



Promoting opportunities. Protecting rights. For older Victorians.

## COTA Victoria and Seniors Rights Victoria

### *Submission on Exposure Draft for New Aged Care Act*

**To:**

Department of Health and Aged Care

Canberra ACT 2600

Via email to: [AgedCareLegislativeReform@Health.gov.au](mailto:AgedCareLegislativeReform@Health.gov.au)

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## 1. About Us

Council on the Ageing (COTA) Victoria is the leading not-for-profit organisation representing the interests and rights of people aged over 50 in Victoria. For over 70 years, we have led government, corporate, and community thinking about the positive aspects of ageing.

Today, our focus is on promoting opportunities for and protecting the legal rights of people 50+. We value ageing and embrace its opportunities for personal growth, contribution, and self-expression.

In addition to our policy advocacy role on aged care issues, COTA Victoria plays an active role in the funded aged care system through delivery of the Care Finders program and in Sector Support and Development for the Commonwealth Home Care Support program.

Seniors Rights Victoria (SRV) is the key statewide service dedicated to advancing the rights of older people and the early intervention in, and prevention of, elder abuse in our community. A team of experienced advocates, lawyers, and social workers provide free information, advice, referral, legal casework, and support to older people who are experiencing or at risk of abuse.

## 2. Overview of submission

COTA Victoria has a vital responsibility to our stakeholders to help ensure the new Act responds effectively to the Aged Care system in Victoria – characterised by a high proportion of public sector residential care, a large number of private-for-profit providers, and the departure of many local government providers from delivery roles. This highlights the need for a framework that drives quality delivery across an increasingly diverse provider market.

Overall, we are pleased to see the draft legislation responding to the changing landscape for service delivery, putting older people's rights and contemporary expectations of quality at the centre of the regulatory framework. We appreciate the effort to respond to our earlier concerns about the structure of the Act and the design of several significant new elements. There is, however, further work to be done to realise a fully workable Act that is understandable to, and meets the expectations of, its key stakeholders: vulnerable older Australians in all their diversity. This must include making the legislation itself clearer and easier to understand and navigate.

This submission is based on an internal staff review and input from COTA Victoria members with expertise and personal experience in aged care, building on our submission to Consultation Paper 1. We have not sought to duplicate wider consumer consultation by COTA Australia and the Older Persons Action Network (OPAN) but have liaised with these bodies and broadly support their views.

We focus our feedback on potential to strengthen the way the Act drives a system that gives older people optimal choice and control while protecting them from abuse. In addition to suggestions for improving clarity and comprehensiveness of particular provisions, we offer ideas to improve the design of arrangements for supported decision-making and older persons' input to system planning and review.

We make a total of 45 specific recommendations for consideration under eight discrete thematic areas, detailed within.

### 3. Key issues and recommendations

Our remaining concerns and associated recommendations for further development and refinement are as follows. The Exposure Draft for the new Aged Care Act is referred to here as “the Draft” while the term “Aged Care” denotes the system of Commonwealth-funded aged care services.

#### 3.1 Driving reorientation of the aged care system

We are pleased to see reference to Aged Care supporting older people’s active participation in the community but would like to see this reinforced. As the balance of the system shifts to home and community-based care, the new Act needs to drive and empower the system to orient itself more to supporting older people to live their best lives as active citizens — similar to the goals of the NDIS — not only to provide narrowly defined, deficit-based care. This must apply in all care settings. This positive approach to the goals of Aged Care needs to be emphasised wherever possible, including the Explanatory Memorandum.

Use of different language to refer to recipients of Aged Care would assist in this shift. Consistent reference to the person accessing services as a “participant” — the term broadly preferred by older people in earlier consultation — would be clearer and convey the sense of an active, engaged consumer, noting the desire to avoid terms like “service user” or “client.” The Draft can be confusing when it refers to the service user simply as “the individual” especially where this is meant in distinction to another category of person.

We welcome references to the system achieving “integrated care” and “continuity of care” yet this remains vague. Greater clarity is needed to avoid the risk that critical service interfaces remain problematic, and that Aged Care is managed as a stand-alone system rather than an integral part of a broader health and social care system, including the crucial role of informal carers.

COTA Victoria believes the Act should be explicit that a key function of Aged Care is to provide disability supports to people over 65 (and those under 65 who may qualify for Aged Care) **whether or not they are also participants in the NDIS** – reflecting the shared and reciprocal commitment emerging from the recent NDIS review. Merely noting people with disabilities as a category of Aged Care user (as in s22(4)(j)) is inadequate.

