Victorian Healthcare Association
Vision • Value • Voice

Submission: Productivity Commission – Delivering Quality Care More Efficiently

15 September 2025

About the VHA

The Victorian Healthcare Association (VHA) is the industry body supporting Victoria's publicly funded healthcare services to deliver high-quality care. Established in 1938, VHA elevates a unified member voice to government, influences policy on sector critical-issues, and presents forward-thinking solutions to achieve a strong healthcare system that meets the needs of all Victorians.

VHA members represent 85% of Victoria's publicly funded healthcare sector and span a range of healthcare organisations. VHA members include Hospitals and Health Services, Community Health Services, Bush Nursing Centres, Specialist Care Services, Public Sector Residential Aged Care Services and non-bed-based services, such as Early Parenting Centres and patient transport services. Working from metropolitan through to rural areas, VHA members deliver accessible healthcare services in line with the needs of the Victorian community.

Introduction

The VHA welcomes the opportunity to provide a response to the Productivity Commission's interim report on 'Delivering quality care more efficiently' and commends the Australian Government's focus on creating a more efficient system that is sustainable into the future.

The VHA acknowledges that the Victorian health sector is vast, expanding beyond the $31 billion public healthcare sector, encompassing private healthcare and not-for-profit organisations, such private hospitals, and general practice. All parts of the Victorian health system play a role in delivering quality, efficient healthcare to Victorians.

As detailed in the VHA's *State of the Health Sector 2025 Report*[1], over 7 million people rely upon Victoria's publicly funded services[2] to provide timely, accessible and high-quality healthcare. The range of services provided by the publicly funded healthcare sector span acute care, emergency care, general surgery, specialist services, aged care, community-based care, health promotion, primary care and health prevention, as examples. Many organisations integrate multiple service types, often under one roof, such as hospitals that provide community health services and residential aged care, or registered community health services that provide home-based aged care and disability services. Given this integration of multiple service types, there are significant opportunities to scale models of care that provide for a more connected

[1] Victorian Healthcare Association. *State of the Health Sector 2025* Report. [Accessed 5 September 2025]. Available from: https://www.vha.org.au/public/184/files/VHA%20State%20of%20the%20Health%20Sector%202025%20Report.pdf
[2] Australian Bureau of Statistics. National State and Territory Population. Commonwealth of Australia; 2024. [Accessed 20 May 2025]. Available from: https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/sep-2024

and collaborative system, and to achieve productivity gains through a more streamlined regulatory environment.

The VHA welcomes the Productivity Commission's focus on achieving regulatory efficiencies and strengthening collaborative arrangements across existing parts of the care economy system, including in preventative healthcare. The VHA offers perspectives on the unique impacts of these issues across Victoria's publicly funded services, and highlights opportunities to leverage system strengths to realise the Productivity Commission's recommendations.

In this submission, the VHA responds only to the Productivity Commission's recommendations, actions and content that are most relevant to publicly funded providers of healthcare services in Victoria.

Reform of quality and safety regulation to support a more cohesive care economy

The VHA welcomes the Productivity Commission's recommendation that the "*Australian Government should pursue greater alignment in quality and safety regulation of the care economy, initially focusing on the aged care, National Disability Insurance Scheme (NDIS) and veterans' care sectors*".

In particular, the VHA supports recommended actions to align the broader regulatory landscape, including to *"establish a standardised quality and safety reporting framework and data repository to hold data reported against the framework, within three years".* The proposed alignment would deliver significant benefits to all healthcare services – including Victorian public sector residential aged care services (usually referred to as PSRACs) and Registered Community Health Services, which deliver home and community aged care, and are a major provider of NDIS services. Operating across parallel care systems, these services are required to navigate layers of compliance burden, which often involves duplicative incident reporting, complaints, quality, financial, and performance reporting to both state and Australian Government entities.

Victorian public sector residential aged care services in Victoria

Victoria's public sector residential aged care services are delivered across 160+ sites and include more than 5,500 beds. They are either integrated within a Hospital or Health Services or as standalone services (i.e., not connected to a Hospital or Health Service). All of these services are governed by a Board of Directors appointed by the Victorian Minister for Health.

As they are often integrated with a Hospital or Health Service, a strength of these services is their capacity to provide clinical and integrated care for people with complex health needs.

