24 November 2005

Mr Gary Banks
Chair
Regulation Taskforce
PO Box 282
BELCONNEN ACT 2616

Dear Mr Banks **CHA Submission on aged care**

Catholic Health Australia welcomes this opportunity to make a submission to the Taskforce on the need for regulatory reform in the Australian Government's Aged Care Program.

Catholic Health Australia (CHA) is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities, and related organisations and services.

The sector comprises providers of the highest quality care in a network of services ranging from acute care to community based services. These services have been developed throughout the course of Australia's development in response to community needs. The service providers carry on centuries-old traditions of bringing Christ's healing ministry to those who suffer – the ill, the disabled, the elderly, the disadvantaged, the marginalised, the poor, serving those that others with a profit motive do not. The services return the benefits derived from their businesses to their services and to the community; they do not operate for profit; they are church and charitable organizations.

The Catholic health and aged care ministry is broad, encompassing many aspects of human services. Services cover aged care, disability services, family services, paediatric, children and youth services, mental health services, palliative care, alcohol and drug services, veterans' health, primary care, acute care, non acute care, step down transitional, rehabilitation, diagnostics, preventive public health, medical and bioethics research institutes.

The Catholic health and aged care sector encompasses:

- 19,000 residential aged care beds
- 5393 independent living and retirement units
- 5,700 Community Care Packages (CACP & EACH) and thousands of people assisted through the Home and Community Care Program (HACC) and other community care support

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The Catholic health, aged and community care sector

Catholic Health Australia Incorporated

ABN 30 351 500 103

- 65 hospitals
- 8,500 hospital beds
- 46 privately funded hospitals
- 19 publicly funded hospitals
- 7 teaching hospitals
- 8 dedicated hospices and palliative care services
- 17 rural and regional hospitals
- 157 rural and regional aged care services

The key areas of regulatory concern for Catholic aged care include the following matters:

1. The Conditional Adjustment Payment (CAP) financial reporting requirements requires Approved Providers to prepare General Purpose financial statements segmented for their residential aged care component and to prepare them as if they are a reporting entity regardless as to whether they are.

CHA supports the need for residents, prospective residents and their families to have access to the financial performance of the residential aged care facility they relate to. The Aged Care Act already allows for residents to have access to this information.

The concern is that these CAP requirements are adding extra cost and administration to residential aged care with little prospect of any gain in meaningful and useful information for consumers.

2. The Building quality Certification procedure in addition to the Building Code of Australia standards is no longer serving a purpose. The required privacy and space minimums for new residential aged care facilities can be mandated without the need for a certification inspection and the associated application and fee process as is the case now.

3. The aged care approved place allocation procedure via the annual Aged Care Allocation Round (ACAR) is a regulatory model whose purpose of controlling Commonwealth outlays can be achieved in another way, via the Aged Care Assessment Team (ACAT) gate-keeping role.

The allocation process has changed in recent years towards allocating through the annual ACAR, larger numbers of places to successful provider applicants for new services.

It would seem the goal is that where the service is a new one, the number of places allocated needs to be sufficient to make the service financially viable from the start. Up to 100 bed places can be allocated in these instances. An additional 100 beds coming on stream in a location can impact on the vacancy level for the remaining facilities in the same location. This can be further exacerbated when at the same time in the same location CACPs and Each packages are also allocated.

The distribution of new residential places in accordance with the planning ratios of 40 High care and 48 Low care beds per thousand people aged 70 plus does not meet the existing demand for that split of High/Low care. Continuing this planning ratio when over sixty five per cent of all residential places are occupied by High care residents does not meet the needs of consumers.

4. The quality framework in residential aged care includes the requirement that each approved residential service be accredited by the Australian Government owned Aged Care Standards and Accreditation Agency (Agency).

There are four accreditation standards covering 44 Expected Outcomes. It is these Outcomes against which the accreditation assessors rate each service as Compliant or Non Compliant.

The four accreditation standards are:

1. Management Systems, Staffing and Organisational development;

2. Health and Personal Care;

3. Resident Lifestyle; and

4. Physical environment and Safe Systems.

CHA contends that the Agency's compliance monitoring function, now performed through its accreditation role, should be achieved by confining itself to rating services as compliant or non compliant on the Expected Outcomes only in Standards 2 and 3. This would reduce the number of Expected Outcomes from 44 to 27.

Also this compliance monitoring function should be a cost to Government with Approved Providers bearing the cost of accreditation against appropriate ISO standards from generic accrediting (certifying) bodies.

5. The professional certification and licensing of nursing staff by State and Territory jurisdictions creates a lack of uniformity for aged care. A uniform national approach is needed particularly with respect to the enhanced role of Enrolled Nurses with respect to medication administration.

6. Workers' compensation requirements vary from jurisdiction to jurisdiction. A national workers' compensation scheme would be better suited to a national program such as aged care than the current variable arrangements.

The aged care program has a tight regulatory regime that controls the numbers of places allocated, when they are allocated, where they are located and controls the income of the approved providers. The operating income is subject to uniform controls across Australia but the operating

environments are not uniform when they are subject to varying jurisdictional requirements. Under these circumstances quality of care can easily become the principal variable between regulated income and unregulated expenditure.

Catholic Health Australia would welcome the opportunity to participate in policy planning processes aimed at amending, reducing or eliminating regulations that impact adversely on approved aged care services and the frail aged consumers of these services.

Yours sincerely

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