers**

    - In meeting regulatory standards, providers would provide best practice oral care, medication management, infection control, pressure injury prevention, wound management, continence care, falls prevention, and information control. A failure to meet those standards would attract

timely and **proportionate regulatory consequences**, including **civil penalties** and **private right of compensation** for certain contraventions and circumstances

- Providers would be governed by **fit and proper key personnel**. Providers would have a duty to provide high quality care so far as reasonable

- Providers would have to meet clear regulatory standards for high quality care and to report on **measurable performance indicators of clinical care and quality of life outcomes**

- There would be a strong regime for ensuring sound **financial and prudential management** by providers

- Information on **staffing levels**, **outcomes, provider performance and pricing** would regularly be reported to the Aged Care Commission, and it would be made available in appropriate form to the public. This would include a **star rating system** for providers

9. **Financing of the reformed system**: Draft recommendations on how the reformed system would be financed have not been released, but Counsel Assisting's concluding comments at the Final Hearings suggest that a national income-related levy is being favoured.

   Counsel Assisting's concluding comments at the Final Hearings also drew out negative issues arising from the sector's dependence on **Refundable Accommodation Deposits (RADs),** and suggested that in due course consideration should be given to phasing out RADs.

## Overview comments

- The recommendations concerning government aged care administrative arrangements, an independent Aged Care Commission with a regional network headquartered outside Canberra, would involve a substantial upheaval of the current administrative arrangements at the same time as the other recommendations will require the development and implementation of a very substantial reform program

  - the consequential reduced role for the Department of Health reflects Counsel Assisting's conclusion that "the Department of Health has been an ineffective system governor", while at the same time recommending independence in aged care administration and price setting because the current system reflects the fiscal priorities of successive governments

  - Commissioner Briggs commented that the proposed machinery of government changes are 'courageous"

- A large majority of the recommendations are high level and will require considerable further program design and development before they can be implemented in a risk-managed way. Hence for many recommendations, the issue will not be the policy intent, but rather the policy detail

- The majority of the recommendations either address measures that were already in train prior to the Royal Commission being called, albeit often criticised for slow progress, or were awaiting consideration by government

- A number of the key recommendations are directed at issues for which previous attempts at reform have been problematic, such as addressing workforce remuneration (there is no Plan B if a combined application to Fair Work Australia does not succeed), and improving the interface between the aged care and health systems, which depends on the successful negotiation of amendments of Commonwealth/state health funding agreements, a process that has proved problematic in the past.

- As one reads through the recommendations and the Discussion Papers, it becomes apparent that much more work still lies ahead

    - and we are yet to see how the proposed reform program will be financed

- Noting that most of the recommendations do not cover new ground and that most will require considerable further policy development, the potential enduring benefit of the Royal Commission would be if it provides the Parliament with the imprimatur to take the hard political decisions that will be required to pursue a comprehensive reform program.

10 November 2020

# Aged Care Royal Commission Discussion Paper 1
# Program Design and Funding

## Introduction

Counsel Assisting the Royal Commission have proposed that a **new aged care program** should be implemented by 1 July 2024, to combine the Commonwealth Home Support Program (CHSP), Home Care Packages (HCP) program, residential aged care, respite and short term restorative care programs (refer R8). The program would have the following core features:

- a common set of eligibility criteria
- an entitlement to all forms of care and support based on need
- a single assessment process
- certainty of funding
- genuine choice accorded to each individual
- portability of entitlement

This has been referred to as a single program. However, whilst there may be a common name and common core elements, in practice there are still likely to be at least two separate programs (residential care and care at home) with different program design and funding approaches. This paper deals with both programs separately, looking at the possible interim and longer term options.

The relevant recommendations from Counsel Assisting are referenced throughout this paper, and are included in full in a separate document.

## Care at Home

### *Interim Steps*

Counsel Assisting has recognised that reform of the CHSP and HCP will take time, and that a new program is unlikely to be in place until at least 2024.

Steps will be needed to address unmet demand in the meantime.

To this end, there is a recommendation that the **home care package waiting list be cleared by 31 December 2021**, and that thereafter new entrants would receive a package within one month (refer R9). This is an ambitious target which will require several billion dollars. It is also not without risks, as releasing too many packages in short succession risks placing significant pressure on the current home care workforce and may create quality issues. The Government is likely to continue to invest in home care packages in the upcoming budgets, however for the above reasons it is unlikely that the proposed target will be met.

**Care management** was highlighted as being an integral element of aged care, and especially important for people who have complex needs or needs which require multiple or intensive responses. In line with this, there is a recommendation that from 1 July 2022, **approved providers must provide care management** that is scaled to match the complexity of the older person's needs and is provided in a manner that respects any wishes of the person to be involved in the management of their care (refer to R14). This would often involve

the assignment of a care manager to each client. Counsel Assisting have suggested that rather than encouraging 'self-management', the program should enable 'shared management', ensuring the lead provider always retains responsibility for ensuring the person's needs are being met and that quality and safe care is provided in accordance with the person's plan or package.

A number of recommendations have been made for the period between June 2022(when the current CHSP grant agreements expire) and July 2024 (when a new program may be implemented).

This includes the introduction of a new **respite support "category"** from July 2022. This would be grant funded (including a capital component), and would provide a greater range of respite support in people's homes, in cottages and in purpose built facilities for up to 63 days per calendar year (refer R13). This recommendation acknowledges that respite care requires urgent attention and expansion in scope, variety and scale in order to support home-based care options. The Royal Commission hearings have suggested that current respite offerings are difficult to navigate, not financially viable for providers and insufficient to address the needs of older people and their carers. The services are currently under-delivered but in high demand, especially in outer regional areas and beyond. The arrangements would include comprehensive assessment of the needs of informal carers of older Australians in their own right, leading to specific assessed entitlements for informal carers to receive support services, such as counselling, training, and respite.

**Social support** activities are also recommended to be grant funded from July 2022 (refer R15). This would replace the social support, delivered meals and transport service types from the CHSP, and would continue under a new program. It is suggested that social support services be co-ordinated to the greatest practicable extent in each location with services and activities provided by local government, community organisations and business designed to enhance the wellbeing of older people.

A similar category is recommended for **assistive technology and home modifications** (refer R16). This would also be grant funded to replace the assistive technology, home modifications and hoarding and squalor service types under the CHSP. Assistive technology services may also be available for people receiving residential aged care, for example equipment to aid mobility.