In February 2025, the VHA produced a White Paper 'Residential Aged Care: Finding the balance between red tape, quality and risk' [3] (see Annex A). The Paper summarises challenges of managing compliance obligations in Victorian public sector residential aged care, and outlines opportunities to streamline Australian and Victorian Government reporting processes through harmonisation of platforms, timeframes and process consolidation to increase efficiency, reduce the administrative impact on services whilst maintaining quality and safety of services.

There is an opportunity to harmonise regulation and compliance across sectors alongside an opportunity to achieve consistency within the aged care sector – between different types of services. For example, Victorian public sector residential aged care services provide more than 5,500 residential aged care beds.

[3] Victorian Healthcare Association. *Residential Aged Care: Finding the balance between red tape, quality and risk.* [Accessed 8 September 2025] Available from: https://www.vha.org.au/public/184/files/Aged%20Care%20-%20Finding%20the%20balance%20between%20red%20tape%2C%20quality%20and%20risk(1).pdf

This equates to approximately 9% of all operational residential aged care beds in the state – compared to 0-4% across other states and territories – fulfilling a critical role in ensuring access to aged care, particularly in rural and regional areas, where there are thin markets. As Victorian public sector residential aged care services are embedded within a health service, they are required to comply with health service standards, in addition to the aged care standards. These health service standards are not always appropriate for the residential aged care environment and are not applied to equivalent private and non-profit residential aged care providers. While the Victorian Government acknowledges this regulatory incongruence through the provision of supplementary funding, a more efficient approach would be to harmonise compliance requirements within the aged care sector. Case Study 1 provides an example of the regulatory complexities, duplicative reporting processes and resourcing burden borne by services operating across parallel systems of care.

Information is often duplicated in reporting across multiple platforms such as AIMS, GPMS, Services Australia and the QI Program. Systems often have varying language and exclusion criteria, which requires manual adaptation to be undertaken by services. For example, the information statement received from Services Australia must be manually reformatted by services before it can be submitted to the Victorian Government, to account for differing definitions of data points. There is a critical opportunity to strengthen alignment of the requirements across the multiple systems and jurisdictions, to streamline the process for providers.

Case study 1 – Large metropolitan service

This Victorian public sector residential aged care service is based in metropolitan areas with multiple sites and more than 190 residents. This service has a notable number of psychogeriatric beds and residents receiving NDIS funding. This service highlights the following:

This service submits 125 external reports over a 12-month period through the Victorian Department of Health (e.g., Agency Information Management System, or AIMS), and the Australian Department of Health, Disability and Ageing (e.g., Government Provider Management System or GPMS, and the National Aged Care Mandatory Quality Indicator Program or QI Program). This equates to approximately 10 different points of external reporting every month.

This service employs 0.8 FTE specifically to manage the compliance reporting requirements, not including the daily clinical and non-clinical personnel reporting contributions.

While the VHA recognises the value of a sector that is held accountable through robust regulatory systems, efficiencies could be made through harmonisation of reporting requirements that would allow sector capacity to focus on innovation, clinical care or other strategic priorities. A person's needs are not confined to a single program; therefore, the systems need to be designed to ensure quality care can be delivered while a streamlined approach to different funding streams is also integrated.

Case study 2 – Medium regional service

This Victorian public sector residential aged care service is based in rural and regional areas with multiple sites and more than 70 residents.

This service shared that they submitted 69 external reports within a 12-month period and has had 15 external audits in the last 12 months. On one occasion, two auditing teams from different agencies attended the service on the same day.

Recommendation: That, by recognising opportunities to better align quality and safety regulation in the care economy, the Australian Government uplift reporting requirements to a common approach to facilitate harmonisation across aged care, NDIS and health.

Embed collaborative commissioning to increase the integration of care services

The VHA welcomes the Productivity Commission's recommendation that:

- *Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings.*
- *In the next addendum to the National Health Reform Agreement, governments should agree to governance and funding arrangements that support better collaboration between Local Hospital Networks (LHNs), Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs).*

In Victoria, the Health Services Plan (HSP) is driving critical reform of the health system and closer collaboration between Victoria's Hospital and Health Services. A key feature of the HSP's implementation has been the establishment of the Local Health Service Networks (LHSNs) from 1 July 2025, which brought the state's 70+ Hospitals and Health Services into 12 Network groupings. The LHSNs are responsible for supporting care for their community, as close to home as possible. All in-scope services within an LHSN are required to work together to progress key priorities, including access, equity and flow; workforce; safety and quality; and shared services[4]. While the establishment of LHSNs is a promising step in driving efficiencies and uplifting productivity across the system, ongoing and sufficient operational funding is required to realise their full potential.

