LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

AGED CARE SYSTEM GOVERNANCE, MARKET MANAGEMENT, ROLES AND RESPONSIBILITIES

Submission, 13 July 2020

A strong voice and a helping hand for all providers of age services

Leading Age Services Australia

Leading Age Services Australia (LASA) is a national association for all providers of age services across residential care, home care and retirement living/seniors housing. Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion – always.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. 55% of our Members are not-for-profit, 37% are for-profit providers and 8% of our Members are government providers. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

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What is system governance?

Governance is a widely used term with a long history.

A very simple definition of governance is the process of steering (with the word itself being derived from the Greek word for the steersman of a ship). Arguably governance is most commonly currently understood in the context of corporate/organisational governance, with clinical governance being a particular subset of that broader idea. The Governance Institute of Australia offers some common definitions of governance in that organisational context:

> Governance encompasses the system by which an organisation is controlled and operates, and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements of governance.[1]

LASA is not aware of any well-established framework for applying or even defining the idea of 'system governance' in the context of human services. A quick review of the academic literature reveals some work that attempts to develop the idea of health system governance. Abimbola et al[2] identifies three approaches to framing health system governance in the broader literature:

1. a government centred approach
2. a building block approach that focuses on the inner workings of health care organisations; and
3. an institutional approach that looks more broadly at how rules governing social and economic interactions are made, changed, monitored and enforced.

LASA prefers the third of these approaches because it takes a more holistic interpretation of system governance, recognising that governance is includes both (1) institutions and their structures and (2) norms that express the values and ethics of the system and inform the behaviours of actors within the system's governance.

Three levels of governance

The governance of the aged care system is complex, so to provide some structure, this submission deals with the aged care system at three different levels. At the macro level governance is undertaken by the federal government. The aged care system represents a meso level of governance and at the micro-level of aged care providers' organisational governance exerts control.

Macro level of governance

At the macro level the Australian Parliament as the law maker, and the Minister of Aged Care and Senior Australians are at apex of the governance hierarchy. Below Parliament and Minister the governance system then consists of a network of government bodies, agencies and entities enacting laws, policies, accountabilities, processes, and procedures. Government agencies acting as data custodians provide information to inform this process. Other governance systems such as for health care and social care, both at state and federal levels influence the wellbeing and health of older Australians and thus also affect the aged care system. Australians, with their voice as citizens, voters and partial payers of services influence government policy on aged care. The governance system of

[1] https://web.governanceinstitute.com.au/resources/what-is-governance/

[2] Abimola, S., Negin, J, Martiniuk, A.L. & Jan, S. 2017 Institutional analysis of health system governance. *Health Policy and Planning,* 32 pp. 1337-1344.

the federal government interacts with service providers by providing oversight and funding, directing and regulating the delivery of aged care.

Meso-level of governance

The aged care system is comprised of a collection of organisations. This includes a diverse range of service provider organisations. Providers interact with the federal government-based governance system directly, such as with the regulator, or indirectly via their chosen representatives, such as peak bodies. Aged care providers interact with the state and federal health services when acting as agents for care recipients in seeking access to primary or tertiary health care. Older Australians and their significant others, as consumers and partial funders of services received, deliver feedback to providers either via their own or their advocates' voice and/or their purchasing decisions. Providers also contribute to system governance through their peak bodies by developing and promulgating industry codes and standards.

Micro-level of governance

Service providers have their own governance systems that direct their service delivery via governing boards and policies and procedures, such as operational policies and procedures, human resource policies, continuous quality monitoring and improvement, risk management etc. These are formulated to deliver good outcomes and align with government regulation, such as the Aged Care Quality Standards and other rules and/or directions. Aged care providers are further subject to state and council regulations. LASA is of the view that the most effective governance of care delivery is at the level of the aged care organisation and its operationalization of direct care delivery. By contrast, regulatory governance constitutes a safety net level of quality only because regulation of care is only as good as its interpretation and implementation by care providers.

Current functioning of the system

As shown above, there are a number of levels of governance within the aged care system and then again within the broader health and social services systems that aged care services and aged care consumers interact with. In its functioning, aged care is less of an integrated system than a collection of diverse service provider organisations regulated by the federal government. These providers interface with a patchwork of private and government funded health and social services. The term system as an organised scheme or method with a set of principles and procedures, over endows the aged care environment with an unwarranted sheen of coordination. As a result, the governance of the aged care system while complex does not necessarily result in the integration that would be desirable for care recipients and their providers.

From a governance perspective the aged care system does not function optimally. There are a number of reasons for this, which tend to be found at all three levels of governance. One reason is that some components of the governance system, such as the National Quality Indicator Programme have been poorly designed. Further, other important systems such as those of health and social care do not meet the needs of aged care recipients and this has not received attention. Stewardship of the system has neglected the generation and analysis of data to inform system development, hampering its ability to adapt, particularly to the impending aged care needs of the baby boomer generation. The quality system is built on a regulatory approach with minimum standards, neglecting the capacity building required if quality is to be improved.

