ACCV RESPONSE TO:

Annual Review of Regulatory Burdens on Business - Social and Economic Infrastructure Services

ACCV's response to the Australian Government Productivity Commission.

March 2009.

INTRODUCTION.

Aged & Community Care Victoria Ltd (ACCV) is the sole industry association and peak body for aged care in Victoria.

This response is being made to the Australian Government's request for the Productivity Commission to undertake a series of annual reviews of the burden on business from the stock of Australian Government regulation. The commission has indicated that in 2009 it will examine regulations that have an impact on social and economic infrastructure services.

The Aged Care industry is both part of social and economic infrastructure. While it stands fairly apparent that aged care is part of the nation's social infrastructure, few recognize its contribution to economic infrastructure. Aged care assumes a place in the profile of economic infrastructure in the same way that child care does as it allows individuals to pursue their livelihoods and contribute to other sectors of the economy which they otherwise might not be able to. Many skilled and talented Australians of working age are unable to pursue their livelihoods or contribute to the nation's economic activity owing to the relationship obligations of caring for an older person.

Recognition has been given to this phenomenom in a number of reports which have paid attention to the health and wellbeing of carers. Displacement from usual workforce roles and consequent income depletion have both been recognized as having social and health impacts on carers. The previous Commonwealth government sought in 2007 to fund specific carer respite initiatives through it National Respite of Carers Program in 2007 targeting "working carers"

This response has been developed from our ongoing dialogue and work with members.

Our response takes consideration of both Aged Residential Care (often popularly understood as Aged Care Hostels and Nursing Homes) and Aged Community Care Services – including services funded under the joint jurisdiction funding arrangements of the Home and Community Care Program (HACC) as well as the Commonwealth's Own Payment Outlays – the Community Aged Care Packages

and Extended Aged Care at Home Packages governed by the Commonwealth's Aged Care Act 1997, and the Commonwealth National Respite for Carer's Program.

We thank the Commonwealth for providing us with this opportunity to provide open, honest and detailed feedback.

Our feedback is divided into the two broad areas of Residential Aged Care and Community Aged Care and also addresses a whole of industry issue. Where relevant, each of these areas has used the following headings subheadings for which the Commission has sought specific focus for its enquiry:

- Duplicate Regulations
- Duplicate role of regulatory bodies
- Unnecessarily burdensome, complex or redundant regulation

Residential Aged Care

Duplicate Regulations.

In relation to Commonwealth funded Residential Aged Care facilities the approach of regulation to quality of care and services is effectively subject to duplicate regulations.

There are, broadly speaking, three schemes which operate to regulate the quality of care and services.

The first scheme is the Commonwealth's own compliance branch whose function is to police compliance by approved providers with both the legislation and principles established under the Aged Care Act 1997.

In turn, the Commonwealth also operates a Complaints Investigation Scheme whose role is to respond to complaints made by aged care recipients, their advocates, or any concerned member of the public.

The Government is also responsible for the operation of the Aged Care Standards Accreditation Agency. This statutory authority exists as a company limited by guarantee. It is a quasi-government entity.

In short there is a very complex interplay when risk situations occur in an aged residential care facility.

The example of a resident who goes missing now requires notification to the Commonwealth Department of Health and Ageing as well as the Victorian Police. Not only will the compliance area of the department commence its own investigation which could lead to a notice of required action (eg to remedy a security deficit), or a sanction (effectively a punitive measure), but these matters are frequently referred to the Aged Care Standards Accreditation Agency

(ACSAA) who may in turn undertake a partial or full review of the nursing home or hostel in relation to the Commonwealth's 44 standards outcomes for Residential Aged Care facilities.

We believe that this is unnecessary duplication of regulation when the matter has been brought to the attention and subsequently investigated by the compliance branch of the Commonwealth Department of Health and Ageing.

In acute public health sentinel events such as death or serious injury of a patient do not result in suspension of licence or funding. The coronial process and internal root cause analysis are used as the chief means to investigate serious incidents. Bureacracy teams and units may become involved when larger scale or unusual incidents have occurred.

The general remit of most quality accreditation programs in the other parts of the health sector is to undertake periodic reviews of health facilities. In this regard, three year review cycles, with some programs undertaking a smaller mid-cycle review to ensure progress on previous review recommendations is most common.

