UTS Ageing Research Collaborative (UARC)

UTS

A New Aged Care Act: A Submission on the Aged Care Bill 2023 Exposure Draft and Consultation Paper No. 2

March 2024 | UTS Ageing Research Collaborative

Suggested Citation

Tsihlis, E., Woods, M., Ries, N., Somes, T., Parker, D., Debono, D., Carnemolla, P., Schofield-Georgeson, E. (2024). *A New Aged Care Act: A Submission on the Aged Care Bill 2023 Exposure Draft and Consultation Paper No. 2.* UARC, The University of Technology Sydney.

Disclaimer

The authors have used all due care and skill to ensure the material is accurate as of the date of this report. UTS and the authors do not accept responsibility for any loss that may arise by anyone relying on its contents.

Contents

1 Background

The Australian Government is committed to replacing the *Aged Care Act 1997* (Cth) with new legislation. The current Act has undergone a series of amendments and inclusions over the past two and a half decades to incorporate the many reforms that have aimed to improve the care and support delivered to older persons. However, the current Act retains a legacy approach of focussing on the responsibilities of providers.

The Government has stated that the re-write of the legislation will focus instead on ensuring that 'older people who need aged care are at the centre of the aged care system. It will provide the framework for fundamental change within the aged care sector' (Department of Health and Aged Care, 2023a, p. 6).

The University of Technology Sydney Ageing Research Collaborative (UARC) made a submission to the Department of Health and Aged Care (the Department) in September 2023 (Tsihlis et al., 2023), in response to matters raised in its Consultation Paper No. 1, *A New Aged Care Act: The Foundations* (Department of Health and Aged Care, 2023a).

Subsequently, in December last year, the Department released an Exposure Draft of its proposed Aged Care Bill 2023, which contains drafting for a number of sections of the Bill. The Exposure Draft was accompanied by *A New Aged Care Act: Exposure Draft Consultation Paper No. 2* (Department of Health and Aged Care, 2023b), which addresses much of the drafted Bill as well as commentary on the missing sections.

UARC is grateful for the opportunity to make the following submission to the Department in response to the matters raised in the Exposure Draft of the Bill and in Consultation Paper No. 2.

2 The Importance of Consultation and Orderly Implementation

While UARC welcomes the opportunity to submit feedback on the Exposure Draft of the proposed Aged Care Act, we note and express our concern that a number of sections of the proposed legislation have yet to be released for consultation and that there is insufficient information on the intended content of the many Rules proposed for the new legislative regime. We are also concerned that a hurried implementation would fail to do justice to this once in a generation opportunity to implement a new legislative regime. Each of these matters is addressed in this section.

Omissions from the Exposure Draft

One of the more significant current omissions from the Exposure Draft concerns 'Chapter 4 – Fees, payments and subsidies' and its four Parts: (1) Introduction, (2) Means testing, (3) Subsidies, and (4) Payments and fee arrangements. The commentary in the Consultation Paper on this is at best a high-level overview. The lack of some of the drafting is understandable given that there has not yet been a Government response to the Aged Care Taskforce recommendations, nor even the release of the Final Report on funding arrangements which was expected in December 2023 (Department of Health and Aged Care, 2023c).

However, the form, level and incidence of funding (public and private) are fundamental to understanding the sustainability of the aged care system in Australia. The issues include the intended call on taxpayers and older people who have significant means; the viability of providers; the ability of the sector to pay for competitive wages and improve conditions for the workforce; and community acceptance that the proposed fees, payments and subsidies are fair and equitable. Each of these matters will need close analysis and meaningful public discourse.

Funding matters aside, UARC is concerned that with less than four months until the currently announced commencement date of the Act, there are many other areas of the primary legislation flagged in the Consultation Paper that have not been included in this Exposure Draft, including:

- New critical powers for the Aged Care Quality and Safety Commission (ACQSC)
- Prioritisation and place allocation changes for funded aged care services
- Requirements surrounding personal information and record keeping
- Incident management system requirements
- Complaints management system requirements
- Financial and Prudential Standards compliance
- Provider governance conditions when delivering funded aged care services
- Providers ceasing the provision of funded aged care services
- Alternative entry arrangements into the aged care system
- Restrictive practices decision-making arrangements

In addition to the absence of many substantive sections of the primary legislation, the Consultation Paper notes that 'the Rules' which cover some of these sections have yet to be released for consultation ahead of the commencement date. The consequences of this tight timetable are compounded by the unexpected and unnecessary reliance on the proposed Rules in the new regulatory regime. These matters are explored next.

Over-Reliance on Secondary Regulation

Part 11 of the Exposure Draft, section 413(1), grants the power to the Minister to make rules by legislative instrument prescribing matters that are required or permitted by the Act or 'necessary or convenient to be prescribed for carrying out or giving effect to this Act'.

UARC recognises that there is a place for rules, such as where changes can be anticipated, but the exact detail of that change is unknown. Annual revisions to annual fees and charges are a case in point. Rules also play a role in being able to adapt to unanticipated exogenous events, such as the Covid-19 pandemic, or to respond to unintended consequences or stakeholder behaviours following the introduction of new legislation, or to address other emerging fiscal pressures. Rules can also set out detailed provisions that are clearly within the scope of an Act but may require minor adjustment and clarification over time to a degree that would not be possible if the primary legislation needed subsequent parliamentary debate and passage.

Under the Australian parliamentary system (and other Westminster models), delegated legislation such as rules and regulations lack the safeguards of deliberative democracy. Specifically, while the proposed Rules can be reviewed by parliamentary committees and subject to disallowance by Parliament, it is accepted that in practice there is limited parliamentary supervision of the myriad of rules and regulations made by authority delegated by Acts.