Note that while the recommendations pertaining to the above program categories refer to grant funding, Counsel Assisting are also recommending that these services should be funded through **a combination of block and activity based funding**, and that the Aged Care Pricing Authority should advise the Aged Care Commission on the combination and form of block and activity based that should be adopted for social supports, respite, and assistive technology and home modifications, having regard to the characteristics of these services and the market conditions where they are delivered (refer R 87).

It is recommended that individuals receiving social supports, assistive technology and home modifications should be required to make **nominal co-payments** (refer to R94). This recommendation is made on the basis that nominal co-payments provide an incentive for the person seeking services to be judicious about doing so, a particularly important point when it comes to services that have intrinsic value in the general economy.

Co-payments also arguably tend to lead to higher levels of consumer engagement in the quality of the services and the way they are delivered.

Individuals receiving **respite care should also be required to contribute to ordinary costs of living and additional services**. However, it is suggested that they should not be required to contribute to the costs of the accommodation and care services that they receive (refer to R95). This is because respite should sustain the long-term capability of people to remain in their own home and to receive care there. Such people are likely to be bearing accommodation-related costs in doing so, and it cannot be assumed that they would be able to pay for additional accommodation while receiving respite.

Surprisingly, there are no recommendations on what is to occur to the CHSP service types that are not covered by the new grant funded arrangements mentioned above, including **personal care, nursing, allied health, and domestic assistance**. It would seem that these service types may be included as individual budgets within a classification based home care program, but it would be difficult to meet all of this demand from within the home care package program from 2022. It is therefore likely that they will continue to be grant funded in some form as the new program is being developed, which is likely to involve a package/individual budget approach.

***Possible Discussion Points***

*1: Do these recommendations raise red flag issues? If so, what are they?*

*2: How well equipped is the current home care system for a significant increase in consumers? What are the likely pressure points?*

*3: Is it reasonable to assign a care manager to each client? What are the implications of doing so under the current home care program? Is 'shared-management' more appropriate than 'self-management'? Does 'shared-management' dilute consumer choice and control, a concern of some consumer groups?*

*4: Do the settings for a new respite program appear appropriate? How is the market likely to respond? Is grant funding the best approach, especially for residential respite? Should consumers contribute to the costs?*

*5: Will providers be able to accommodate nominal co-payments? How would this best be achieved? What are the implementation implications?*

*6: What is the best approach for the remaining CHSP services (personal and nursing care, domestic assistance etc)? Should they continue to be grant funded until the new program is established? Or should these services be moved to the home care packages program?*

### *A new care at home program*

The necessary first step in moving to a new care at home program will be the integration of Regional Assessment Services (RAS) and Aged Care Assessment Teams (ACAT). This is recommended to occur by July 2023 and would include a **single comprehensive assessment process**. This service would be independent of providers and scalable according to complexity of need (refer to R12).

The recommendation does not address the sensitive issue of administrative arrangements i.e. whether the service is to be out-sourced and to what type of organisations, an issue which previously put the development of a single assessment service on hold. (Meanwhile, the Department of Health has gone to tender to identify organisations to conduct independent shadow assessments in preparation for the new AN-ACC funding model.)

It is proposed that a streamlined assessment process would be complemented by the introduction of a **regional network of care finders** to support people navigate aged care (refer to R10). This role would span all care types including residential and care at home. The degree of involvement by the care finder will vary depending on the complexity of the person's needs and their assessed vulnerability. However, the range of services could include:

- providing face-to-face assistance to help people understand the processes involved in obtaining aged care (this would be additional to the current online support via My Aged Care)
- assisting the older person through the assessment process
- understanding the expressed needs and goals of the older person and helping the person to make a plan for the services they wish to receive
- ascertaining the best options for services in the local area and linking the person to these options.
- following up to make sure that the referrals have been accepted and the support and care identified in the assessment is in place
- conducting regular check-ins with the person receiving aged care services to ensure that the services are meeting their needs
- where changes in the older person's needs occur, or services are not meeting the older person's needs, taking any necessary steps in consultation with the person receiving aged care services, including arranging re-assessments or referrals to other services.

There are several implementation issues that will need to be carefully considered if a care finder network is to be rolled out. This includes the significant overlap between the role of care finders and the ongoing care/case management role which will still need to be undertaken by providers. The employment model is also important, and on this point Counsel Assisting have recommended that care finders be Commonwealth, State or Territory or local government employees. It is yet to be seen how likely Government is to support this approach.

Counsel Assisting made several comments about how a new care at home program may operate, and suggested that as a starting point it should:

- support older people living at home to preserve and restore capacity for independent and dignified living to the greatest extent and prevent inappropriate admission to long-term residential care
- offer episodic or ongoing care from low needs (for example, one hour of domestic assistance per week) to high needs (for example, multiple hours of personal care and nursing care)
- provide a package/budget based on assessed needs which allows for a coordinated and integrated range of care and supports across the following domains:
    - care management
    - living supports - cleaning, laundry, preparation of meals, shopping for groceries, gardening and home maintenance

- personal, clinical, enabling and therapeutic care - including nursing care, allied health care and restorative care interventions, and
- palliative and end-of-life care

- require a lead provider, nominated by the older person, who would be responsible for ensuring that services are delivered to address the assessed needs.

Notwithstanding the above, Counsel Assisting did not give specific program design recommendations and instead suggested that the new program should continue to be developed under the new organisational structures. This development is likely to include a study to ascertain the need characteristics, service usage patterns and resource requirements of people who access care at home. This study should be used to develop a classification system with distinct classes of need within categories based on clinically meaningful differences in service usage patterns and resource requirements. The study should address whether individualised budgets, casemix funding levels, or some other mechanism for funding, such as direct grants, are appropriate. Regardless of the approach to funding, the above mentioned grant funded arrangements for social support, assistive technology, and home modifications would be expected to continue.

Counsel Assisting recommended that the **maximum Commonwealth funding available for a person receiving care at home** should be the same as the maximum Commonwealth funding amount that would be made available to provide care for them if they were assessed for residential aged care (refer to R89). It is recognised that where funding is approaching the maximum level, people may need to purchase additional services with their own funds, access additional informal care, or move into residential aged care. In going down this path Counsel Assisting has, in the end, opted to deviate from the NDIS model, although both models involve individual budgets and choice of provider.

Counsel Assisting have recommended that individuals receiving care at home should **not be required to contribute to the costs of any care services** that they receive. They should, however, be required to make **nominal co-payments for any domestic assistance** services (refer to R96). It has been suggested that this is consistent with a universal entitlement of older people to receive support and care for ageing-related conditions, on the basis of assessed needs – drawing on Medicare Principles. (Note that Counsel Assisting are also recommending that means tested care contributions be removed from residential aged care – R 98).