At the level of aged care providers progress on addressing sector-wide governance issues has been held back by the fact that the sector has traditionally been divided into different groups based on

size or ownership structure. The sector is being represented by at least three peak industry groups and faith related groups, again largely along the profit and not-for profit categorisation. The aged care workforce is being represented by multiple unions and professional bodies. Another body represents in the main academics involved in aged care research. There are also multiple groups representing older Australians receiving aged care, as well groups that represent particular groups of consumers.

This fragmentation has been somewhat inhibiting the sector's ability to provide leadership to the sector to consider a changed future in line with the demographic changes underway in Australia. This is a pity, because many of the smaller, freestanding providers (which can be for-profit or not-for-profit) would not have had the capacity in terms of time, skill and finance to engage with these future-directed questions, thus being most in need of sector-wide leadership. Consequently, necessary activities such as taking stock of care performance, exploring different models of care, undertaking market research to determine future directions and devising the strategies required as to how to move into the future did not occur at a system-wide level.

However, it would be wrong to say that the sector did not collaborate to exert leadership. There are various representative and discussion forums for sector stakeholders, including the Aged Care Sector Committee (ACSC) and the National Aged Care Alliance (NACA). ACSC and NACA both articulated future visions for the sector. In 2016 the ACSC devised the *Aged Care Roadmap* which presents the Aged Care Sector Committee's views on how to make the future aged care system sustainable, consumer driven and market based.[3] In 2015 NACA published its Blueprint: *Enhancing the quality of life of older people through better support and care.* NACA also publishes Issues Papers, a proposal for a new residential aged care funding model and a Position Statement to the 2019 election.[4]

NACA, as well as many other committees constituted for more narrow purposes suffer greatly from the number of organisations that participate. This high number of participants makes it difficult to pass the basic threshold of having a productive, in-depth conversation about an issue, and make it almost impossible to genuinely debate and resolve difficult and controversial issues. They are however useful to share information and seek initial feedback on issues.

The focus of this submission is to (1) elucidate the reasons why governance at the various levels is not optimally effective (2) identify steps the sector has undertaken to strengthen governance and (3) to propose further solutions.

In the sections below LASA discusses the issues and negative impacts on care recipients and providers that arise out of the governance design at the macro, meso and micro levels of the aged care system and proposes solutions. These system- level shortfalls can be categorised as following:

- Gaps in the institutional design of the aged care system
- Components of the aged care system of governance that are poorly designed
- Governance systems in health and social care do not meet needs of aged care recipients
- Lack of system stewardship

[3] https://www.health.gov.au/committees-and-groups/aged-care-sector-committee
[4] https://naca.asn.au/

LASA also includes contributions to governance the aged care sector has made via the development and introduction of Codes, Charters and professional development programs and proposes new components for inclusion in the governance system.

Proposals for governance improvements at the macro-level of government

Failure of stewardship

LASA is of the view that a succession of federal governments have failed in their stewardship of the aged care system by not giving it the consideration it requires. The federal government can achieve improvements to governance at the macro level by (1) paying more attention to the aged care system (2) pursuing better collaboration between federal and state governments in the delivery of health care and social care and (3) ensuring valid and reliable data is available as system feedback at all three levels of governance. Below LASA proposes some ways how the federal government could improve its engagement with issues pertaining to the ageing population, the aged care system and the system's interaction with health and social care.

Lack of engagement with issues pertaining to the ageing population

Political leadership

LASA strongly believes that the Minister for Aged Care and Senior Australians should be included in Cabinet. Being member of Cabinet would give the Minister a stronger voice and greater opportunity to represent the needs and expectations of the growing numbers of older Australians directly to other Ministers. This would support a discussion at ministerial level on how to understand the shift towards an ageing demographic currently underway, determine solutions, manage expectations, and reach agreement on how to enable and support the growing number of older Australians to age well. Older Australians that age well will continue to contribute our society and economy for longer. Finally, agreement has to be reached on how older Australians will be appropriately cared for and supported.

Arguably also important is greater stability in the leadership of aged care at a ministerial and departmental level as corporate memory is retained, supporting organizational learning.

Use of Delegated Instruments

Much of the introduction of new regulation of the aged care system occurs via Instruments delegated under the authority of the Aged Care Act 1997. Delegated Instruments are efficient and often justified by their facility for adjusting administrative detail without undue delay. While Delegated legislation is in principle subject to parliamentary scrutiny, very few are ever formally considered. This can be a disadvantage as some Delegated Instruments do not receive the scrutiny and debate they deserve.

The extensive use of Delegated Instruments in the regulation of aged care is demonstrated by the list in the box below:

Delegated instruments under the authority of the Aged Care Act 1997

Principles

- Accountability Principles 2014
- Allocation Principles 2014 (ACAR)
- Approval of Care Recipients Principles 2014 (Assessment and approval of recipients)
- Approved Provider Principles 2014
- Classification Principles 2014
- Committee Principles 2014 (ACFA)
- Extra Service Principles 2014
- Fees and Payments Principles 2014 (No 2) (refundable deposits and accommodation bonds)
- Grant Principles 2014
- Information Principles 2014
- Prioritised Home Care Recipients Principles 2016
- Quality of Care Principles 2014
- Records Principles 2014
- Sanctions Principles 2014
- Subsidy Principles 2014
- User Rights Principles 2014 (including Charter of Aged Care Rights).