#### Recommendations

1. Replace the term “individual” with “participant” or similar to refer to the person receiving Aged Care services. A person seeking access to Aged Care could be referred to as a person seeking to become a participant or being assessed for participation. These terms should be included in the Definitions at s7.
2. Expand and explain references to “integrated care” and “continuity of care” in the Objects (s5) to emphasise the aim of streamlining system interfaces and ensuring aged care is complementary to other health, disability, and social support services.
3. State explicitly in the Objects (s5) that the Aged Care system has a key function to

provide disability supports to people over 65 (and people under 65 who qualify for Aged Care). The need for disability supports, regardless of the association with ageing, should be an explicit reason for people over 65 years entering the Aged Care system (Chapter 2). It should also be clearly stated being a NDIS participant does not preclude access to Aged Care.

4. Bring carer recognition more strongly into the Act by reference to the *Carer Recognition Act 2010*, with more explicit inclusion of informal carers in key areas such as appointment of Supporters and Representatives, complaints, and whistleblower protections (add to s7 Definitions).
5. Amend language that suggests a predominantly medical or deficit model – such as the term “sickness” which is defined in the Draft as including infirmity, illness, disease, incapacity, or impairment – notwithstanding Constitutional constraints in respect of the foundations of the Aged Care system (s7 Definitions and s8(6)).

### 3.2 Putting older people at the centre of the system

We appreciate the commitment to focus regulation of Aged Care on older people themselves. The critical role of the Statement of Rights in achieving this is addressed below. There are several other ways in which the Draft demonstrates this commitment.

- i. A critical issue is the individual’s **participation in service planning**. The concept of co-design or co-production is missing from the Draft. In the section dealing with assessment at s44(2), for example, the Draft talks about “discussion with the individual” and the individual “being informed of the outcome” of the application, but falls short of committing to a fully engaged, mutually determined planning process. This should be strengthened in line with contemporary best practice in health and social care.
- ii. Another key issue is the promotion of **supported decision-making** throughout the system. While this concept implicitly underpins proposed nominee provisions (see below) it is disappointing not to see it named and referred to more widely. It should be a discrete element of the Objects (rather than the oblique reference currently at 5(f)) and commitment made to referencing a recognised endorsed framework or model (such as proposed by the Disability Royal Commission) in the rules. Supported decision-making must encompass co-determinative and cooperative processes appropriate to First Nations and other culturally diverse groups.
- iii. The commitment to strengthen the **complaints system** is welcomed. We note the proposal for a Complaints Commissioner appointed by the Quality and Safety Commissioner, with all powers for complaints delegated to this officer. While we would have preferred to see a fully independent office as the Royal Commission recommended, our main concern is that this role provides a single high-profile point of responsibility for complaints and associated education functions, with defined reporting responsibilities to the Minister and public, as well as a clear capacity to influence proactive quality and safety improvement functions. We look forward to seeing further details of this office and accountability arrangements.

One aspect of this that should be defined is the link with the Aged Care Quality and Safety Advisory Council (s168-177). Consistent with advisory committees linked to complaints



commissioners in other systems, it would be good to see this body support and respond to the complaints function. This should involve direct two-way communication channels with the Complaints Commissioner and a stated function to advise on the effectiveness of the complaints process and the adequacy of systemic responses to complaints.

While noting wider commitments to enhance the complaints system, we strongly advocate that the Act itself articulate key aspects of this system that have been lacking to date — including early assisted negotiation, non-determinative dispute resolution, restorative justice pathways, public reporting of aggregate information about complaints and actions taken, and enhanced communication with complainants, their carers, and advocates. We highlight the multiple sources of support that individuals and carers need in relation to complaints. Consideration must be given to the role and resourcing of bodies such as COTA Victoria that are actively involved in advising older people and their families about how to pursue concerns related to aged care.

- iv. We note new **whistleblower protections** to address factors deterring older people and others from making serious complaints. This is a welcome response to current concerns. From the perspective of older people themselves, we are concerned at the absence of a clear statement that where disclosure is made on behalf of another (including by family members), then protections apply to both parties. This will be important to older people both as potential whistleblowers on behalf of their spouses and friends in care, and to aged care participants concerned not to involve family members in action that may expose them both to some form of recrimination.
- v. While it is good to see these moves to strengthen the voice of older people to address their concerns, the Act is heavily focused on dealing with problems after they have occurred. We would also like to see the Act establish an expectation that proactive mechanisms be available to **involve older people in system and service planning and review** at all levels, working in conjunction with regulators and other community partners. This must include structures at Aged Care Planning Region level, operating in close alignment with state-funded elements of the broader health and social care system.