This approach to co-payments will place considerable pressure on the assessment function to correctly determine eligibility, assess the persons need, and approve a set of associated services. The generous contribution arrangements may also significantly increase demand on aged care services and lead to people seeking care through this program rather than through the private market or through other settings (for example obtaining nursing and allied health through the MBS, community health or through private health insurance arrangements). The Government response to this recommendation will be interesting, especially considering the additional funding it will require.

The development of the new program is a very large undertaking, with an extremely complex transition impacting over one million people and more than one thousand providers. This is on top of all the other suggested reforms.

***Possible Discussion Points***

*1: Do these recommendations raise any red flag issues? If so, what are they?*

*2: What are the key risks in moving to a single assessment model? Are these risks heightened if tenders allow for non-government assessment providers, in addition to state and territory government providers?*

*3: Are the suggested domains for the new care at home program appropriate? Are there any gaps?*

*4: What is the best funding approach for the new program? Should the funding arrangements be different for different care types? Could it all be grant funded? Or could it all be funded through individualised budgets? Are the proposed grant program arrangements consistent with supporting consumer choice?*

*5: Are the proposed client contribution recommendations supported? Are the potential risks acceptable? What are possible mitigations?*

*6: What are the key transition issues? How can these best be overcome?*

## Residential Aged Care

*Interim steps*

Counsel Assisting acknowledge that in recent years the aged care sector has been under significant and increasing financial pressure, and that the continued viability of a significant number of residential care providers is doubtful under current funding levels and arrangements. The risk of financial failure by residential care providers is particularly acute in regional, rural and remote areas.

CHA's pre-Budget submissions and evidence to the Royal Commission highlighted that the current punitive indexation arrangements are a major structural impediment to appropriate resourcing of aged care services.

In recognition of this, Counsel Assisting have recommended that from 1 July 2021, **indexation arrangements for residential aged care** should be amended so that they increase by the weighted average of:

- annual increases in minimum wages for an Aged Care Employee Level 3 under the Aged Care Award 2010 (45%),
- annual increases in the minimum wages for a Registered Nurse Level 2 under the Nurses Award 2010 (30%), and
- CPI (25%) (refer to R80)

Independent pricing based on the efficient cost of delivery of aged care services determined by an Aged Care Pricing Authority is expected to mean that indexation will no longer be required (especially if the recommended combined application to Fair Work Australia for Award increases is successful – R41).

In addition it is recommended that by 1 July 2021, the **Basic Daily Fee** should be increased by $10 for all residents, subject to accountability requirements, including an annual report to be provided by providers to the Aged Care Commission on the adequacy of the goods and services provided, including detailed expenditure information (refer to R82). The accountability requirements are onerous and unnecessary given that care subsidies are currently subsidising living expenses, and the requirement ignores the complexity arising from fees for additional services.

It is further suggested that there is a continuation beyond March 2021 of the 30 per cent COVID-related increase in the **viability supplement** (refer to R83).

***Possible Discussion Points***

*1: Do the recommendations raise any red flag issues? If so, what are they?*

*2: Are the suggested indexation arrangements appropriate?*

*3: Are the accountability requirements for the basic daily fee too onerous? Are they required or how could they be improved?*

## *A future residential aged care program*

The three current funding streams (living expenses, accommodation and care) are likely to continue, with **one provider being responsible for delivery of the entire bundle of supports and care** that residents will receive (refer to R17). Counsel Assisting acknowledges that a bundled approach is the most appropriate model "because there are significant overlaps between the daily living and care needs of residents, and between the built environment in which care and daily living supports are delivered".

Aged care is also to continue to be provided by a mix of private for-profit businesses, private not-for-profit entities, social and charitable enterprises, religious bodies and governments.

However, there are several changes recommended for the design of a future residential care program.

**Care funding** would be provided under a **casemix-adjusted funding** approach, such as is already being developed through the Australian National – Aged Care Classification (AN-ACC) (refer to R88). A single provider will be responsible for providing or coordinating all the aged care services the resident needs to receive. Under these circumstances, and given the expected elimination of rationing (ie the removal of ACAR), consumers would be able to direct their funding to their preferred provider. There is unlikely to be scope for funding to be split between providers for different services and activities.

Counsel Assisting are also recommending changes in relation to **allied health** services, with a recommendation for funding to be provided to approved providers by 1 July 2024 for the engagement of allied health professionals through a blended funding model, including a capped base payment per resident and an activity based payment (refer to R18).

Counsel Assisting recommended that from 1 July 2022, incentives should be included in the principles and guidelines for assessment and funding eligibility that **incentivise an enablement approach to residential care**, including that a resident should not be required to be reassessed if their condition improves under the care of the provider (refer R 90).

Potentially the most significant recommendation concerning residential aged care (and home-based care) is Counsel Assisting's recommendation that an **Independent Aged Care Pricing Authority** is established to set prices and price caps (inclusive of subsidies and user contributions) for aged care services having regard to market circumstances and the reasonable and efficient costs of delivering these services (refer to R5). The independent authority would also provide advice to the Aged Care Commission on optimal forms of funding arrangements, and undertake costing studies using data required to be provided by approved providers as a condition of approved provider status (R 85 and R86). To date, the Commonwealth has consistently maintained that the results of independent costings undertaken in the AN-ACC context should inform price setting by Government, rather than set the prices. Counsel Assisting's recommendation will raise concerns about loss of Commonwealth Budget control, but on the other hand Counsel Assisting has provided evidence that Commonwealth fiscal objectives are partly responsible for the current poor state of aged care services.

Under the new approach to funding, it is recommended that from July 2023, the **means tested daily care fee** in residential care should be repealed (refer to R98). This would be done for the same reasons as the repeal of income tested fees in the care at home program (refer above).

**Ordinary costs of living** would be determined by the Aged Care Pricing Authority, with funding provided by:

a) A basic daily fee set at 85 per cent of the pension – this would be paid by all residents.
b) A means tested fee – this would be zero for full pensioners, with progressively greater contributions from part-pensioners who have greater levels of assets and income. Non-pensioners would be required to pay the full costs of ordinary living expenses.
c) A subsidy paid by the Australian Government to make up any gap between the amount raised through the above and the price set by the Pricing Authority (refer to R97).

Counsel Assisting's recommendations do not address fees for additional services or the future of extra services.