Determinations

- Aged Care (Conditions of Allocation) Determination 2016.
- Aged Care (Subsidy, Fees and Payments) Determination 2014

LASA would prefer if primary legislation was used more often to regulate aged care and if more of the detail how the aged care system operates should be enshrined in primary legislation. The existing degree of using Delegated Instruments makes it easier for the government to change key features of the system without adequate consultation and scrutiny. A set of criteria that identifies the issues requiring primary legislation and those that can be regulated by Delegated Instrument could be developed in consultation with industry and consumer groups.

A National Strategy for Healthy Ageing as a way forward

The ageing of Australia's population arguably constitutes the biggest demographic shift since the large migrant intake after WWII. Ageing and aged care need to be recognised as the matter of national priority they are and must be addressed with a national strategy that includes governance mechanisms for accountability that actions are taken. LASA proposes that an all-of-government National Strategy for Healthy Ageing should be devised to realise the opportunities and challenges inherent in an ageing population. The National Strategy for Healthy Ageing (the Strategy) should focus on:

- Respect and rights for older Australians

- Healthy Ageing (realising a better aged care system and better integrating aged care, health care and social services across primary and tertiary systems)
- The 'silver' economy (economic opportunities arising from the provision of goods and services specifically to meet the needs of older people in Australia and beyond)

The Strategy should enunciate a broader policy on ageing, which includes everything from age services to retirement income policy, health, social housing, transport and urban planning. Within a broader healthy ageing system, the goal of age services policy should be to facilitate the provision of services that delay or prevent the onset of functional decline, and improve quality of life for those whose functional capacity is impaired. The overall aim should be to help Australians make the most of their increased longevity and ultimately make Australia the best place in the world to grow old.

Governance for the strategy could be of similar structure as the National Science and Technology Council or a National Cabinet sub-group could be set up to drive this agenda on its own or in conjunction with a Council for Healthy Ageing.

Improving health and social care for older Australians

Australia's primary care system is potentially ideally suited to support older people to maintain an optimal level of wellness. However, government policy directing funding and access to particular workforces does not support this outcome.

Further, system stewardship has been lacking by failing to ensure the aged care system and the tertiary care system interact well to the benefit of residents who have fallen ill and require hospital-based medical care. LASA proposes that action taken under a system stewardship approach could enhance acute medical care for older Australians.

Primary care

The federal government funds the primary health care system on a model that pays general practitioners (GPs) for individual patients seen. As funding for GPs remains uncapped, this gives GPs the incentive to see as many patients as possible. However, older Australians, in particular those who receive residential aged care tend to have a number of chronic health conditions, they often converse and move more slowly and conversation may be made more difficult by dementia. A funding model that financially rewards GPs for the number of patients seen may not encourage optimal primary care for older people where consultations take time. Further, this funding system may not support a GP to leave his booked practice to attend to a request to see a resident in a Residential Age Care Facility (RACF) for an urgent health condition or to visit a patient at home who is unable to get to the doctor's rooms. Telehealth promises to improve access to primary care services and LASA would be pleased if this delivery option would be strongly pursued across Australia for residential aged care and home care.

Some important primary care could be delivered by nurse practitioners (NP) specialised in aged care, palliative care or mental health. But here funding policy that severely restricts the item numbers the NP can claim for undermines aged care recipients' access to this much needed care.

Dental care is primary care by nature but the funding system does not support optimal access to dental care for older people in residential care. For example, a role for dental hygienists in addition to dentist visits should be considered to improve dental care.

The care delivered by allied health practitioners contributes much to older people retaining or regaining an optimal state of health and functioning but funding policy constraints access to this care

to a bare minimum. Often the minimum access given is insufficient to obtain the gains in function potentially possible for older people in residential care.

The primary care funding system as it pertains to older Australians receiving aged care should be reviewed. For residential care 'bundles of primary care' could be developed, using a resident casemix formula to derive the mix and amount of primary care needed by residents. Outcome measures should be taken to ascertain whether the amount of input provided improved resident outcomes.

Similarly, 'bundles of primary care services' could be developed for individual recipients of high-level home care packages.

Tertiary care

Outreach services from tertiary hospitals have been shown to be successful in many cases to retain residents in their RACF while receiving medical treatment for their condition.

Currently, funding for outreach services is ad hoc with some state public hospitals establishing these services. However, no systematic approach has been taking to establish such supports.

LASA proposes that the federal government negotiate with state governments some shared funding arrangements that will give access to these services via telehealth and/or in person to all government subsidised RACFs.

Proposals for governance improvements at the meso level of the aged care system

At the meso level, the governance of the aged care system suffers from a number of weaknesses. In the section below LASA identifies gaps in the institutional design of the aged care system and discusses governance components whose poor design hamper the sector's ability to function optimally and deliver improved care.

However, the aged care sector is undertaking steps to strengthen the governance of the aged care system to ensure, without fail, the quality of care for all care recipients.

This section also considers the potential role of a separate systems governor as proposed by the Royal Commission. While perceiving potential benefits, lack of time does not allow LASA to draw firm conclusions regarding its support for such a systems governor.

Development of industry codes

Peak bodies representing the aged care sector realise that they need to play a greater role in setting standards for excellence. Some of this work is underway.