The Aged Care Quality and Safety Advisory Council referred to above is one important mechanism for this participation. While Council membership (s173) refers to expertise in “health consumer issues”, we advocate a stronger and clearer requirement for older persons with actual system use experience to be directly represented.

### Recommendations

6. Strengthen the stated approach to individual service planning at s44(2) and elsewhere as relevant to promote a fully engaged, co-production approach involving the service participant, carers, and planners.
7. Extend the Objects at s5 to provide a stand-alone element about embedding Supported Decision Making throughout the system and define this at s7.
8. Specify that the Complaints Commissioner will have defined reporting responsibilities to the Minister and the public, and an information sharing and advice-seeking relationship with older people through structures including the Aged Care Quality and Safety

Advisory Council.

9. Ensure that the complaints system allows for the involvement and resourcing of community organisations such as existing older people’s advisory bodies in supporting individuals and families to make complaints and in educating the community.
10. Clarify the whistleblower protections at Part 5 to ensure that where a disclosure is made on behalf of another (including by family members) then protections apply to both parties.
11. Establish an expectation that mechanisms be available to involve older people proactively in system and service regulation, planning, and review at all levels (see also Principles below.)
12. Amend the proposed membership of the Aged Care Quality and Safety Advisory Council at s173 to include a clearer requirement for older persons with actual system use experience to be directly represented.

### 3.3 Statement of Rights

COTA Victoria appreciates the effort to streamline the Statement of Rights and organise this under sub-headings. We are pleased to see several elements not previously emphasised, including dignity of risk, modes of communications, and right to express opinions about service provision. The redrafting goes some way to resolving our earlier concerns that combining basic rights (e.g. 4a freedom from all forms of violence) with more procedural rights (e.g. 9a right to make complaints using an accessible mechanism) may dilute the focus on fundamental human rights while raising unrealistic expectations that operational matters will be treated as absolute rights.

There remains a confusion, however, between these Aged Care Rights and key human rights commitments referenced in the Objects. This could be addressed by a preamble that states that this Statement is to be understood as rights to be exercised by Aged Care participants (at all stages of engagement), interpreted in reference to key human rights statements and intended to underpin all operational arrangements including funding decisions. Breaches of human rights need to retain access to broader established pathways for recourse, while breaches of more procedural rights will be more dependent on pathways embedded in the Aged Care system itself.

An example is the “right to health” — currently missing from the Statement. This should be included, reflecting the definition in the International Covenant on Economic, Social, and Cultural Rights Article 12(1), to be interpreted in the context of the health impact of the environments and services facilitated by Aged Care.

We are pleased to see the right to be “free from all forms of violence, degrading or inhumane treatment, exploitation, neglect, coercion, abuse or sexual misconduct” at 20(4)(a) but seek confirmation that the term “abuse” includes the full range of elder abuse concerns – including financial abuse – as perpetrated by anyone in the community not only by Aged Care providers.

We advocate for inclusion of a right to access home-based care as a first option, where preferred and feasible. While we recognise that this is not an absolute right, it would give people comfort

that they will not be inappropriately pressured to accept a residential care option. This would be consistent with the Principles at s22(3)(a).

We add our voice to the wide call from older people for the right to visitation from named persons of the participant's choice at all times. This links to the basic human right to free association and avoidance of social isolation. While specific circumstances (such as an epidemic) may require a visitor to follow various protocols and reasonable requirements, this should never effectively bar visitation.

The Effect of the Statement of Rights (s21) needs to indicate that reasonableness in terms of resource availability and utilisation for specific services may be a factor in application of rights but not an excuse for denial of rights. While reference is made to balancing competing or conflicting rights, this needs to be more clearly described as including the rights of other service users, care workers, and providers.

The sub-section on "Equitable access" at s20(2) usefully includes reference to palliative/end of life and dementia care but we are unsure why these are only mentioned in regard to equity rather than as a more general right. It is not clear what "equitable" actually means – is this equity with individuals not in Aged Care or only equity across those in Aged Care?