It is proposed that in future the **accommodation supplement** should be determined by the Aged Care Pricing Authority on the basis of an estimate of the required returns on capital investment of approved providers of residential care in particular categories or rooms, and in particular regions or areas categorised by remoteness. A **means test for accommodation charges** is recommended to continue, but through a reformed approach that is calibrated to achieve progressively greater contributions from people who have greater levels of assets and income without imposing hardship, or arbitrary outcomes on people in certain asset or income brackets (refer to R99).

Counsel Assisting, drawing on Medicare Principles, recommend that from 1 July 2023, the **means tested daily care fee** for care provided in residential care should be repealed (refer R 98).

It is also proposed that by July 2024, the Australian Government should replace **the Aged Care Provision Ratio** with "a new planning regime" which is demand-driven based on need, and is not influenced by government fiscal priorities (refer to R20). This would most likely be complemented by discontinuing the Aged Care Approval Round (ACAR) process. Under this approach places would be assigned directly to consumers, freeing up the supply-side of residential aged care places to provide greater competition amongst approved providers. This would be consistent with the proposed core features of the new program – entitlement, genuine choice accorded to each individual and portability of entitlement. It would also be consistent with the recommendations of the recent 'Impact analysis of alternative arrangements for allocating residential aged care places' report. This report noted that there are risks associated with this approach, including concerns about a possible need for a prioritisation arrangement (i.e. a queue similar to home care packages) if demand exceeded funded assignable places. However, the report concluded that such an arrangement will not be required under current policy settings given that supply will exceed demand for the foreseeable future. The report noted in particular the significant expansion of home care places and the declining age-specific utilisation of residential aged care.

Counsel Assisting have stated a preference for **congregate small home models of residential care** compared with the current "institutional models". To that end, Counsel Assisting has recommended that capital grants be available for building or upgrading residential aged care facilities to provide small scale congregate living (R 58).

Counsel Assisting's concluding comments at the Final Hearings drew out negative issues arising from the sector's dependence on **Refundable Accommodation Deposits (RADs),** and suggested that in due course consideration should be given to phasing out RADs. It seems that the final recommendations will not include a plan for the phased removal of RADs.

Other key changes suggested for residential care relate to quality and safety, workforce, provider governance, prudential regulation, and financial oversight. These issues are discussed in other Discussion Papers.

***Possible Discussion Points***

*1: Do these recommendations raise red flag issues? If so, what are they?*

*2: Is a bundled approach supported? Are there any better alternatives?*

*3: Is the introduction of an independent Aged Care Pricing Authority supported? How far should its responsibilities extend?*

*4: What are the risks of moving to a new case-mix model? How could these be mitigated?*

*5: Should consumer choice in residential care be limited to choosing a single provider?*

*6: Are the proposed settings for funding living costs adequate? What provisions should be made for fees for additional services or extra services?*

*7: Do accommodation subsidies need to be more flexible? And is a new means-test required for care and accommodation? If so, what principles should apply?*

*8: Is it appropriate to remove the planning ratio? And should this be done at the same time as discontinuing the ACAR? What are the key risks in this approach?*

*9: What are the key transition risks?*

10 November 2020

# Aged Care Royal Commission Discussion Paper 2
# Workforce

## Introduction

The Royal Commission has examined the aged care workforce in detail.

In doing so there has been a consensus view that the quality of aged care is in large part determined by the people who deliver it on a day-to-day basis and the quality of leadership and governance. Further, it has been agreed that the current workforce is under pressure and that a larger, better trained, and more highly valued aged care workforce is needed. There has been an acknowledgement that additional funding must be provided to facilitate this.

Counsel Assisting the Royal Commission have proposed a range of recommendations, including that residential aged care providers meet mandatory minimum staff time standards (in effect staff-to-resident ratios), with some flexibility to take into account the mix of residents. They have also set out a registration scheme for personal care workers which would require them to be screened and to have minimum qualifications and certain proficiencies.

Access to allied and other health professionals has also been examined, with a view that there needs to be far better access to these services in accordance with assessed need. Improved access to general practitioners, specialists, dentists and pharmacists is also required at a person's place of residence, whether that be at home in the community or in residential aged care.

This paper explores these issues and the associated recommendations under four headings: governance; mandated minimum staff ratios; personal care workers; and access to health care.

The relevant recommendations from Counsel Assisting are referenced throughout this paper, and are included in full in a separate document.

## Aged Care Workforce

*Governance*

Counsel Assisting are critical of the leadership role by Government and the aged care industry in relation to aged care workforce planning.

They are of the view that the Australian Government must exercise a leadership role in planning for the future needs of the aged care workforce. They consider that the aged care industry has not done this and cannot be relied upon to do it in the future.

They propose the establishment of an **Aged Care Workforce Planning Division** from 1 January 2022 in the Department of Health, and then transferred to the new Aged Care Commission (refer to R39). This Division would be responsible for long term workforce modelling on the supply and demand of health professionals, including allied health professionals, and care workers. This would include the development of an interim

three-year workforce strategy and a subsequent ten-year strategy, which would be supported by an **Aged Care Workforce Fund** to support training, clinical placements, scholarships and other initiatives to respond in a targeted manner to the workforce challenges (refer R39.4).

This approach would be a change from the current policy whereby Government acts as a facilitator, rather than a leader. The Government's current position regarding a national strategy for the development of the aged care workforce is that it will support industry in developing a strategy, but that it is ultimately the industry's responsibility, coordinated through the recently established **Aged Care Industry Workforce Council.**

Counsel Assisting were critical of the slow progress in implementing the recommendations of the Aged Care Workforce Strategy Taskforce and the unrepresentative membership of the Council. As such, there is a recommendation to revamp the Council and rename it the **Aged Care Workforce Council** (refer to R40). The Council would have a revised membership, including more worker representatives, and would be chaired by the head of the Workforce Planning Division. The Council's role would include leading the Government, the unions and the aged care industry to a consensus application to the Fair Work Commission to improve Award wages based on work value and/or equal remuneration (see below).