For example, the LASA Membership Charter brings clarity of vision for our Membership and the aged care industry by articulating a set of operational principles for LASA and its Members to aspire to, whilst also providing supports to enable progress towards them.

The need for a Charter was highlighted by a desire to enable and support LASA and its Members to actively contribute to continuous improvement and accountability for quality services and outcomes, whilst also ensuring LASA can support Members. The LASA Membership Charter demonstrates leadership in and to the sector, to 'get ahead' of community expectations as noted in the Aged Care Workforce Strategy (Strategic Action 2). The Charter was endorsed by the LASA Board

and took effect on 27 October 2019. Operationalization of the Charter sees the Charter's governance and administrative arrangements being formalised in September 2020.

Building on the leadership of LASA's Membership Charter, LASA is leading the development of a Voluntary Industry Code of Practice, as proposed by the Aged Care Workforce Industry Council in Strategic Action Number 2 in the report *A matter of care*. LASA is undertaking consultation with consumers, workers, providers and other stakeholders to inform the formulation of this Code of Practice. This activity is being undertaken at LASA's expense as a contribution and commitment to sector development in response to issues identified by the Royal Commission.

In the future there could be a greater role for industry check marks to denote quality in a particular area. This could include pet friendly aged care, culturally specific care or care with an emphasis on creative activity or a focus on community engagement. Industry schemes are able to go further than regulatory arrangements because they can embody particular choices or preferences for how an issue should be addressed and monitored. Since regulatory schemes set a standard that applies to everyone they should be more conservative in the requirements that they apply. Check marks are also a way to recognise the pursuit of excellence over and above minimum regulatory requirements.

A separate system governor

The Royal Commission raises the role a separate system governor, a notion that has been put to discussion before. In 2011 the Productivity Commission (the PC) in its report *Caring for Older Australians* the PC recommends the establishment an independent regulatory agency, the Australian Aged Care Commission (AACC) as a prescribed Agency under the Financial Management and Accountability Act 1997. [5] The AACC would have a stakeholder advisory committee to provide advice to the AACC in relation to consumer and industry interests. An Aged Care Standards and Accreditation Agency (ACAA) would be established as a statutory office within the AACC with three Commissioners: a Chairperson, a Commissioner for Care Quality and a Commissioner for Complaints and reviews.

Key functions of AACC were envisaged as:

- administering the regulation of the quality of community and residential aged care;
- promoting quality care through educating providers and assisting them with compliance and continuous improvement;
- approving community and residential aged care providers;
- administering prudential regulation and all other aged care regulation;
- monitoring, reporting and assessing costs and transparently recommending a scheduled set of prices, subsidies and a rate of indexation;
- handling consumer and provider complaints and reviews; and
- providing information to stakeholders, including disseminating and collecting data and information.

The Department of Health was to retain the provision of policy advice to the Australian Government on regulatory matters, including advice on the setting of quality standards.

[5] Productivity Commission, 2011, Caring for older Australians, Recommendation 15.1

LASA observes that some the AACC's proposed very important functions put forward 19 years ago have not been implemented. Examples are the assessing of costs, a transparent process for recommending prices and the collection and dissemination of data.

Alternatively, the Royal Commission may be referring to creating an agency similar to the National Disability Insurance Agency (NDIA). LASA notes that even the NDIA is not fully responsible for the governance of the disability support system, with a separate regulator and many decisions about the system and funding made by government. The NDIA does have very wide-ranging responsibilities for the operation of the NDIS, but that is because it is in theory managing an insurance system. Legislation sets out an entitlement to support, and the NDIA implements that by deciding (subject to judicial and administrative review) whether a person is eligible, what level of support is consistent with the legislative entitlement, and the price to be paid to providers to deliver those services.

LASA does see a benefit in separating more regulatory functions from the Government and the Department of Health, including assessment of care needs. A separate system governor as was proposed by the PC may be more agile and as a prescribed Agency may have desirable independence from political processes or interference, enabling the Agency to focus on the interests of aged care recipients first and foremost. However, LASA has not had time to consider the precise institutional arrangements of a separate system governor and its interaction with other parts of the aged care system and broader healthy ageing system.

Gaps in the design of the aged care system

Evidence-based funding for aged care services

LASA strongly believes that funding policy for aged care should be based on evidence about the actual cost of care but this is not the case to date.

The Aged Care (Subsidy, Fees and Payments) Determination 2014 sets out the subsidy for residential care, respite care, various supplements etc. The Government sets the prices paid to providers. However, evidence shows that these prices are not based on the actual cost of care incurred by providers. For example, the care subsidy paid by government (also known as the Aged Care Finance Instrument) has risen by 12 per cent since 2016, while direct care costs have gone up by 21 per cent.[6]

Further, the Commonwealth Own Purpose Expenses (COPE) indexation should reflect the inflation rate for Australia generally at the same time. In 2019, the COPE indexation rate was set at approximately 1.6%. This was made alongside a drop in the Maximum Permissible Interest Rate (MPIR)[7] immediately negating this indexation gain, notwithstanding the COPE was 65 basis points below the true inflation and half the inflation of many commerce items such as food stuff (3.2%) and