Many of Victoria's Hospitals and Health Services have existing partnership arrangements with ACCHOs, varying in formality and scope. Most commonly, the partnerships enable referrals to culturally safe support for First Nations patients and staff, and to engage First Nations voices and input on governance and operational matters. There are opportunities for governments to work in partnership with ACCHOs and Health Services to design, fund and deliver a standardised approach to these collaborative partnerships, which would ensure more consistent practices across the health service system.

Beyond the partnerships with ACCHOs, the VHA sees significant potential for Victoria's Hospitals and Health Services (e.g., in-scope of the HSP) to strengthen arrangements with services out-of-scope services, including Registered Community Health Services and Bush Nursing Services through formal partnership arrangements. The Community Health Service model a key component of the Victorian primary care, prevention and community services sector. Community Health Services are known for facilitating seamless transitions and coordination of care across sectors, by establishing strong partnerships with other health and social care providers, including hospitals and specialist services.

[4] Further information about the Health Service Plan, Local Health Service Networks and their priorities can be found here: https://www.health.vic.gov.au/health-services-plan-reform/local-health-service-networks

Community Health Services are an integral part of Victoria's publicly funded services and fall into two legal and governance arrangements:

• Integrated Community Health Services operate as part of Victorian public Hospitals and Health Services. They are subject to the health services accountability framework. These services are embedded within health service organisational structures and operate as an integral pillar of the overarching organisation.

• Registered Community Health Services are independent companies limited by guarantee. They are registered under the Health Services Act 1988 and typically operate in a not-for-profit model.

Registered Community Health Services

The VHA's *State of the Sector 2025* Report defines Registered Community Health Services as those that "deliver a range of comprehensive services, including primary care, allied health, counselling and mental health, chronic disease management and community nursing services, and are focused on providing accessible and affordable health and social care"[5]. Some Registered Community Health Services are also major providers of drug and alcohol support services, disability services, dental, post-acute care, home and community care and community rehabilitation, as well as other health and social care services.

Registered Community Health Services are not-for-profit companies (limited by guarantee), funded through a combination of Victorian Government, Australian Government, client and patient fees and philanthropic donations.

Importantly, owing to its flexibility and its philosophy, the Community Health Service model has the capacity to coordinate the care of clients requiring a range of health and social services, a cornerstone of the recommendations of the Strengthening Medicare Taskforce Report[6]. The model is also consistent with the goals of the *National Health Reform Agreement*, to better deliver 'safe, high-quality care in the right place and at the right time' and to 'prioritise prevention' including to help people manage their health across their lifetime.

Recommendation: That the Australian Government considers the Victorian Community Health Service model as a scalable solution to realise the objectives of the national primary healthcare agenda.

Recommendation: That governments strengthen arrangements between services to drive innovation and minimise fragmentation across the health system, prioritising Community Health Services as an effective model for delivering place-based, integrated and preventative care.

A national framework to support government investment in prevention

The VHA supports the Productivity Commission's recommendations to "*establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure*."

[5] Victorian Healthcare Association. *State of the Health Sector 2025* Report. pp12. [Accessed 5 September 2025]. Available from: https://www.vha.org.au/public/184/files/VHA%20State%20of%20the%20Health%20Sector%202025%20Report.pdf

[6] Australian Government Department of Health, Disability and Ageing. *Strengthening Medicare Taskforce Report 2022.* Available from https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en

In particular, the VHA supports the recommended action to establish "*a funding mechanism that supports eligible prevention initiatives across Australian, state and territory governments*". This would help to reduce pressure on the acute end of Victoria's publicly funded services, by driving investment in preventative models of care – such as Community Health Services and early interventions for the ageing population. The framework should include a funding mechanism that recognises the role of these services in driving prevention, as well as investment in workforce, digital technology and infrastructure to expand their service capacity and support their long-term sustainability.