It is proposed that any meaningful improvements to the aged care workforce will require that staff providing personal, nursing and allied health care are remunerated at comparable levels to their counterparts working in the health and disability services systems. Noting the experience of previous attempts to address this gap by providing additional funding to providers (notably the Workforce Compact), Counsel Assisting conclude that aged care workers will not be paid more unless there is a legal right to do so. As such, they recommend that **e**mployee organisations, the Government and employers should collaborate to **apply under the *Fair Work Act 2009* to increase wage rates under aged care-relevant Awards** (refer to R41). The advantage of this approach, in conjunction will independent costing studies to inform prices, is that it would provide greater certainty to government and the public that additional funding intended to improve remuneration levels was used for this purpose. However, it would not be a simple or quick process, and several previous approaches to Fair Work Australia for Award increases by unions have failed. Counsel Assisting recognise the difficulties but think that the chances of success would be enhanced through a combined approach by the Government (including supporting a funding mechanism), the unions and industry, led by the Aged Care Workforce Council.

***Possible Discussion Points***

*1: Do any of these recommendations raise red flag issues? If so, what are they?*

*2: Why have workforce challenges persisted? And why have wages remained low?*

*3: Should Government play a facilitation or leadership role in relation to workforce planning?*

*4: Is a new workforce strategy required? And should it be the responsibility of the Government?*

*5: What role should industry take? Does the Aged Care Industry Workforce Council membership need to be expanded?*

*6: Are there better ways to increase wages than through a change to Award wages? How quickly could they be implemented?*

*7: Should there be a link between increased remuneration and skills development?*

### *Mandated minimum staffing levels*

A number of witnesses to the Royal Commission have proposed that the best way to ensure appropriate staffing levels is to adopt a regulatory requirement that establishes a minimum staffing level.

Counsel Assisting agree with this view and have recommended that the Australian Government implement a **minimum staff time quality and safety standard for residential aged care** (refer to R47). This would be achieved through a quality and safety standard for residential aged care, with some allowance for approved providers to select the appropriate skills mix for delivering high quality care in accordance with their resident profile and model of care.

It is acknowledged that the new requirements should be phased in across a reasonable time frame that aligns with other reforms, and allows providers and government adequate time to prepare. The phased implementation would involve the following:

- From 1 July 2022 approved providers would be required to:
    - engage registered nurses, enrolled nurses, and personal care workers for at least 215 minutes per resident per day for the average resident, with at least 36 minutes of that staff time provided by a registered nurse
    - ensure that at least one registered nurse is on site per residential aged care facility for the morning and afternoon shifts (16 hours per day)

- From 1 July 2024 approved providers would be required to:
    - engage registered nurses, enrolled nurses, and personal care workers for at least:
        - 215 minutes per resident per day for the average resident, with at least 44 minutes of that staff time provided by a registered nurse, or
        - 264 minutes per resident per day for the average resident, with at least 36 minutes of that staff time provided by a registered nurse.
    - ensure that at least one registered nurse is on site per residential aged care facility at all times

This approach to mandated staffing ratios differs from the previous proposal put forward in February, though both approaches are based on the American star rating model. The previous model was opposed by several provider groups and the Government on the basis that it could stifle innovation and create rigidity in individual provider approaches to workforce staffing which would not necessarily lead to more positive outcomes for care recipients. The new proposal attempts to address this by allowing providers to apply for an exemption to the standard relating to staff skills mix, but not the standard relating to numbers of staff (hours of care staff per resident). There is also some flexibility to adjust staffing profiles to suit resident profiles.

Counsel Assisting also recommend that the Government establish from 1 July 2020 **a two-year scheme to improve the quality of the aged care workforce**. The scheme would reimburse providers of home support, home care and residential care for the cost of education and training of the direct care workforce, including the cost of additional staffing hours required to enable existing employees to attend education and training (refer R84).

It is further recommended that providers be appropriately funded to meet these new requirements, with a suggestion that the Aged Care Pricing Authority would take into account the need to **attract sufficient staff with the appropriate skills to the sector when setting prices**, noting that relative remuneration levels are an important driver of employment choice (refer to R42). In residential care, it appears that the minimum staff time standard would be linked to the case mix adjusted classification based funding model. This would mean that approved providers with a higher than average proportion of high needs residents would be required to achieve higher minimum staffing standards, and vice versa.

In line with the recommended approach to mandated staffing ratios, Counsel Assisting have proposed that from 1 July 2022, residential care approved providers would be required to submit quarterly **reports in standard format setting out total direct care staffing hours provided <u>each day at each facility</u>, broken into different employment categories** (refer to R91). In reaching this position, Counsel Assisting have acknowledged that acquittal of expenditure on care and potential return of unspent care funding has significant risks, including that it may dissuade providers from operating more efficiently and innovating (a position put by CHA). This approach places greater emphasis on disclosure, including to an independent pricing authority, rather than acquittal of expenditure. This reporting/disclosure requirement would be in addition to increased financial reporting requirements at a facility level. Both would involve an expansion of the scope of the current StewartBrown quarterly surveys.

Note that pending the implementation of the new funding and pricing model for care in residential aged care, Counsel Assisting is recommending changes to the current indexation arrangements to apply from 1 July 2021.

***Possible Discussion Points***

*1: Do the recommendations raise any red flags? If so, what are they?*

*2: What are the strengths and weaknesses of a minimum staff time quality and safety standard for residential aged care?*

*3: Are the risks to innovation adequately mitigated by allowing providers some flexibility to adjust their staffing mix and to apply for an exemption to the staff skills mix standard? Should this exemption be extended to the numbers of staff?*

*4: Will it be sufficient to fund this through a new case-mix model and independent pricing arrangements? Or are different approaches required?*

*5: Are the proposed reporting arrangements too onerous? What level of reporting is reasonable?*

*6: How far short of the staffing standards are providers currently?*

*7: Are the operational requirements of achieving variable staffing minimums in each facility according to resident profiles manageable?*

### *Personal Care Workers*

Counsel Assisting have proposed that the Australian Health Practitioner Regulation Agency (AHPRA) establish a **registration scheme for personal care workers** (refer to R48 and R49). This would involve the establishment of a National Board which would have responsibility for accreditation standards and a registration scheme that includes:

- mandatory minimum qualifications (Certificate III)
- ongoing training and continuing professional development requirements
- minimum levels of English language proficiency
- criminal history screening
- a Code of Conduct and power for the registering body to investigate complaints into breaches of the Code of Conduct

Counsel Assisting outline that registration standards, a code of conduct and scopes of practice informed by regulation would assist to define, professionalise and improve the quality of the aged care personal care worker workforce. They believe that this would enable employers of aged care personal care workers and the community generally to have greater confidence in the skills and qualification of the workforce.