[6] StewartBrown, 2020, Aged Care Financial Performance Survey, Nine month ending 31 March. https://www.stewartbrown.com.au/images/documents/StewartBrown_-_Aged_Care_Financial_Performance_Survey_Sector_March_2020.pdf

[7] The Maximum Permissible Interest Rate (MPIR) applicable to accommodation prices and to refund periods for refundable deposit balances and accommodation bond balances will decrease from 4.98% to 4.91% for the period of 1 January 2020 to 31 March 2020. https://www.health.gov.au/news/schedule-of-fees-and-charges-1-january-2020-update-to-maximum-permissible-interest-rate#:~:text=Health%20sector-,The%20Maximum%20Permissible%20Interest%20Rate%20(MPIR)%20applicable%20to%20accommodation%20prices,Rate%20remains%20unchanged%20at%203.00%25.

healthcare costs generally (3.2%). This highlights the need for decisions about indexation to be based on actual costs.

LASA observes that the Australian National Aged Care Classification (AN-ACC) currently under development (Version 1.0) does use a 'bottom-up' approach to gaining evidence about the care-related drivers of aged care costs. However, LASA is concerned about the AN-ACC because it reflects current aged care practices, delivered within the existing funding envelope, whilst the Royal Commission is also identifying unmet care needs. The AN-ACC to date does not include mechanisms for identifying gaps in care and for obtaining evidence as to the cost of delivering this care so that missing or inadequate services can be addressed.

To have funding based on data about the actual cost of care, annual costing studies should be carried out by the Independent Hospital Pricing Authority (IHPA) or another body independent from government. These studies should be published in full and the aged care sector should have the opportunity to make submissions on these studies.

LASA's detailed submission to the proposed AN-ACC can be accessed here: https://lasa.asn.au/wp-content/uploads/2019/06/20190530-LASA-submission-to-proposed-AN-ACC-funding-model-FINAL.pdf

Finally, the issue of how aged care costs will be split between government and consumers' costs requires resolution. This is a fundamental tension that having an evidence-based price paid for aged care will not remedy.

Procedural fairness

System governance needs to ensure fairness and justice for all the stakeholders participating in the system.

While LASA acknowledges the key role the Aged Care Quality and Safety commission (ACQSC) plays, there are continuing concerns with the current approach to the interpretation of the standards, that sees assessors able to make determinations on what is and is not compliant with limited review. There should be a more public and transparent process for developing and issuing interpretations of elements of the standards, just as there is with the public rulings from the ATO or ASIC.

Further, aged care providers in their dealings with the ACQSC experience lack of ready and reliable access to procedural fairness when they disagree with an assessor's appraisal of performance against the Aged Care Quality Standards.

LASA would like to see a clear pathway of opportunities for independent review of decisions taken by the ACQSC. This is of particular importance because currently findings of non-compliance cannot be disputed on their merits unless a sanction is issued. Further, from July 2020, every Commonwealth subsidised residential aged care service will have a Service Compliance Rating in the 'Find a Provider' section of the My Aged Care website. This rating is intended to inform consumers in their search for a service provider. For this reason, easy and reliable access to challenge the ACQSC's appraisal that is low cost in terms of time and money should be available to providers. This is of particular importance so providers' reputation is not damaged by a Service Compliance Rating that contains features of having been derived in a subjective way and does not fairly represent performance.

An issue that requires preparation to see procedural justice issues addressed is the planned external assessment of aged care residents' care needs. The provider and external assessor may form different views of a resident's needs. Or there may be inconsistency in assessments between assessors or regions which may systemically bias funding. There must be quick, simple and low-cost procedures for providers to challenge and review the needs assessments of residents.

Another issue providers have raised with LASA is that under the proposed AN-ACC an external body assesses potential residents to determine need/funding but the provider will not know the assessment.[8] This is unfair to the provider and prospective resident as providers are unable to assess whether they have the resources in terms of equipment, staff and expertise to provide expert care for this potential resident. They are also unable to determine whether the funding attached to the prospective resident will meet their RACF's overall financial criteria.

An independent board of governance for the Aged Care Quality and Safety Commission

A case could be made for the ACQSC to have oversight by an independent, governing board.

Currently, the ACQSC has the services of an Advisory Council only. The Aged Care Quality and Safety Commission Act 2018 specifies the functions of the Advisory Council as providing advice to the Commissioner in relation to the Commissioner's functions and/or advice to the Minister. Members to the Advisory Council are appointed by the Minister.

LASA believes that an independent board of governance could help ensure that the ACQSC benefits from a wider range of views that includes dissenting voices in discussions. The composition of the board of governance may be specified by the Aged Care Act such as to include consumer groups, service providers as well as relevant experts in care systems and their governance, evaluation of quality of care, models of care and healthy ageing, etc.

If a range of critical views is available to inform decision-making, decisions are likely to be explored in more depth. If reviewed by an independent board of governance, decisions on strategies to increase productivity with a likely negative effect on the output of the ACQSC may not have been made. An example of one such strategy is the trade-off in the quality of assessment reports that was made when computer-generated templates were introduced.

Lack of stewardship of the aged care system

Earlier in this submission LASA identified a lack of stewardship for the aged care system at the macro level of governance. This lack of stewardship is also evident at the meso level of the aged care system.