If funded to scale up, the Registered Community Health Service model is well-positioned to provide early primary and wraparound services that prevent entry into hospital, keep people at home and in their community. These services enable timely access to care through a coordinated, place-based and easy-to-navigate model. Unpublished insights from the VHA's State of the Health Sector Report reveal that 100% of Victoria's Registered Community Health Services have a desire to expand their service in size and scope. However, 66% of services strongly agreed that funding constraints are a major challenge to existing service delivery, let alone expansion. Similarly, workforce pressures are a major issue, with only 54% of services reporting sufficient levels of clinical staff to operate effectively. Virtual care has the potential to alleviate some of these challenges, with 64% of publicly funded services reporting that virtual care is key to enabling service continuity while managing workforce and resource limitations. Sustainable service funding for Registered Community Health services – alongside a skilled and transferable workforce that has adequate access to technology and digital care – will enhance prevention, access and service coordination.

In addition to access to digital care, infrastructure investment is required to support these service models to meet community demand. A recent report by Infrastructure Victoria, 'Investing in Community Health Infrastructure'[7], found that by 2036, demand for Community Health Services in growth areas is predicted to more than double. However, many Registered Community Health Service's buildings are ageing and may not be fit for use in the coming years. 40% of services have issues that either limit service delivery or reduce the number of people they can support. The report notes that access to high-quality primary and community care, particularly for managing chronic conditions, can reduce the number of hospital presentations each year. The findings indicate that government planning processes should be reviewed and that greater long-term investment is required by both the Victorian and Australian Governments to support Community Health Services to deliver more effective early intervention and preventative health measures. The VHA has welcomed these findings, emphasising the opportunity to maximise the capability of Community Health Services to deliver early intervention, health prevention and promotion, if long-term and sustainable infrastructure investment is provided to support critical facility upgrades, maintenance and expansions.

The VHA sees opportunities to prioritise investment in entry-level and home-based aged care, which support older people to say healthy and well in their communities for longer. In essence, this is preventative care that reduces the risk of hospitalisation. The *Aged Care Act 2024* (the new Act) will be implemented from November 1, under which the Support at Home program and Commonwealth Home Support Program will be delivered by publicly funded services, including Registered Community Health Services. As these programs aim to keep older people in their homes for longer, they will result in a reduction of costs and pressures on the residential system while preventing avoidable hospitalisations.

[7] Infrastructure Victoria. *Investing in Community Health Infrastructure.*[Accessed 5 September 2025] Available from https://www.infrastructurevictoria.com.au/resources/investing-in-community-health-infrastructure

However, the success of these programs depends largely on whether the sector can meet growing demand as the population ages, and the pressure this demand places on workforce, infrastructure and ICT systems.

The VHA welcomes the Australian Government's recent commitment to supporting an additional 4,000 home care workers over three years through the Regional, Rural and Remote Home Care Workforce Support Program. Nevertheless, the impact this will have on the publicly funded health system is yet to be seen. Moving forward, there should be a focus on ongoing monitoring and targeted investment to expand assessment services in order to enable more in-person assessments. This is critical for ensuring clients receive prompt and appropriate care packages, reducing risks for those with complex or escalating needs and preventing further hospitalisations.

Further, ICT upgrades required by aged care services preparing for the transition to the new Act have exceeded financial support provided by the Australian Government. Grants of $10,000 have been insufficient to cover the true cost of upgrades, which often exceed $40,000. It is not sustainable for services to absorb such costs. The Australian Government must provide sufficient investment to support the successful transition to the new programs so that services have the required capacity to continue to provide critical early intervention and preventative care.

Recommendation: That the National Prevention Investment Framework include criteria to drive adequate investment toward workforce, technology and infrastructure that enables models of preventative care across service systems – including supporting people to remain at home, in their communities and reduce pressure of the acute healthcare system.

Summary of Recommendations

- That, by recognising opportunities to better align quality and safety regulation in the care economy, the Australian Government uplift reporting requirements to a common approach to facilitate harmonisation across aged care, NDIS and health.
- That the Australian Government considers the Victorian Community Health Service model as a scalable solution to realise the objectives of the national primary healthcare agenda.
- That governments strengthen arrangements between services to drive innovation and minimise fragmentation across the health system, prioritising Community Health Services as an effective model for delivering place-based, integrated and preventative care.
- That the National Prevention Investment Framework include criteria to drive adequate investment toward workforce, technology and infrastructure that enables models of preventative care across service systems – including supporting people to remain at home, in their communities and reduce pressure of the acute healthcare system.