The Department of Health has undertaken extensive consultation on the development of an aged care worker regulation and registration scheme, including through a consultation paper in May 2020. While the general principles in the consultation paper were generally supported, several risks were identified, including risks in relation to Counsel Assisting's suggestion that administrative responsibility for managing a registration scheme should reside with the Australian Health Practitioners Agency (AHPRA). This option included in the consultation paper generated mixed views. For example, AHPRA's current focus is on clinical scopes of practice, including an emphasis on tertiary education and rigorous continuous professional development requirements. It is questionable whether such a demanding process is necessary for personal care workers, noting also that by virtue of sheer weight of numbers, the personal carer workforce role would dominate the work of AHPRA. AHPRA's cost recovery approach through the charging of annual registration fees may also be inappropriate for this workforce.

The above arrangements would need to be complemented by approaches to attract new workers to aged care and to address current skills gaps. This would be partly achieved through the roles of the Aged Care Workforce Planning Division and the Aged Care Workforce Council mentioned above, including their approaches to increases in Award wages. Further measures are also recommended including:

- making approved provider status conditional on ensuring that direct care staff undertake regular approved **training about dementia and palliative care** (refer to R44)
- **reimbursing providers** from 1 July 2021 under a two-year scheme **for the cost of education and training of the current direct care workforce**, including the costs of additional staffing hours required to enable an existing employee to attend the training or education (refer to R84)

- reviewing **certificate-based courses for aged care** (refer to R43)

Many of Counsel Assisting's recommendations concerning a registration scheme were addressed in CHA's submission in response to a Department of Health consultation paper on options for development of an aged care worker regulation scheme.

***Possible Discussion Points***

*1: Do the recommendations raise any red flags? If so, What are they?*

*2: Is a registration scheme for personal care workers needed? Are the proposed elements supported? Are there any gaps? Are there any implementation challenges?*

*2: Who should be responsible for the registration scheme? Is AHPRA the most appropriate organisation?*

*3: Are the additional measures needed? And is so, are there any risks in their implementation?*

## *Access to Health Care*

The Royal Commission process has identified the difficulties that people receiving aged care, especially those in residential facilities, have in accessing adequate health care.

This was commonly blamed on a breakdown in the interface between the aged care and health care systems and a lack of clarity on respective roles and responsibilities. To this end Counsel Assisting have recommended that the **National Health Reform Agreement be amended to include an explicit statement of the respective roles and responsibilities** of approved aged care providers and State and Territory health care providers (refer to R75). In their view:

- allied health care should generally be provided by aged care providers;
- specialist services, including specialist palliative care and subacute rehabilitation, should be provided by State and Territory health care providers, even if these services involve allied health practitioners ; and
- less complex health conditions should be managed by aged care provider staff, particularly nurses.

A range of more specific recommendations have been proposed to facilitate this split of roles and responsibilities, including the following:

  - reviewing **undergraduate curricula** to ensure that entry qualifications are appropriately addressing age-related conditions and illnesses, including dementia, to ensure that health professional graduates have the education and knowledge to meet the care needs of older people (refer to R45).
  - implementing a blended funding model for aged care providers to obtain **allied health services** (refer to R18)
  - enhancing **multidisciplinary outreach** services led by Local Hospital Networks, including nurse practitioners, allied health practitioners and pharmacists, and providing for access to relevant

specialists, including geriatricians, psycho-geriatricians and palliative care specialists (refer to R64)
- increasing access by aged care consumers to **Older Persons Mental Health Services** (refer to R65)
- establishing a new **Senior Dental Benefits Scheme** (refer to R66)
- introducing new **MBS items** to improve access to **medical and allied health** services (refer to R67)
- increasing funding for the **Rural Health Outreach Fund** to include delivery of geriatrician services in regional, rural and remote areas (refer to R68).
- expanding access to **MBS Schedule-funded specialist telehealth services** to people using aged care services (refer to R69)
- increasing **medication management reviews** by pharmacists, including on entry into residential aged care (refer to R70)
- amending the MBS Schedule so that only a psychiatrist or geriatrician can initially prescribe **antipsychotics** (refer to R71)

These recommendations would no doubt expand access to services and would be well received by aged care consumers. However, there are some risks, including in relation to the level of responsibility that residential aged care providers would have for residents receiving outsourced services within their facility. The recommendations would also require a significant level of funding and it remains to be seen how likely government will be to support them, especially those related to additional MBS items and expenditure.

Several of the above recommendations, and in particular the multidisciplinary outreach services led by Local Hospital Networks, would also require the successful negotiation of changes to the National Health Reform Agreement.

In terms of general practice, Counsel Assisting have recommended that by January 2024, a new **voluntary primary care model for people receiving aged care** be established (refer to R62). This would involve the ability for general practices to enrol people receiving residential care or personal care at home, and receive an annual capitation payment to meet the person's primary health care needs. This would include developing an aged care plan for each person, undertaking medication reviews, and reporting on performance.

This is an ambitious proposal, especially given the difficulty governments have historically had in changing general practice behaviour. Any approach in this regard would also need to be considered alongside the current practice incentives programs and any future moves to continue and/or extend the Health Care Homes program which targets people (especially older people) with comorbidities, a primary care model also based on general practice, capitation payments and voluntary enrolments.

***Possible Discussion Points***

*1: Do the recommendations raise any red flags? If so, what are they?*

*2: How should the roles and responsibilities be defined for aged care? Are the proposed definitions appropriate? Should they be included in national health care agreements?*

*3: Are the suggested access measures achievable? What are the risks for aged care recipients? What are the risks for providers?*

*4: Can responsibilities be adequately shared if outsourced services are provided within residential facilities? What strategies are providers currently using?*

*5: Is a new approach to general practice care needed? Would the proposed model work? Are there other better suggestions?*

10 November 2020

# Aged Care Royal Commission Discussion Paper 3

# Quality, Safety and Regulation

## Introduction

Quality and safety is the key topic of the entire Royal Commission process. Although the definitions of high quality aged care may differ, and although the outcomes are currently difficult to measure, most people would agree that a high quality and safe aged care system is the end goal.

Counsel Assisting have proposed that a high quality aged care system is one that puts older people first and assists them to live a self-determined and meaningful life, with personal care services and other supports provided when needed in a dignified, safe and caring environment. High quality aged care is respectful, timely and responsive to older people's preferences and needs. It is provided by caring, compassionate and skilled people. It enables older people to maintain their capacities for as long as possible, while supporting them when they experience functional decline or need end-of-life care. High quality aged care delivers a high quality of life.