### Recommendations

13. Add a preamble to s20 making it clear that the rights in the Statement are to be interpreted with reference to the key human rights documents referred to in the Objects and elsewhere.
14. Clarify reference to "equitable access" to specific care at s 20(2) – particularly palliative care and dementia care – and, preferably, elevate this to a more general right of access to this care according to need.
15. Include a specific right to access home-based care as a first option wherever feasible and preferred by the individual, consistent with the current draft Principles at s22(3)(a).
16. Include a specific right to visitation from people of the participant's choice at all times, with any specific protocols or requirements being subject to transparent rationale and review processes, and not effectively barring visiting.
17. Amend s20(3) to include reference to "the right to the highest attainable standard physical and mental health" consistent with the International Covenant on Economic, Social and Cultural Rights article 12(1).
18. Confirm and, if necessary, clarify that the term "abuse" at 20(4)(a) includes the full range of elder abuse concerns – including psychological and financial abuse – as perpetrated by anyone in the community not only by Aged Care providers
19. Include a right to be free from restrictive practices except where required as a last resort and transparently justified in the interests of safety (as set out in s16-17).
20. Amend s21(2) to make it clear that limits on the rights may relate to reasonable constraints on resources available for specific service elements that impact on a right, and as necessary to balance competing rights of others including aged care staff and other care recipients.



21. Specify a requirement not just to make the Statement of Rights available in every service but at all key points in an individual's care pathway. This must be done in a form that is accessible and appropriate to the individual care participant, including in respect of language, disability, and diversity of identity.

### 3.4 Principles

We are pleased to see the Principles now framed more explicitly as system-focused expectations. We understand that the intention for this is to guide the design and management of the system at all levels. Yet, some elements are pitched to higher level system management, while others may be applied to persons or bodies exercising relevant powers under the Act at a more local level. The intended scope of application of these Principles needs to be explained in the Act and supporting documents.

Our other continuing overarching concern with the Principles is consistency with the Statement of Rights. Much of sub elements 22(3) and 22(4) repeat the individual/participant perspective covered in the Rights but using slightly different language. A closer matching between the two sections and/or reliance on cross-referencing would be helpful.

The need to respond to the diverse experiences and identities of participants is currently incorporated in element (4) by way of a commitment to offer accessible services "regardless of the individual's location, background and life experiences" with a long list of specific aspects included as a note. This fails to adequately address the expectation of positive, proactive effort to embed the needs of diverse older people throughout the system.

Diversity needs to be recognised as a feature of all service users not just those in particular categories. It may be preferable to separate response to diversity into its own sub-element, matching the content of the Statement of Rights, incorporating a consistent list of broad aspects of diversity that must be considered, which can be expanded in rules and elsewhere, rather than a lengthy list which will inevitably be read as exhaustive and risks a two-tiered approach with some groups seen as more deserving than others.

We note that the only statement relating to participant payments — element (10) — is very broad. We assume this will be reviewed against the forthcoming Aged Care Taskforce report on funding principles and look forward to seeing a strong commitment to "capacity to pay" reflected here.

#### Recommendations

22. Add a preamble to s22 explaining that the Principles are about system stewardship and intended to underpin the design, funding, management and accountability of services as exercised by system managers at all levels.
23. Review elements (3) and (4) which heavily duplicate the Statement of Rights to achieve a

- closer matching of language and/or streamline the sub-elements to reduce duplication.
24. Redraft element (4) to create a specific Principle about embedding a positive, proactive, and inclusive effort to address participant diversity. Rather than a supplementary note listing some broad and specific groups (but not purporting to be comprehensive) the Principle should include a set of broad aspects of diversity that must be addressed (Aboriginality, cultural and linguistic background, sexual orientation and gender identity, disability, social and financial disadvantage, geographic isolation, and traumatic life experience) with detail and examples provided elsewhere.
  25. Refine element (5) to clarify what is meant by “continuity of services” preferably to embrace both continuity of care for individuals across time and across types of aged care supports. Reference to “access to integrated services” should be focused on streamlined care and clear interfaces between different types of services. From a system management perspective, this needs to be expressed in terms of supporting the capacity of registered providers to create service linkages across service systems.
  26. Strengthen (13)(f) to better convey the commitment to active participation of older people in system design, management, monitoring, and accountability, including at different geographic levels of the system.