Importantly, quality accreditation reviews are not undertaken in response to such incidents by the accrediting bodies such as the Australian Council on Healthcare Standards (ACHS)

We therefore consider that it is both unnecessary and duplicated regulation if incidents which have resulted in a complaint or compliance investigation also trigger an accreditation review.

Duplicate role of regulatory bodies

Duplicating the role of responsible authorities.

In incidents such as gastroenteritis outbreaks, private and public hospitals and human services and Residential Aged Care Facilities are all required to notify the relevant state health authorities' infectious diseases units for assistance with incident management.

In the aged residential care sector, there is also a requirement upon the provider to notify the Department of Health and Ageing, who, in turn, will likely respond both directly through its own compliance investigation as well as triggering the Aged Care Standards Accreditation Agency to also undertake a partial or full accreditation review of the Residential Aged Care facility.

In such situations other health and human services (eg child care centres) are not subject to additional compliance or quality reviews. The relevant state infectious diseases units are there to both assist and regulate an entity's activity when an infectious disease outbreak has occurred as a recognised public health role of government.

The industry find the additional interference of both the compliance branch of the Commonwealth Department of Health and Ageing and the Aged Care Standards Accreditation Agency confusing and burdensome under these situations. These additional regulatory burdens do not permit the aged care facility to focus its resources and attention on resolving the infectious disease outbreaks under the guidance of the expert authority and regulator in relation to such matters – the infectious diseases unit.

Three further areas in relation to the duplication of regulatory activities of authorities in other jurisdictions are Occupational Health and Safety, Food Safety and Nursing Scope of Practice.

Occupational Health and Safety
In Victoria, Occupation Health and Safety is governed by the Occupational Health and Safety Act 2004 and the Victorian WorkCover Authority is charged with the responsibility and authority to operate the legislation. In turn WorkSafe Victoria is the manager of Victoria's workplace safety system.

Broadly, the responsibilities of WorkSafe are to:

- help avoid workplace injuries occurring
- enforce Victoria's occupational health and safety laws
- provide reasonably priced workplace injury insurance for employers
- help injured workers back into the workforce
- manage the workers' compensation scheme by ensuring the prompt delivery of appropriate services and adopting prudent financial practices.

Worksafe Victoria also visit and inspect workplaces as well as target specific industries' practice areas for risk management. Manual handling injuries in aged care have, for example, been the subject of an extensive "no-lift " campaign to improve manual handling practices in our sector.

It is problematic when non-expert generic quality systems reviewers from the Aged Care Standards Accreditation Agency attempt to comment and make recommendations on Occupational Health and Safety matters.

Under Standards Area 4 of the Commonwealth residential Aged Care Standards, which governs quality and systems around physical environment and safe systems, there is an observed tendency of individual reviewers to make judgment and recommendations about occupational health and safety matters. For the Aged Care Standards Accreditation agency to attempt to do this is unnecessary duplication of a well established regulatory role of state government.

Food Safety
A similar phenomenom also occurs for food safety. In Victoria, food safety is governed by the Food Act 1984. The principle state act that controls the sale of food in Victoria is the Food Act 1984. In relation to Residential Aged Care Facilities this act is the means through which the National Food Safety Standards are applied, municipal councils register food businesses as defined in the Act and whereby Food Safety programs are a prescribed pre-condition for food business registration

Under this legislation annual reviews of food preparation facilities and systems in "businesses" including hospitals and aged care facilities have been occurring for 11 years in Victoria, while other state jurisdictions have only started to undertake such reviews in the past 1-2 years. Any attempt by the Aged Care Standards Accreditation Agency to have non – experts comment or make recommendations in relation to food safety is another confusing duplication of regulation.

Nursing Scope of Practice.
A final area of concern in relation to the duplication of regulation in Residential Aged Care pertains to those areas of legislation which govern "specified care and services". Certain types of care can only be provided or managed by health professionals such as nurses within their legislated and regulated scope of practice. In Victoria, the legislation is the Nurses Act 1993 and the regulating authority that determines scope of practice is the Nurses Board of Victoria.

It interferes with the productivity of this sector, confuses providers and makes for unnecessary duplication of regulation when individual assessors undertaking reviews for the Aged Care Standards Accreditation Agency attempt to delimit the scope of practice of Victorian Division 2 Registered Nurses (known in other states as Enrolled Nurses) when their scope of practice under their registration has already been determined in Victoria.