For further information, contact:

[redacted]

Annex A

Victorian Healthcare Association

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February 2025

WHITE PAPER

Residential Aged Care: Finding the balance between red tape, quality and risk

Prepared by

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Residential Aged Care: Finding the balance between red tape, quality and risk

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About the VHA

The Victorian Healthcare Association (VHA) is the peak body supporting Victoria's publicly funded health services to deliver high-quality care. Established in 1938, the VHA represents Victoria's diverse public healthcare sector, including public hospitals, community health services, public sector residential aged care services and bush nursing services. As well as providing a unified voice for the sector, the VHA advocates sector-critical issues on behalf of its members by engaging and influencing key decision-makers involved in policy development and system reform.

Executive Summary

Over the past five years, State and Commonwealth entities have introduced numerous compliance measures across residential aged care services in order to uplift sector quality and safeguard older Australians. While the VHA recognises the vital need for robust quality systems, these measures are cumulative and have a substantial impact on the sector. Public sector residential aged care services (PSRACS) are disproportionately impacted compared to private and not-for-profit providers due to their position within parallel care systems, including health services, aged care, NDIS, and mental health. This paper seeks to summarise the sector challenges in managing compliance across parallel care systems and briefly outline the opportunities for alignment and consolidation of processes.

Residential Aged Care: Finding the balance between red tape, quality and risk

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About publicly funded aged care services

Across the VHA's membership, residential aged care services are delivered across 171 public sector residential aged care services sites (most in regional and rural communities), which are either:

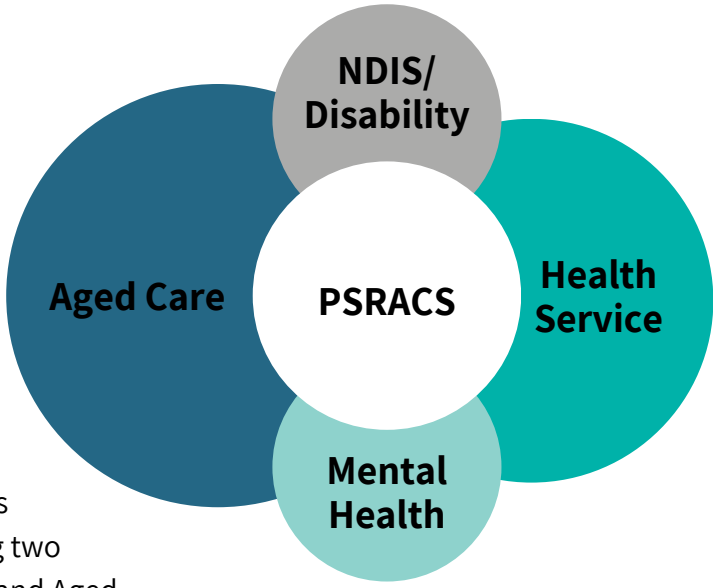
- Delivered as part of a broader health service offering. These health services are governed by a Board of Directors appointed by the Victorian Minister for Health, or
- Standalone (i.e., not connected to a health service).

Unlike most other states and territories, PSRACS are a unique service option in Victoria. The 171 sites include more than 5,000 residential aged care beds. This equates to approximately nine percent of all operational residential aged care beds in the state, compared to zero to four percent across other states and territories. In an environment of growing complexity for health services seeking to discharge older Australians from acute care, PSRACS offer an important service option for rural and regional Victorians who are unable to remain at home.

What we have heard from services

Caught in the middle of parallel regulation

Victorian's unique system design means that PSRACS occupy a challenging yet essential space between parallel care systems. While PSRACS primarily offer residential aged care services, they also intersect with health services and, on a smaller scale, mental health and the National Disability Insurance Scheme (NDIS) - all with different quality standards, reporting, auditing, accreditation, and compliance requirements.



Over the last five years, the compliance burden on services from parallel systems has significantly increased following two Royal Commissions (into Victoria's Mental Health System and Aged Care Quality and Safety) and the introduction of the NDIS practice standards.
The independent aged care news publication, Insider Ageing[1] stated that on average, providers reported a 32% increase in compliance since the Aged Care Royal Commission, and three out of four providers report it as a major issue.

1 https://insideageing.com.au/a-perfect-storm-in-aged-care/

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Services report that competing systems often lead to additional layers of compliance burden, such as duplicate incident reporting, complaints, quality, financial, and performance reporting to both state and Commonwealth entities. Several services note that the complexity of funding streams and reporting and compliance requirements across State and Commonwealth impacts their decision-making when accepting new residents.