### 3.5 Service architecture and elements

Chapter 1, Division 2 sets out a service framework based on a “service list” incorporating Services, Service Types, Service Settings, and Service Groups, as well as “specialist aged care program” and “provider registration category”. It is unclear in the Draft what are the key distinctions between the categories and how they are intended to act as a coherent system architecture. Rather than providing definitions, the Draft merely states that the rules will prescribe what is included.

Further work is needed to present this schema in a way that stakeholders can understand and use to participate effectively in their service planning. For example, the purpose of “service type” and how it relates to specific services is not spelt out. It appears that service types have no function other than as groupings of services. This leaves it unclear as to the extent to which the types (to be specified in the rules) may be subject to expansion and amendment.

COTA Victoria has a keen interest in assistive technology, being the convenor of the national Assistive Technology for All Alliance. We are unclear how these critical services – to which the Commonwealth has committed developing a new scheme for in-home aged care – are to be accommodated in the service list. We urge this to be clearly articulated as a service type and possibly a service group.

One of the most common comments COTA Victoria receives from members about residential aged care is the inadequacy of social participation and lifestyle programs. We believe it is critical that the service list provides very explicit encouragement for improved effort in this area by naming and defining these types of activities prominently.

It would be helpful for the Act to broaden the framework to specify that funding, regulation, and oversight is also to be applied to other elements of the system including assessment, facilitation and care navigation, and independent advocacy. These should all be recognised and defined in

the Act, albeit in distinction from core aged care services. This would also help overcome current uncertainty as to status of such auxiliary services in relation to obligations and liabilities (notwithstanding the material in the draft at s127 in relation to the proposed duty on aged care digital platforms). There may be also a need to amend sections dealing with provider registration to encompass these

We note that “digital platforms” are referred to elsewhere in the Draft (s128) as a facilitation or intermediary service. We question whether it is the digital nature of such services per se that is key, as opposed to the nature of their intermediary relationship with the provision of other aged care services. There is a risk that such services are confused with other aspects of aged care that are delivered through online means.

### Recommendations

27. Incorporate relevant material in s8, or as a preamble to Chapter 1, Division 2, that explains the purpose of the key dimensions of the service list and how they relate to each other.
28. Provide an explanation as to how assistance technology supports are proposed to fit into the service list framework.
29. Enhance the profile given to social participation and lifestyle programs in residential aged care by elevating these types of activities in the service list.
30. Reconsider the use of the term “digital platform” to better represent a particular type of service access facilitation service rather than a technological mode of delivery.
31. Incorporate reference to assessment, facilitation, navigation support, and independent advocacy services to recognize their vital role in the overall system and need for appropriate funding and oversight, in distinction from core aged care services.

### 3.6 Restrictive practices

The Draft at s16-17 sets out broad risk-based conditions for the application of restrictive practices, noting this is essentially a roll-over of current arrangements. We note that arrangements for substitute decision-making on such practices are under separate discussion between the Commonwealth and States and that this will be reflected in the rules. We believe nonetheless that there is a need to reflect these arrangements in the Act itself not only in the rules.

Notwithstanding the commitment to further work, COTA Victoria is concerned that the Draft presents an inadequate response to a key issue raised in the Royal Commission and of major concern to older people. At the broadest level, it is disappointing to not see stronger signalling of an intention to work towards the elimination of restrictive practices, such as appears (for example) in the *Victorian Mental Health Act 2022*. Such a statement would be in accord with the stated intention of this Act to be “forward looking”.

The definition of a restrictive practice at s16 is extremely broad. While not wanting to overly narrow the scope, it would be helpful to specify the five key elements of restriction recognised



by the NDIS — physical/bodily, chemical, mechanical, environmental, and seclusion — to be clear what is intended. Including the limitation of any right (as defined in the Statement of Rights) as a restrictive practice per se, hence subject to these particular provisions, is far too broad and could dilute the focus and force of these provisions.

### Recommendations

32. Incorporate an explicit statement that the Act requires all involved in the system to work towards the elimination of the use of restrictive practices and to ensure that individuals have freedom from such practices.
33. Amend the definition of restrictive practices in this section to be clear that these provisions relate to those practices covered by relevant policies and protocols (preferably by reference to the five key categories of restrictive practices) rather than a much broader concept of any restriction of rights.

### 3.7 High Quality Care

While we support the broad intention, the specific purpose of this section and how it is to be operationalised remain unclear. It would be helpful to see guidance in the Act on how this term is to be applied and how it relates to “standard” or “required” care. The consultation paper describes it as “aspirational” and leaves it vague as to how accountability to the definition is to be achieved.