Duplicating responses and investigations into non -compliance
The other area of duplication is when areas of non-compliance have been identified by the Aged Care Standards Accreditation Agency. Part of their obligation is to notify the DoHA of these non-compliances. This can result in the approved provider having to write up and provide 2 slightly different reports to the

two agencies responding to the identified issues. If the areas of non-compliance are significant and result in the sanction process being invoked, then this dual reporting is further extended.

As well as having to provide multiple written reports to the two different entities, then the facility will also have to comply with 2 separate on-site visits which are serving the same purpose.

In addition to the stress involved in managing the different reporting requirements and on-site visits of the 2 entities, the facility is also trying to manage the time requirements of implementing the remedial actions while also spending substantial time responding to the requirements of the multiple on-site visits, ostensibly achieving the same aim - that the care of the residents is not compromised.

Duplicating financial regulation.

The current global financial crisis has necessitated the imposition of deposit insurance for deposits into accounts held with financial institutions over $1 million. The average aged care accommodation bond paid by a financially eligible low care resident is some $250,000. These bonds are refunded to the resident or their estate on their departure from the residential aged care facility. Most of the deposited funds held on behalf of residential aged care facilities by financial institutions comprise these bonds.

However the Commonwealth Government also operates a Bond Guarantee Scheme in the event that approved providers of aged residential care default on the re-payment of bonds to former residents (or their estates). The scheme, in turn, is financed by the industry through a levy. While the bond guarantee scheme guarantees the financial obligation of a provider to the departing resident, the deposit insurance scheme guarantees the obligation of a financial institution to an approved provider.

Notwithstanding the two separate relationships, we believe that more economical and less burdensome regulatory arrangements would reduce the cost imposition on the industry. One possibility would be for the Commonwealth's own deposit insurance scheme to pay the deposit insurance on behalf of the approved provider and reclaim the bond amount off the financial institution where the scheme has been required to refund a bond as a consequence of a financial institution being unable to return deposited funds.

Unnecessarily burdensome , complex or redundant regulation.

The Aged Care Standards Accreditation Agency is also discharged with the authority to undertake unannounced visits of Residential Aged Care Facilities.

These may occur at any time. All aged care facilities are subject to these unannounced visits on at least an annual basis.

It is reasonable to consider that the manager of a facility should be available to assist the inspection and answer any questions. Relief staff, or direct care workers may not be able to answer all questions.

The nature of these unannounced visits is such that there is an apparent legislated right of refusal by the approved provider, under the Aged Care Act Accountabilty Principles 1998 (S.1.8) but a provider is generally by default of the legislation considered to be non-compliant with legislation if they do refuse access, mitigated only by section 1.13 of the same principles. This of itself is very confusing.

An unannounced visit may occur when the manager or other designated person is about to undertake another activity such as leave work for the day to pick up children from care, take residents on an outing or conduct an event or activity as part of the service's general offering of social and recreational participation for its residents. To think that an assessor can simply arrive on the doorstep of a facility and deprive the facility of its manager or key personnel who are undertaking other important scheduled roles is unnecessarily burdensome.

These unannounced visits are not just conducted on facilities where there has been an established pattern of complaints, non-compliances or previous failure to meet standards. Under these circumstances, common judgment would justifiably give rise to concerns about strategies to avoid discovery of problematic aspects of their operation (this would be a negligible minority of providers).

The evidence is one of an industry that achieves well in quality - the "Report into the Operation of the Aged Care Act 2007-2008" showed that 98.4 percent of providers were fully compliant with all 44 accreditation outcomes at all times. Therefore, our industry finds the unannounced visit regime to be unnecessarily burdensome and an enterprise pursued at great cost to the government and sector, out of proportion to the overall risk of substandard care.

In general terms we believe that the system of aged care accreditation, if it purports to promote continuous improvement, must itself be subject to a major review. The four standard areas and 44 standard outcomes have remained unchanged for almost 12 years. There is in the broader health literature serious concern about the overall cost benefit of accreditation as the best pathway to improving health and care outcomes

As one recent Australian study has explored, ,

> *After decades of accreditation development in health, and multi-million euro, dollar and pound investments, the extent to which accreditation processes and outcomes accurately reflect and motivate high quality clinical and organisational performance is poorly understood and under-investigated. The need to undertake research in this area is of considerable public interest given the extent and cost of accreditation processes in use today and the importance to consumers of efforts to improve the safety and quality of health care services (Braithwaite et al 2006)*