An example of duplicative arrangements is that as a health service, PSRACS boards are appointed by the Victorian Minister for Health. However, as a residential aged care service, services must notify the Commonwealth within 14 days of a board member's appointment. As these appointments are made through an independent process, services often do not have access to the 'key personnel' information and are required to retrospectively follow up with board members post-appointment. It is a requirement that is difficult for services to meet within the notification timeline and is also duplicative and unnecessary. There is an opportunity to exclude PSRACS from this process, either by Commonwealth acknowledgement of the state's responsibility to ensure that board appointments meet the necessary skills and safety requirements or by the state assuming the reporting responsibility for all PSRACS as an embedded part of the health service board appointment process.

This example highlights one simple duplicative process between Commonwealth and state and between aged care and health. For PSRACS there are many of these examples for each of the parallel care systems they intersect with, including mental health and NDIS, resulting in a volume of duplication and waste.

Residential Aged Care: Finding the balance between red tape, quality and risk

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Case study - Large metropolitan service

This service is based in metropolitan areas with multiple sites and more than 190 residents. This service has a notable number of psychogeriatric beds and residents receiving NDIS funding.

This service highlights the following:

- There are incongruent policies between health services and aged care, although sometimes co-located, resulting in conflicting operational directions. For example, the PSRAC threshold for wearing marks differs from private providers due to their connection with health services.
- Frustration that the NDIS does not recognise their trained health service teams that support restrictive intervention and behaviour support processes for psychogeriatric residents, often resulting in duplicative processes.
- This service employs 0.8 FTE specifically to manage the compliance reporting requirements, not including the daily clinical and non-clinical personnel reporting contributions over the course of their shifts.

This service submits 125 external reports over a 12-month period through the Agency Information Management System (AIMS), Government Provider Management System (GMPS) and the National Aged Care Mandatory Quality Indicator Program (QI); this equates to approximately ten different points of external reporting every month.

Recognition of expertise and safeguards

As PSRACS are part of a health service they have robust governance and governance mechanisms in place and access to a highly skilled workforce. There is an opportunity to recognise the level of oversight and safeguards to consolidate or align parallel reporting requirements. All services contributing to the set of case studies spoke of the challenge of duplicative compliance within PSRACS and questioned why there are no additional exceptions for services that are successfully operating in these already highly regulated environments.

Fragmented and manual systems don’t speak the same language

Reporting within services is fragmented by topic, funder, and accountable agency. Reporting requirements often use system-specific definitions for terms that do not align with sector systems. For example, the definition of ‘employed’ for workforce reporting under the aged care National Quality Indicator Program is based on a threshold number of hours within a set period, which means that despite working a shift, an employee may still not meet the workforce data definition of employed.

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Sector-specific definitions often mean services rely on manual reviews and processes, with several services describing the workforce data submission as 'taking hours' to manually adapt prior to submission.

In addition, information is often duplicated in reporting across multiple platforms such as AIMS, GPMS, Services Australia and My Aged Care; systems often have varying language and exclusion criteria, contributing to the rates of manual adaptation required at the service level.

Case study - Large metropolitan service

This service is a large provider based in metropolitan areas with multiple sites and more than 110 residents.

This service highlights the following:

- The time taken to submit workforce data via manual collection and adaption processes due to the definition of 'employee' and 'hours'. This service raises challenges with reporting thresholds and the need for supplementary explainer information outside a specific figure. This adds additional and often unseen workload to the process.
- The information statement received from Services Australia is reformatted and submitted to the State. Raising additional opportunities to streamline data submissions.

Case study - Small regional service

This service is a small provider based in rural and regional areas. It has a single site, less than 60 residents, and several residents receiving NDIS funding.

This service highlights the following:

- Concern about the ability of systems to cope with the reporting requirements and often resorts to manual workarounds to compensate. For example, GMPS cannot upload more than three documents at a time, and key personnel data submissions don't always accommodate culturally sensitive naming conventions, e.g. the submissions require a first name and last name.
- This service raises the risk of compliance burden contributing to a single point of failure, particularly on smaller, more rural services, where the skills and experience often fall to one person within the service.

This service submits 129 individual data points each quarter through the QI program, equating to approximately 516 data points over a 12-month period.

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The value of reporting can be unclear

Several services report that the value of external reporting is often unclear at the frontline level and perceived to be sparked by requirements rather than quality practice provision. With one service submitting 125 external reports within a 12-month period, members question the reporting volume versus its impact on quality service delivery. There are also questions about the active use of data, as members query whether reports are effectively used if they are evaluated by artificial intelligence (AI).