In so far as the Act aims to provide an overarching rationale for quality monitoring schemes like star ratings, it needs to be clear how these schemes are to work with the definition of High-Quality Care – for example, whether they are to be set against absolute benchmarks or be comparative against best practice across the sector.

An appropriate balance must be struck between having mechanisms for monitoring and promoting the extent to which services are meeting High Quality Care aspirations and avoiding a two-tiered system, in which some services put themselves forward as “high quality” (and possibly charge higher fees on this basis) rather than all services being on a continuous improvement pathway.

It is unclear whether the list at s19 is intended to be definitive or indicative. As it stands, it is pitched somewhere between a broad description of key dimensions and a more specific list of criteria or ways in which high quality might be achieved. It may be preferable to keep the list higher level, with reference to a more detailed definition or set of criteria in the rules or elsewhere that can be updated more flexibly. This applies particularly in regard to the way dimensions of client diversity are addressed (see also comment under Principles above).

We agree that it is appropriate for the definition of High Quality Care to apply across all care settings, it will be important to emphasise that residential care settings or “homes” need to focus on a range of particular elements, including the provision of meaningful social activity and community interaction opportunities. It is also surprising not to see some direct reference to food given the vital importance of this issue for older people in Aged Care.



We are unsure that “upholding rights under Statement of Rights” should be seen as high quality rather than a fundamental requirement. The inclusion of similar sounding elements of high quality care in the Statement of Rights itself adds to this confusion and circularity. Most of the elements in the definition seem quite achievable rather than highly aspirational and should be seen as reasonable expectations at least to some level. The extra “high quality” dimension would be about the extent of achievement.

A number of specific aspects of quality raised in our earlier submission remain missing and, even at a higher level of generality, should be incorporated. A key issue for COTA Victoria and SRV is the expectation that services work towards being well-equipped and trained to provide prevention, early intervention, and front-line response to situations of elder abuse that may be occurring in a client’s family or broader social network, not just that perpetrated by Aged Care providers.

### Recommendations

34. Provide a clear statement in the Act on how the description of High Quality Care is to be used and how it relates to more basic standards (particularly in regard to adherence to the Statement of Rights) and to underpin quality assessment schemes in all care settings.
35. Reconsider the purpose of the definition at s19 and clarify that it is a framework for a more detailed list of criteria to be provided elsewhere and regularly updated. Seeing the definition as supporting continuous improvement rather than an absolute set of achievements would be consistent with the fact that it is not to be the basis for prosecuting breaches of rights or statutory duties.
36. Use a more inclusive overarching description of “diversity” (as suggested in recommendation 24) and incorporate a stronger statement about embedding a positive, proactive, and inclusive approach to participant diversity.
37. Include specific reference to the capability of services to provide effective prevention, early intervention and front-line response to elder abuse that may be occurring in a client’s family or broader social network.
38. Include explicit reference to the use of communication platforms and technologies consistent with the individual’s capabilities and stated preferences, and to the provision of nutritious, varied, and culturally appropriate food.

### 3.8 Supporters and representatives

We note these issues are split in the Draft between Chapter 1, Part 4 (where roles and responsibilities are defined) and Chapter 8, Part 4 (where appointment processes are set out). This makes it difficult to gain a coherent picture of proposed arrangements. Integrating this material into one section would be preferable.

Our earlier submission raised concerns about the definition of Supporter and Representative roles, and how these will operate in conjunction with other (chiefly state-based) nominee regimes. We note that the Draft makes several helpful changes while also raising some further issues.

While endorsing the proposal for a specific nominee regime for Aged Care, we remain concerned that this element of legislation is proceeding ahead of defined administrative arrangements. We urge that further detail — beyond what is to be in the Act — be made available prior to introduction of the Bill into Parliament.

For example, the System Governor is to be responsible for appointment of nominees, but no advice is given on how this would function. Assurance is sought that the Secretary would delegate this role to appropriately qualified officer operating with effective independence at regional level and how effective protections against abuse will be put in place.

We urge recognition of the burden on older people that such a scheme creates. Significant effort will be required to provide education, training, and hands-on support. Many nominees will be older people themselves and require a range of tailored supports to carry out these roles safely and effectively. It is critical that the diversity of nominees – including ethnicity, sexuality, gender identity, regional and rural location, and disability – is recognised and respected given that these characteristics will be central to their ability to effectively support the individual in care.