This has been given further veracity in a recent international literature review and meta-analysis,

> *This review of health care accreditation research literature reveals a complex picture. There are mixed views and inconsistent findings. Only in two categories were consistent findings recorded: promote change and professional development. Inconsistent findings were identified in five categories: the professions' attitudes to accreditation; organisational impact; financial impact; quality measures; and program assessment. In the remaining three categories – consumer views or patient satisfaction; public disclosure; and surveyor issues – we did not find sufficient studies to draw conclusions. (Greenfield, D. and Braithwaite J. 2007, p.11).*

These issues must be given serious consideration when the overall cost of compliance is very high both in dollar terms and staff time. The industry feels that this detracts from having sufficient time to care - the overhead of this compliance burden is felt even more keenly in smaller "stand-alone" facilities and local community organisations.

Aged Care Accommodation Bonds Refunds

There is a financial cost currently born by providers as a result of burdensome regulation in relation to the prudential requirements for aged care accommodation bonds. The issue relates to the refund of accommodation bonds to the estates of deceased residents where these have been paid by financially eligible residents who have been in entered low level residential care.

The regulatory imposition is that penalty interest is payable at 5% on non–refunded bonds. In the case of a resident who has died, this penalty rate applies

from the time the resident has died up to the time that the approved provider receives letters of administration or probate (from 7 days after this time, and until the bond has been refunded a penalty then applies of 11.31%). Letters of administration or probate may take a few months to be sent to the aged care provider. The average bond is approximately $250,000.

At present aged care providers are only receiving up to 3% on these invested bonds. While they hold onto the bond during the period in which the 5% penalty applies until letters of probate or administration have been received, the approved provider is actually making a 2% or greater net loss for retaining these funds. Four months of delay, in the case of a $250,000 bond, may therefore cost the approved provider almost $1700 .

The industry would therefore like to be able to expedite the refund of bonds, The industry would like to be able to forward a refund cheque to the executors of the estate of the deceased, made out to "the estate of [*the deceased person*]…". instead of waiting for letters of probate or administration.

Aged Community Care

Since 2004 the Commonwealth has endeavoured to "streamline" quality standards across four major program areas, the joint jurisdiction funding arrangements of the Home and Community Care Program (HACC) as well as the Commonwealth' Own Payment Outlays program – Community Aged Care Packages and Extended Aged Care at Home Packages governed by the Aged Care Act 1997 and the Commonwealth National Respite for Carer's Programs

A third draft of a set of common standards or the aged community care sector have recently been released. For the purposes of this submission we have used the term "Community Care Standards package" to refer to the standards, expected outcomes, self assessment tool and guide.

Unnecessarily burdensome , complex or redundant regulation
Uniform high level standards and outcomes can be worthwhile if, in essence, they constitute a set of benchmark principles or aspirations which are relevant to a wide range of service and program types in different settings and across different organisation types and sizes.

However these standards have been developed as a "locked down" package with the performance criteria and the guide – not simply published as standards of an

aspirational or principled nature. From a balance perspective they are in essence highly prescriptive and risk being incorrectly interpreted in their application by auditors who have not worked in the field with various organisation types or particular funded programs.

Procedures, therefore, might not necessarily be embedded in the handy types of "policy and procedure" documents which some auditors might expect to be handed to them on a platter. A procedure might be embedded in a tick list, form, training materials, care plan or computer data entry and record management system.

There is no sense that these standards, the expected outcomes and the performance criteria have thought about the wide scope and variation in programs, organisation size and type, setting or cultural context. We can predict that inexperienced auditors armed with the highly prescriptive outcomes and performance criteria coupled with an equally prescriptive guide of "good examples" will attempt to seek the same "policies and procedures" from a small $50,000 per annum funded social support group for homeless men as they would from a $20 million per annum home care service.

For what the standards package attempts to measure, we believe that he package does not demonstrate economy of process – surely a matter of concern.

There is an over-emphasis on assessing ethical practices and client empowerment. We believe that for many programs this will come at the cost of other continuous quality improvement (including clinical governance) activities which are increasingly important in the provision of safe and effective care to people in the community.

Duplicate Regulations

In some respects, the standards package misses the point that many community care programs are now part of the health care continuum as chronic disease contributes to the disability burden which leads to people to using community care services.