To this end, Counsel Assisting propose that **high quality aged care is embedded into the Aged Care Act** as being: diligent; skilful; safe; insightful; empowering; timely; and supporting caring relationships (refer to R21). Further to this, Counsel Assisting propose that there be a **general duty on approved providers to ensure the quality and safety of its aged care services** (refer to R22). This is intended to send a clear message to providers, the community and the regulator about the primary duty of an approved provider to protect the health, wellbeing and safety of its residents.

Regulation is also important in this context, and it is proposed that the new Australian Aged Care Commission will act as a proactive regulator of providers, with more powers and greater preparedness to use them. Counsel Assisting has stated that there should be zero tolerance for abuse and neglect, and an effective means of redress for people receiving aged care services who are not provided with high quality care.

A new approach to prudential regulation has also been recommended, including increased financial reporting and prudential management requirements for providers.

The relevant recommendations from Counsel Assisting are referenced throughout this paper, and are included in full in a separate document.

## Quality and Safety

### *Quality Standards*

Counsel Assisting states that quality standards are a powerful tool to maintain and improve quality of care. Standards are statutory-based obligations for service providers that set the characteristics of aged care and the care environment that contribute to the safety, health, wellbeing and quality of life of the people receiving care. Such standards also function as motivators for providers to achieve quality expectations, and can set the parameters for objective, consistent assessment and reporting of provider performance.

Counsel Assisting propose that quality standards in aged care should become the responsibility of the renamed **Australian Commission on Safety and Quality in Health and Aged Care** (refer to R23). This suggestion follows their view that standards prepared by the Australian Commission on Safety and Quality in Health Care are far more comprehensive, rigorous and detailed than the existing Aged Care Quality Standards, especially with regard to clinical considerations. This transfer of responsibility may have advantages in aligning quality standards between health and aged care settings. However, there are also key differences in aged care quality that would need to be well understood by the renamed Commission, including the importance of quality of life and the wide spectrum of aged care services which extend well beyond clinical services. The expertise of the Commission would need to be enhanced in this regard.

Several witnesses to the Royal Commission were critical of the current standards, citing a lack of detail and a lack of objective measurements. However, noting that the current standards have only been in place since July 2019, Counsel Assisting acknowledged that they need time to be embedded within the system. With this in mind, Counsel Assisting have suggested that the Australian Commission on Safety and Quality in Health and Aged Care undertake an **urgent review of the current standards** by 31 December 2022, and then complete a comprehensive review of the current aged care standards within three years, and thereafter every five years (refer to R24, R25 and R26).

### *Quality Indicators*

Counsel Assisting have noted that quality indicators enable quality (as set by the quality standards) to be measured, and that there needs to be an alignment between the two – what the standards identify as high quality aged care ought to be what is measured. In line with this, Counsel Assisting have recommended that from 15 July 2021 **the Australian Commission on Safety and Quality in Health and Aged Care should take responsibility for the introduction, implementation and amendment of aged care quality indicators** (refer to R30). Then, by 1 July 2023 they should:

- expand the suite of quality indicators for care in residential aged care;
- develop quality indicators for care at home; and
- implement a comprehensive quality of life assessment tool for people receiving aged care in residential care and at home.

This approach should be designed so that reporting requirements align with data available in the clinical information technology systems used by approved providers, which should limit the administrative burden on providers. A process to **benchmark provider performance against quality indicators** should also be introduced by 1 July 2022 (refer to R31). This would allow providers to be benchmarked against similar providers.

Counsel Assisting noted that quality indicators would also enable the Australian Government to track and publicly report on sector and provider performance, and set progressive improvement targets to raise performance against quality indicators over time. It has been recommended that reporting on quality should be facilitated by a system of **star ratings** based on objective and measurable indicators that allow people to make meaningful comparisons (refer to R117). This would incorporate:

- graded assessment of service performance against standards;
- performance against relevant clinical and quality indicators;
- staffing levels; and
- robust consumer experience data (including **consumer experience reports** informed by interviews with at least 20 per cent of care recipients or service users – refer to R113).

Reporting in this way is considered to be an improvement from the current 4-dot ratings scheme whereby services that meet all minimum standards, and have no current sanctions, are automatically given the highest rating. The current approach does not recognise or assess the extent to which care exceeds the minimum standards, or provide incentives for providers to provide a higher level of care.

The use of quality indicators and this approach to reporting has potential benefits. However, there is also evidence that poor use and implementation of quality indicators data can lead to unintended consequences, including undue emphasis being placed on what is measured, and gaming where actual behaviour (rather than just reporting) is manipulated. Care will be needed to mitigate against these risks.

***Possible Discussion Points***

*1: Do the recommendations raise any red flags? If so, what are they?*

*2: Does it make sense for the aged care quality standards to be the responsibility of the Australian Commission on Safety and Quality in Health and Aged Care? Does the involvement of an additional organisation pose any risks?*

*3: Are the current standards fit for purpose? If not what are the gaps? Is a review necessary? In what timeframe should a review be considered?*

*4: What are the key benefits and risks in the implementation of a new quality indicator program? Should the existing measures be maintained?*

*5: What role do quality of life measures play? How easy/hard will they be to objectively measure? Is there existing data within provider systems that would be suitable to use?*

*6: Is benchmarking supported? What risks would this pose to providers? Would these risks change if the data was publicly reported?*

*7: Is a star ratings system an effective way to support informed consumer choice? What advantages does it have over the current system? Do these outweigh the costs of implementation? Are there any better alternatives?*

## Regulation

### *Provider Approval*

Counsel Assisting have indicated that an effective process to assess and approve providers is an important mechanism for ensuring quality and safe aged care.

Counsel Assisting noted that the current approach has a number of limitations. It is a one-size-fits-all approach that is not flexible enough to reflect the diversity of aged care service provision, which includes both very large and very small providers delivering a wide range of services. It also does not accommodate Commonwealth Home Support Program (CHSP) providers, who are not subject to approval and are not regulated under the current Aged Care Act.

It is proposed that a **new approval process** would commence from 1 July 2024 for all aged care providers to ensure their suitability, viability and capability to deliver the kinds of services for which they receive subsidies (refer to R120). There would be a robust yet flexible system to allow approval to provide only a limited scope of services. For example, providers that seek only to provide relatively low risk services (such as basic domestic assistance), would be subject to a different set of considerations than a provider seeking to deliver riskier services involving hands-on personal care, nursing or allied health.

It is suggested that **approvals would be ongoing but subject to continuing suitability**, including the fitness and propriety of the provider and its key personnel (refer to R121). This approach would limit regulatory burden associated with re-approval, and should provide certainty to approved providers and encourage continued investment in the aged care sector.