Evasion of responsibility

LASA contends that the current design of the aged care system enables some parties to the system to evade responsibility for the effects of their decisions.

Providers are concerned that the government has the power to make funding decisions but denies responsibility for the effect these decisions have on quality of services that can be delivered. Funding is not the sole driver of care quality, staff skill and morale and organisational leadership are other

[8] AHSRI AN-ACC presentation March 2019: Recommendation 15: That residential aged care facilities not be advised of the resident's exact AN-ACC class until after the person is in care. Recommendation 16: That the default payment class at entry be Class 2. Payments are retrospectively adjusted to the date of entry once the assessment is undertaken. https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/residential-aged-care-funding-reform

important factors contributing to quality, among others. However, funding is a most important enabler of quality performance. LASA believes that it is inappropriate to expect providers to effectively meet all the care needs of residents/clients if they are not funded adequately to do this. If valid and reliable outcome measures were introduced, this would enable the gaining of insight into the important causal relationship that exists between financial resourcing and care outcomes.

Further, consumers advocate for changes in the quality of services they receive and additional administrative measures to provide greater quality assurance. However, consumers are not asked to pay for any of the associated costs.

Poorly designed governance components of the aged care system

LASA is deeply concerned that design faults in important governance components, such as the National Quality Indicator Program, may hold back efforts to improve quality of care.

Measurement of quality performance

Residential care

LASA believes that effective measurement of the quality performance of aged care services and the aged care system as a whole is vital to improving quality of care and implementing broader policy reform. Reliable and valid quality measures would support a shift from the current focus on inputs to outputs achieved.

While the National Quality Indicator Program (NQIP) was started on 1 July 2019, LASA does not believe the NQIP to be the most effective way of measuring quality. The NQIP indicators are relatively narrow, are at a rudimentary stage of development (partly because they are not risk adjusted) and are costly to collect. The collection cost is important because often providers already collect similar information in ways that they have incorporated into their quality management systems, but must now consider whether to run those existing systems in parallel with NQIP or switch to a new system.

To advance improvement in the approach to quality measurement LASA conducted a Member-driven project of thought leadership to identify indicators for quality of clinical care and Quality of Life for LASA to recommend for the NQIP. A LASA Member Working Group evaluated three sets of quality of clinical care indicators and six indicator sets of Quality of Life, rating their suitability for the residential and home care sectors and for the NQIP. For clinical indicators the Working Group decided on the set developed by the Registry of Senior Australians (ROSA) as the best option. The Adult Social Care Outcomes Toolkit (ASCOT) was first choice as indicators for Quality of Life.

ROSA indicators of care quality in residential care

LASA believes that the work being undertaken by Registry for Senior Australians (ROSA)[9] at the South Australian Health and Medical Research Institute which uses administrative data to measure quality should be the preferred approach to measuring clinical quality outcomes. The system developed by ROSA is risk adjusted, comes with little cost to providers to collect data and only a small cost to government, and is less vulnerable to perverse incentives than self-collected data. Since it is based on administrative data new indicators can be added or adjustments can be made with relatively little cost.

[9] https://rosaresearch.org/ In May 2020 Associate Professor Maria Inacio, Director of ROSA, received a NHMRC Investigator Grant to investigate a better way to monitor and deliver safe and quality aged care services to older people.

LASA reiterates that the risk adjustment of quality indicators is essential to the success of any program of quality measurement. If the NQIP indicators are to truly represent a RACF's quality of care performance, then the indicators need to be adjusted to the profile of the RACF's resident mix. This is of particular importance for small, freestanding providers whose resident mix can skew their quality outcomes due to their low resident numbers. For example, a Member who owns a small, freestanding RACF reported to have nine residents receiving palliative care, which amounted to almost 12 per cent of all residents. The high percentage of residents receiving palliative care may skew a specific quality outcome measure, such as unplanned weight loss. This could make the provider's performance look poor when in fact outcomes may be good or excellent considering the fairly large cohort of residents receiving palliative care. Larger providers are more insulated from specific resident cohorts affecting overall quality outcomes as large numbers of residents act to dilute this effect. Thus, the quality performance of providers with small resident numbers may be misrepresented by the NQIP.

LASA is concerned that the lack of risk adjustment resulting in (1) the potential misrepresentation of small providers' care performance and (2) making impossible a comparison of quality outcomes across RACFS will undermine providers' commitment to the NQIP. This would be a lamentable, missed opportunity to put well-working structures into place to support the quality performance of the residential aged care sector. Meanwhile, scientists at ROSA have been developing ways to risk adjust measures of quality outcomes in residential aged care, yet the Department of Health does not avail itself to this expertise.

Measurement of quality- home care

The governance design of the current home care system is heavily focused on inputs both in terms of looking at quality and financing. In a home care environment the goal is to assist people to live longer at home, yet this outcome is not being measured. A proposed metric may be length of tenure in a Home Care Package (HCP) as this outcome is considered to be largely driven by the quality of a provider's care management rather than the number of hours of service delivered. Length of tenure in a HCP could be risk adjusted, measured at a systems level, using administrative data.

Clinical outcomes are only one important dimension of aged care, just as important is the quality of life care recipients experience. LASA believes that the measurement of clinical outcomes should be supplemented by indicators of quality of life and broader system performance.