Each reporting element contributes to the time frontline staff spend in direct care minutes supporting older Australians. While the VHA recognises the value of an accountable sector, sector capacity should be directed at innovative and quality delivery rather than keeping up with compliance, of which the value is sometimes unclear.

Case study - Medium regional service

This medium service is based in rural and regional areas, with multiple sites and more than 70 residents.

This service highlights the following:

- Frustration with the volume of reporting under the National Quality Indicator Program and the proposal of an expanded program, including the inclusion of community settings.
- This service raises the opportunity to streamline auditing requirements through communication and consolidation of the assessment process, assessing the service overall rather than by separate sites.

This service has submitted 69 external reports within a 12-month period. This service has had 15 external audits in the last 12 months, and on one occasion, two auditing teams from different agencies attended the service on the same day.

The sector is bracing for more compliance

While PSRACS falls under the umbrella of a health service, the health service standards are not always appropriate for the residential aged care environment and are not comparable to the standards applicable to private and non-profit aged care providers. While the Victorian government recognises this incongruence and burden through the provision of top-up funding, services still report fatigue from the combination of Commonwealth and State-based requirements.

PSRACS are already bracing for more compliance, with the Commonwealth planning to expand the National Quality Indicator Program by introducing three new staffing indicators. Services raise that they already report on 129 different data points as part of the existing program.

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Services are frustrated that growing compliance requirements are taking staff away from caring for residents. Additionally, changes under the Aged Care Act and NDIS reform will likely result in additional compliance measures.

While the change from accreditation to a registration model under the Aged Care reforms is predicted to streamline processes, there is an additional opportunity to further streamline sector compliance through the introduction of the Local Health Service Networks in 2025.

Recommendations:

- The VHA recommends investigating opportunities for further harmonisation of Commonwealth and State base compliance.
- The VHA recommends identifying opportunities to streamline Commonwealth and State reporting processes through platform, timeframe and process consolidation to increase efficiency and reduce the impact on services.
- The VHA recommends further recognition of the expertise and safeguards within PSRACS and a review of the balance across parallel systems such as health service, NDIS, mental health and aged care compliance.

Conclusion

The VHA recognises that a high-quality aged care system must safeguard and respect the rights of older Australians and be innovative, efficient, and well-governed. However, as outlined in this paper, VHA members are concerned that the strengthened regulation has not yet struck the right balance between incentivising quality practice and over-burdensome and duplicitous compliance.

The VHA recognises that the upcoming implementation of the Local Health Service Networks poses an opportunity for sector review, including but not limited to compliance systems.

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Appendix 1 - Examples of compliance reporting mechanisms across Aged Care and parallel systems

External reporting requirements

Quarterly national quality indicators

- Pressure Injuries
- Physical Restraint
- Unplanned Weight Loss
- Falls and Major Injury
- Medication Management
- Activities of daily living
- Incontinence care
- Hospitalization
- Workforce
- Consumer experience
- Quality of life
- State-based indicators

Quarterly financial reporting

- Viability and Prudential Compliance Questions
- Year-to-Date Financial Statements
- Residential Care Labor Cost and Hours Reporting
- Quarterly Food and Nutrition Report
- Home Care Labor Cost and Hours Reporting

Other

- Care minutes
- AN-ACC scores, number of residents
- Respite places and new admissions
- Demographic classifications
- Statutory duty of candour
- Medication, including PPIs
- Workforce reporting – 24/7 RN
- Vaccination data
- Use of agency staff

Annual service operations reporting

- Executive position details
- Governing body membership
- Statement signed by the governing body they did or did not comply with its duty
- diversity information
- Kind of feedback and complaints

Annual financial reporting

- Statement of Financial Performance
- Statement of Financial Position
- Statement of Changes in Equity
- Notes to the Financial Statements
- Prudential Compliance Questions

External auditing requirements

- Aged Care Quality and Safety Commission
- Local council – food and kitchen audit
- Food and dining experience
- Fire inspection
- Hand hygiene
- NDIS Quality and Safeguards Commission
- Community Visitors
- Infection control monitoring
- Covid – emergency preparedness
- Financial audits – resident agreements
- NSQHS Standards
- Prudential audit
- Care minute audit
- Workforce audit
- Medication compliance audits
- VAGO auditing

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