Moreover the standards are not an accredited Quality Improvement framework. They are actually an accountability and reporting mechanism for government. The Thus our concern is that while complex care and chronic health management are the territory of many community care programs, these organisations would be better served by using recognised and accredited quality programs such as the Quality Improvement Council's Quality Improvement in Community Services Accreditation (QICSA) package or the Australian Council of Health Care

Standards' (ACHS) Evaluation and Quality Improvement Program (EQuIP) frameworks which have been designed for health and community care settings.

On the other hand we recognise the Commonwealth's strong desire for funded agencies and services to be accountable for the programs they provide. There is an inherent confusion in the draft Community Care Standards package between accountability and reporting on one hand and quality improvement on the other. Accountability and reporting sits at ninety degrees to quality improvement – i.e. they are not one and the same.

The sector is therefore highly confused by what the government is actually seeking out of this package – is it a quality framework, or is it an accountability and reporting framework?

If it is an attempt at a quality improvement framework then it is destined to be inadequate. If it is an accountability and reporting framework it is uneconomical in its approach and will displace the capacity of organisations to focus on quality improvement even though the standards package purports to account for this.

Combined with the lack of economy for gathering evidence around each of the "standards", the proposed standards package will displace resources in many organisations which they would otherwise acquit by subscribing to the aforementioned accredited quality programs

We put forward that the Commonwealth could effectively account for every one of the Community Care Standards and the Expected Outcomes it is seeking if it were to give organisations the choice to use the EQuIP or QIC frameworks (which many organisations already use)

We also are aware of a phenomenom whereby multiple accrediting programs compete with each other due to different time cycles in the review process.

We put forward that the government needs to urgently consider the alternative approach already in place (at least in Victoria) for funded health agencies who also acquit a serious responsibility to public every day across the entire age spectrum - to make membership and accrediting by an appropriate Quality Improvement framework a condition of funding - and simultaneously minimise the direct detailed reporting to the Commonwealth of the standards and expected outcomes

To satisfy itself of this, it would be better for the Commonwealth to undertake a comprehensive detailed analysis of these quality improvement frameworks mapping the Community Care Standards and Expected Outcomes to the

standards sections, standards and evidence questions used in these quality improvement frameworks.

There is also need to resolve the problem of duplicating the same review process by the Commonwealth under its own Draft Community Care Standards package within the one organisation or even service outlet who might operate HACC, CACP, EACH and NRCP programs.

In its current proposed form the aged community care industry is concerned that there will be separate reviews for these differently funded programs This will defeat the very intent of "streamlining" to reduce the already prevalent red tape over-burden under which the sector operates.

Multiple funding sources and service programs are necessary in community care for two reasons. The first reason is because it enables services to provide a comprehensive and integrated response to their clients' health needs, and secondly because it enables service operational viability to be achieved. Most Aged Community Care services are built upon multiple program funding sources and service type programs as most funding allocations are insufficient to develop a stand-alone service base on one type of program funding.

Services achieve comprehensive and seamless services for clients by integrating their service delivery systems, policies and processes, across these programs. From an accrediting and standards perspective, efforts to integrate differently funded care and service delivery systems to achieve "best care" will be effectively ignored by a standards and accrediting framework which sees policy systems from a stand-alone view of each funded program.

This stand-alone approach to separately review each different program species in the same organisation or even service outlet will conflict with the provision of integrated programs and seamless care.

WHOLE OF INDUSTRY ISSUES.

Unnecessarily burdensome, complex or redundant regulation

There are unequal regulatory arrangements in relation to the administration of payroll tax. Not-for-profit Commonwealth aged providers are automatically exempt from all payroll tax while the Commonwealth refunds "for-profit" providers of aged residential care via a payroll supplement. For-profit providers of Community Aged Care Packages and Extended Aged Care at Home packages do not receive such a payroll tax supplement. We suggest that the regulation of taxes be aligned in the longer term interests of supporting all aged care as important social and

economic infrastructure and propose that all aged care providers should be exempt from payroll tax in all jurisdictions.

CONCLUSION

There are several areas across the Residential Aged Care and Community Aged Care Sectors where the Commonwealth Productivity Commission might seek to pursue further enquiry in relation to unnecessarily burdensome, complex, redundant or duplicate regulation. ACCV therefore welcomes further discussion with the Commission in relation to how to more efficiently re-regulate these areas, especially where the Commonwealth government and its entities might seek to be assured about the quality of care being provided to vulnerable members of our community.

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