With these overarching cautions in mind, we would like to raise the following issues:

- i. The Draft allows for an individual to have multiple Supporters or multiple Representatives. We agree with this but note that the Draft is unclear how arrangements for multiple nominees to act “jointly or severally” will be enacted. A statement in the Act would be helpful to avoid situations where conflict between nominees act against clear communication of decisions. The Draft does not refer to limitations on the type of decisions a particular Representative may make (as allowed, for example, in the *Victorian Medical Treatment Act 2016*). Some categorisations on the basis of areas like Financial, Legal and Medical, would be helpful in this regard and could act as a safeguard.
- ii. It is proposed that a person may not have both a Supporter and a Representative at one time. While the reasons are not spelt out in the consultation paper, we assume the idea is that if you have a Representative then the Supporter’s role in helping to communicate the person’s wishes becomes redundant. We are not convinced this is necessarily the case and cite other regimes (again for example the *Victorian Medical Treatment Act 2016*) where both types of nominees co-exist. This would make sense where there are limitations on the scope of a Representative (as above) or where a separate Supporter may provide additional advice to assist a Representative to make the best decision.
- iii. The proposal is to allow replication of nominees under other schemes. An existing Guardianship or Enduring Power of Attorney (EPOA) appointment will need to be specifically duplicated under this Act, although the Draft suggests that such a person would “almost

always” be appointed under this Act. There may be practical issues here regarding information sharing between jurisdictions and consequential action (e.g. if a state-based nominee is cancelled, should that person remain a Representative under this Act). We would like to see consideration of some form of mutual recognition, particularly where the nominee is a key body such as the Victorian Office of the Public Advocate.

- iv. A related issue concerns scope boundaries in relation to what an Aged Care Representative can do. Even with guidelines on what kind of decisions fall under the Representative role viz a viz another nominee role, it will be difficult (and unhelpful) in some circumstances for a person holding joint nominee roles to compartmentalise the decisions relevant to one regime versus another. An ability to make decisions in accordance with the interests and preferences of the individual in a more holistic way is required.
- v. We are concerned that no mention is made in the Draft about Advance Care Statements or Directives. It will be important to be clear that appointment of a Supporter or Representative may occur irrespective of whether there is an Advance Care Statement in place but if there is, then it must be provided and form a key factor in advice and decisions of the nominee.
- vi. We remain unclear as to how these nominee roles relate to support provided by Care Finders and Advocates, and to “representative” and “agent” roles under My Aged Care. These co-existence of different regimes, using similar but slightly different language, is likely to create confusion (noting that individuals receiving support under My Aged Care may or may not already be participants in the Aged Care system). Will there be an ability for representatives for My Aged Care to be appointed as ongoing Supporters or Representatives in a streamlined way in order to optimise continuity of support once the individual is receiving aged care services, including where reassessment is required? There may be a role for services acting as Agents under My Aged Care to facilitate this.

### Recommendations

- 39. Integrate material in Chapter 1, Part 4 and Chapter 8, Part 4 to facilitate a fully coherent picture of arrangements for Supporters and Representatives. This scheme should be more clearly positioned within a supported decision-making framework.
- 40. Provide further advice on administrative arrangements for operation of the Supporters and Representatives scheme — beyond what needs to be included in the Act — prior to introduction of the Bill into Parliament.
- 41. Incorporate further detail on how arrangements for multiple nominees to act “jointly or severally” will be enacted, including potential to specify limitations on the type of decisions a particular Representative may make on the basis of areas like Financial, Legal, and Medical.
- 42. Amend the Draft to enable an individual to have both a Supporter and a Representative at one time (Chapter 1, Part 4, Division 1).
- 43. Clarify arrangements for appointment of Representatives already appointed under other nominee regimes with a view to facilitating a more integrated approach. We

would also like to see consideration of some form of mutual recognition, particularly where the nominee in question is a recognised body such as the Victorian Office of the Public Advocate.

44. Specify that appointment of a Supporter or Representative may occur irrespective of whether there is an Advance Care Statement in place. If one is in place, then it must be provided and form a key factor in advice and decisions of the nominee.
45. Clarify how the proposed arrangements interface with the nominee scheme under My Aged Care and align terminology to avoid confusion. Subject to this, we recommend a process to streamline the appointment of My Aged Care representatives once the individual is receiving aged care services.