Adult Social Care Outcomes Toolkit

The Adult Social Care Outcomes Toolkit (ASCOT) measures the impact of social care delivered on consumers' quality of life. The ASCOT can be used across residential and home care. It has well an established set of indicators and is being used in Australia by some aged care providers. Because the ASCOT measures eight broad quality of life domains, service delivery is unlikely to focus unduly on measurement points. As changes in the ASCOT domains tend not to occur quickly, providers report that they collect data annually. The ASCOT has some disadvantages that will require trading-off against the positives. The cost of system-wide implementation is likely to be significant for government and providers. Data collection is likely to be reasonably time intensive. Staff will require training in administering the ASCOT, in particular when administering it to people with dementia. Management and front-line staff will need training in the interpretation of results. However, LASA has heard from Members who use the ASCOT that staff experience learning its results as highly motivating because the measurements demonstrate the impact of staff's efforts at delivering person-centred care.

Lastly, as outcome measures are developed further as a system governance tool, attention needs to be paid to the measurement of quality of care received by special needs groups, including remote, regional, CALD and indigenous care recipients.

Governance improvements at the micro level of the aged care system

The aged care sector has experienced over a decade of disruption in funding, clinical requirements and legislative changes amidst a background of changing consumer needs and expectations. LASA believes that aged care providers' leadership and governance practices need to reflect this changed environment and has taken a professional development approach to assist the sector to meet these challenges.

Governance training

In 2019, LASA responded to the deficiencies in providers' governance the Royal Commission identified at the micro level of aged care by partnering with the Governance Institute of Australia to deliver a national series of workshops tailored for the aged care sector. These workshops which continue to be delivered throughout 2020 aim to equip anyone responsible for operational governance in aged care including directors, company secretaries, risk-managers and other senior and mid-level managers**,** with the insights, tools and questions to refine and strengthen their organisational governance. Governance training addressing the specific needs of Bush Nursing Boards and Committees is available as part of this program

LASA's Leadership Professional Development Program has been developed to give employees and others in the sector the opportunity to enhance their skills and knowledge, with the option to also work towards a formal Diploma of Leadership and Management.

Recognising that the aged care sector needs to focus on attracting and developing young talent, LASA instituted NEXT GEN that targets all young professionals, current leaders, emerging leaders and Board Directors in aged care. Promoting best practice in leadership development, this national initiative is designed to attract the best and brightest young leaders and professionals to steer the age services industry through a period of unprecedented growth and change and into the future. Key projects include:

- developing an emerging leader's strategy
- a young leader's national network
- a mentoring program

LASA is currently undertaking the development of a clinical governance training program which expected to be available by August this year. This program will be accessible via information technology.

Care recipients' contribution to providers' governance

LASA believes that consumers should be involved in the governance of aged care providers.

Many providers of residential care have residents' groups or committees of residents and their significant-others who meet to discuss any issues affecting residents living in aged care facilities. By participating in meetings, residents and their significant others can make decisions about issues affecting the residents' quality of life, comment on the care and services provided and make informed decisions and choices. Meetings also provide an opportunity to express complaints and

grievances. It is a responsibility of the management to communicate and consult with the committee members about care and services.

However, while many providers of residential care have put formal mechanisms in place that enable residents to participate in governance, LASA agrees that the facilitation of resident voice could be further developed and refined in the sector. The governance of home care services would also benefit from a formal inclusion of consumer voice.

Market management and commissioning

The Royal Commission asks about the role of market management and commissioning in system governance, as well as when the system governor should intervene in the market. These questions cut very close to broader issues of system design.

Notably the Commission does not ask about direct government provision of services, this being a further alternative to both the market management and commissioning models.

LASA broadly supports the existing approach to service provision in home care packages and residential care where non-government service providers are accredited to deliver a service, and service recipients are given a subsidy based on their level of need and their ability to contribute to the cost their care to access services from these accredited providers.

Below LASA discusses a selection of market management issues that should be addressed to make the aged care system more responsive to older Australians' assessed care needs and the delivery of services sustainable for providers.

Number of places

LASA disagrees with government capping the number of places, both overall and in different programs. This is a mechanism for containing the fiscal cost and puts fiscal considerations before the care needs of older Australians. The Legislated Review of Aged Care (Tune Review) in 2017 recommended that this device for the rationing of care for older Australians be abandoned and the caps be lifted. A fairer alternative approach would be to provide services aligned to assessed need based on agreed eligibility criteria and agree the level of co-contributions expected from individuals receiving services as a mechanism for managing the cost of government subsidies.

Subsidy and indexation rates

LASA disagrees with the current determination of subsidy and indexation rates being primarily a matter of discretionary policy for the executive government. LASA believes that subsidies should be based on the measured cost of achieving acceptable levels of care for older people based on need and other cost drivers beyond the control of providers. As mentioned before in this submission, indexation should in turn be based on measured changes in cost.

Allocation of places

LASA disagrees with the current approach to the allocation of residential care places by location through the ACAR – but as discussed in our submission to the Tune review[10] – unwinding the ACAR needs to be done carefully and has various unmet preconditions, particularly around the maintenance of service to vulnerable groups.