Transition of current providers to the new framework will need to be well sequenced and co-ordinated, especially considering that many of the existing 1,500 CHSP providers would not yet have been subject to the current approval process.

### *Quality regulation*

Many witnesses to the Royal Commission have been critical of the current regulatory framework within aged care.

Counsel Assisting have put forward a raft of measures to be set within a new Aged Care Act to provide significantly **more power to the regulator** (refer to R111). In Counsel Assisting's proposed governance settings, the new Australian Aged Care Commission would take on responsibilities for regulation. The new Commission would have more power than the current Aged Care Quality and Safety Commission, including the ability to apply **enforceable undertakings, infringement notices and banning orders**. They would also have the power to revoke the provider's approval, or suspend or remove the group of people responsible for the executive decisions of a provider.

Providers would also be exposed to much harsher penalties. Counsel Assisting recommends that:

- certain contraventions (such as a breach of a general duty to provide high quality and safe care so far as reasonable) may attract a **civil penalty and accessorial liability for directors, key personnel and any other person** who aids, abets, counsels or procures the approved provider to commit the contravention (refer to R109) and

- there would also be a **private right of compensation** for certain contraventions, whereby an approved provider or a person involved may need to pay damages for any loss and damage suffered by a person (refer to R110).

These measures would be a significant extension of the current approach which targets approved providers and not their directors, key personnel or other people involved. Counsel Assisting suggests that deterrence is more likely to be effective if a wider range of decision-makers can be held accountable for contravention of standards.

### *Prudential and Financial Regulation*

Counsel Assisting point to the fact that the Commonwealth accepts that the current 'prudential framework is not fit for purpose, and that it requires fundamental reform to make sure that it can meet the contemporary needs in the system'.

As such, Counsel Assisting propose a new prudential and financial reporting framework that will include the **Aged Care Commission having a statutory role as the prudential regulator** from 1 July 2023 (refer to R100). This will include responsibility for ensuring that, under all reasonable circumstances, providers of aged care have the ongoing financial capacity to deliver high quality care and meet their obligations to repay accommodation lump sums as and when the need arises.

As part of this approach, the Australian Aged Care Commission would impose **liquidity requirements** on approved providers of residential aged care which hold refundable accommodation deposits (refer to R102). There are several different views as to the level and nature of the potential liquidity requirement, for example some have proposed that an approved provider must maintain 10% of the value of lump sum accommodation payments held, whereas others have suggested it be set at 15% of total debt. Counsel Assisting have not suggested a preferred threshold, but have instead recommended that it be determined on a basis that strikes a balance between the risk of providers defaulting on their obligations, and the capital requirements of the providers' operations necessary for the provision of high quality aged care services. They have also recognised that a careful transition pathway is required.

A similar approach has been suggested for **capital adequacy requirements** which would also be the responsibility of the Aged Care Commission. Again, the exact nature of the requirements have not been recommended.

Several witnesses to the Royal Commission have suggested that more stringent financial reporting requirements are needed within aged care to:

- improve the transparency of approved providers' businesses and how they use accommodation payments; and
- improve the understanding of the financial sustainability of approved providers and assist the regulator to identify and monitor providers who are potentially at risk of financial failure or non-permitted use of accommodation payment balances.

Counsel Assisting agree that a new approach is needed, and have suggested that approved providers should be required to **submit regular financial reports**, with the frequency and form prescribed by the Aged Care

Commission (refer to R104). Importantly, it has been recommended that the Aged Care Commission consult with the aged care sector prior to making any determination as to the content of aged care specific financial reports. Policy reporting in this context will need to be coordinated with financial reporting to support the costing reviews by the independent Aged Care Pricing Authority.

Note that the Department of Health has advised recently that it will soon commence a formal consultation process with the sector to increase the scope of the current financial reporting arrangements, encompassing **consolidated parent level reporting, a liquidity based balance sheet and reporting at the facility level**.

As well as more transparent (and potentially more regular) financial reporting, Counsel Assisting have suggested that **continuous disclosure requirements** are introduced (refer to R105). This recommendation is made on the basis that prudential and financial risks occur in real time and that the regulator needs timely information so that they can effectively respond to risks as and when they occur. The new requirements would cover material information that affects the provider's ability to pay its debts, or continue to provide aged care that is safe and of high quality.

Counsel Assisting recommends that providers should also be required to **report on outsourcing of care management** (refer to R108). This recommendation is made with reference to the events at Earle Haven, which exposed the risks (and gaps in regulatory oversight) of approved providers sub-contracting the management of aged care facilities to separate organisations.

In line with the proposed prudential standards and financial reporting requirements, it is proposed that from 1 July 2023 the Aged Care Commission should also have the power **to impose a range of regulatory responses** where there has been a breach of the new requirements (refer to R106). This would include the power to impose civil and administrative penalties, the ability to apply enforceable undertakings, and the ability to impose sanctions to limit the ability of the provider to expand its services, revoke accreditation for a service, or revoke approved provider status.

Many of Counsel Assisting's recommendations concerning prudential regulation parallel options for strengthening management of prudential risk that were canvassed in a Department of Health consultation paper in March 2019, and in CHA's response to the consultation paper.

## Research, innovation and technology

Counsel Assisting recommend that by 1 July 2022, the Australian Government should establish a dedicated Aged Care Research Council, funded by a special appropriation of 1.8% of the total government expenditure on aged care (refer R 55).

***Possible Discussion Points***

*1: Do the recommendations raise red flags? If so, what are they?*

*2: Should the provider approval assessment be flexible to accommodate the services they provide? Or should a single one-size-fits all approach be continued?*

*3: Should all providers be subject to approval? Even those delivering the most basic services, for example gardening services?*

*4: Should approval be made on an ongoing basis? Or should it be time-limited?*

*5: Should regulation be the responsibility of the new Australian Aged Care Commission? And are the proposed set of new powers appropriate? What are the risks for providers?*

*6: Is it appropriate to subject providers and key individuals to harsher penalties? How will this impact on ability to recruit high quality managerial staff? How do the proposed penalties compare with other relevant sectors?*

*7: Are new liquidity and capital adequacy requirements needed? If so, what are the important aspects to consider? What risks should be considered in transitioning to a new model?*

*8: What form should any new financial reporting requirements take? And how frequent should reports be provided? Are continuous disclosure requirements needed on top of an expanded reporting framework? If so what elements should be in scope?*

10 November 2020