[10] https://lasa.asn.au/wp-content/uploads/2018/01/17-12-23-FINAL-Submission-to-government-on-Tune-report.pdf

Price regulation

LASA disagrees with the level of price regulation. In residential care, there should be more flexibility for residential care providers to charge higher fees. The current model of requiring services to demonstrate that services delivered are additional to the care and services specified in regulation is problematic as those services are not clearly defined. A better approach is likely to be the Tune Review recommendation of price flexibility up to cap, and thereafter subject to review by the Pricing Commissioner. This would mirror current arrangements for accommodation pricing.

Security of tenure

Security of tenure rules are a crucial intervention in the market because they prevent contracts for service from being broken when they are no longer working for one of the parties. At one level this gives important protection for older people and limits cherry-picking of only the most profitable clients. On the other hand, it leads to the continuation of arrangements that are not working. It also causes problems when providers need legitimately to change the terms of which they offer a service because their own circumstances have changed (e.g. rising costs).

Quality regulation

Regulation of aged care quality in addition to broader consumer regulation is understandable for a sector dealing with a very vulnerable client group. One of the oddities in aged care regulation is that – unlike most forms of product regulation – the rules are linked to whether or not a service is receiving a subsidy from government rather than the nature of the services that they are providing.

While LASA sees a key role for the ACQSC we have concern with the current approach for the interpretation of the standards, that sees them able to make determinations on what is and is not compliant with limited review, often in subjective ways.[11] There should be a more public and transparent process for developing and issuing interpretations of elements of the standards, just as there is with the public rulings from the ATO or ASIC.

LASA also sees a much greater role for non-government organisations, including peak bodies, in setting industry standards that go beyond the baseline set by the regulator.[12]

Navigation and consumer support

There is a role for additional support for older people in understanding and making decisions about their care, but appropriate accountability for the services provided here is important. Some issues with referral type services have arisen and these are discussed in the next section below.

Current issues with commissioning in aged care

Commissioning means the government (or their agents e.g.: Primary Health Networks) contracting the provider or providers of a service directly. The main current use for commissioning is for the government to procure Commonwealth Home Support Programme (CHSP) services. Commissioning arrangements also allow local health authorities to procure transition care arrangements from chosen partners. In LASA's view these arrangements have not been entirely successful with the Department of Health not managing perceived conflicts of interest. Commissioning arrangements

[11] Also see this submission under the heading: *Procedural fairness.*
[12] Also see this submission under the heading: *Development of industry codes*

need to include mechanisms for the rectification of issues in the early stage contracting to deal with any unintended impacts.

LASA has heard of Member concerns about problematic commissioning approaches for the establishment of the Regional Assessment Services (RAS) where CHSP providers were contracted to deliver the RAS. LASA Members perceive that the conflict of interest between an organisation's assessment and service provision functions are not being managed by the Department of Health. LASA has repeatedly engaged the Department of Health about these concerns but did not get any resolution and these arrangements are still in place.

LASA also referenced this matter in its submission: Streamlined Consumer Assessment for Aged Care:

> LASA Members have strongly argued that a clear demarcation between providers of aged care services and assessment services should be put in place. Currently a large number of RAS assessments are conducted by organisations also providing aged care services. LASA is of the view that the delivery of assessment services by care providers constitutes a conflict of interest. Assessors employed by aged care providers may refer people they assess for services to their employer for service delivery. Such activity would distort the operation of a competitive market where price and quality of offering should influence a person's choice of provider rather than the assessor's employment affiliations. [13]

Other options

Moving forward, we would see a primary role for commissioning as procuring services to meet the needs of consumers in vulnerable groups that are not being adequately addressed through mainstream funding mechanisms, or to deliver minimum geographic access to services in thin markets.

Primary Health Networks (PHNs) and local health authorities may also have a role in commissioning arrangements to ensure that particular types of services, or services for particular groups are available at a local level. This can be informed by the Population Health Plans conducted by PHNs at regional scales.

LASA does not support the broader commissioning approach used in many other countries where local authorities are primarily responsible for commissioning all aged care services in their area. Without being hampered by the jurisdictional issues of Australia's health care system, countries with a national system do benefit from the drivers of collaboration and innovation that can be part of the commissioning approach. However, due to the division of Australia's federal structure determining the division of health care delivery, commissioning could only be considered following wholesale reform to primary, acute and social care systems. Such a reform has been undertaken in New Zealand by the Canterbury Integration Model of Care in a long, sustained and successful process aimed at reducing avoidable hospital admissions and to support peoples' health in the community. However, New Zealand health boards have under their umbrella social care and this existence of a single health and social care budget has been an enabler for change.[14] In Australia, PHNs offer the best structure to use commissioning and to learn about what does and does not work within jurisdictional structures.

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[13] https://lasa.asn.au/wp-content/uploads/2019/02/Streamlined-consumer-assessment-FINAL.pdf

[14] https://www.hsj.co.uk/opinion/canterbury-tale-making-a-success-of-integrated-care/5063073.article#

Local vs national governance

The Royal Commission asked about local versus national roles for system governing bodies. While LASA sees a potential role for local authorities in coordinating services, monitoring the availability of services, and potentially commissioning services to fill gaps where services are not adequately available. LASA does not see a major role for governance of the aged care system at a local community level.