In UARC's view, the Exposure Draft places unnecessary reliance on rules. The term 'the Rules' is mentioned 43 times in the Consultation Paper.

In some instances, there are relevant legislative precedents that could be drawn upon. Rules can more easily be changed by the Government of the day, rather than be given more certainty in the principal Act. Some examples of where 'the Rules' are proposed to be relied on in the Exposure Draft, but merit further consideration of their appropriateness as delegated legislation, are:

- The meaning of and use of restrictive practices (sections 16 and 17)
- Other powers provided to 'supporters' of an older person and their duties (section 24(c) and section 26(d))
- Additional duties of representatives (section 30(1)(d))
- Information relating to an individual's care needs in relation to eligibility determination for an aged care needs assessment (section 40(b))
- The tools and requirements for undertaking aged care needs assessments (section 44(1))
- Audit requirements for registered entities' compliance with the Aged Care Quality Standards (section 69)
- Workforce and aged care worker screening requirements (section 91)
- What information and kinds of records must be kept and retained by registered providers (section 93)
- Provisions on the Complaints Commissioner's function of dealing with complaints or information provided to them about an entity's compliance with the Act (section 183)

As a case in point, the required processing timeframes for assessing an older person for access to Commonwealth funded aged care services has been a pain point in the system, as was highlighted during the Royal Commission into Aged Care Quality and Safety (Department of the Attorney-General, 2024). Restrictive practices decision-making arrangements are another example of this, which could also sit within the Act, possibly as an addendum to 'Chapter 1, Part 4 – Supporters and Representatives'.

In relation to complaints handling, an established legislative precedent can be found in the *Ombudsman Act 1976* (Cth), which details complaints powers of the Ombudsman. Although this Act makes references to Regulations in section 38 being able to be made by the Governor-General, it makes the point to state 'in particular, prescribing matters in connexion with fees and expenses of witnesses appearing before the Ombudsman'. References to the Private Health Insurance Ombudsman and the making of Rules for it under section 20ZJ have also not entirely limited the substantive provisions in the Act itself on its functions.

UARC looks forward to being able to respond to the consultation processes that should accompany the full provisions of the proposed Rules that will be integral to the operation of the new Aged Care Act. UARC further recommends that where possible, substantive provisions should be made within the primary legislation.

Orderly Implementation of the New Legislation

The extensive nature of these omissions, and the importance of their subject matters, have significant consequences for the timing of the introduction of the Bill into Parliament and the announced commencement date of 1 July 2024. There needs to be full and proper consultation on the Exposure Draft in its entirety, and on such Rules as have been considered necessary for the effective functioning of that legislation.

Already, the period of consultation on the incomplete Exposure Draft, absent the Rules, has been extended from 16 February to 8 March. That leaves less than four months for the Department to respond to submissions and to release and consult on drafts of the missing sections and the Rules, for the Government to finalise its position and introduce the Bill, for parliamentary consideration of the Bill, and for passage of an Act.

Once the legislative regime has been enacted, the commencement date must allow sufficient time for older people and their carers, providers, the workforce, financiers and other stakeholders to understand and prepare for the new provisions, including rolling out community education campaigns, re-writing operating manuals, introducing new administrative software, training staff, etc.

The development and passage of re-written legislation is an opportunity that only arises once in a decade or more. UARC is strongly of the view that replacement of the original *Aged Care Act 1997* (Cth) should occur when the full suite of primary and secondary legislation has been extensively debated publicly, is fit for purpose, and is sufficiently stable so that further otherwise unintended amendments are unlikely until the medium term. It is also imperative that the sector as a whole is properly prepared for the new regime. If this proves to be later than 1 July 2024, then so be it.

Indeed, as discussed in several instances in this submission, the re-writing of the Act also provides an opportunity for the Commonwealth and the states and territories to address some of the nationally inconsistent legislation that applies to matters drawn on in the aged care Exposure Draft. They include the regulation of retirement villages, nurse responsibilities and enduring guardianship and powers of attorney.

As a practical footnote to conclude this section, UARC urges the Government to commence the new legislation on 1 July of the relevant year. The financial, data collection, analytical and reporting consequences of other commencement dates would add to administrative costs and create complex breaks in longitudinal data series. While these issues may be largely transitional in the context of the longer term, they are also avoidable.

3 Refinements to the Objects of the Act and the Aged Care System

Section 5 of the Exposure Draft contains several important changes to the proposed objects that were set out in the Department's *A New Aged Care Act: The Foundations. Consultation Paper No. 1* (Consultation Paper No. 1), released for public consultation in August 2023 (Department of Health and Aged Care, 2023a). In some instances, as noted in the following discussion, the changes respond to matters raised by UARC in its submission of September 2023 to Consultation Paper No. 1 (Tsihlis et al., 2023). There remain several opportunities to refine the final set of objects.

Mitigating Adverse Impacts on the Fiscal Sustainability of the Aged Care System

Consultation Paper No. 1 proposed, as the first object of the legislation, that the Act would give effect to Australia's obligations under various international conventions, covenants and other relevant instruments under the Commonwealth's constitutional external affairs powers (section 51(xxix)) (underlining added).

UARC was critical of this approach in its submission on the grounds that the wording represented overreach of the purpose of an Aged Care Act and of the aged care system. That overreach was manifest in relation to the breadth of those instruments and could lead to 'an over-reading of the application of public funding to meeting the needs of older people' (Tsihlis et al., 2023, p. 5).

UARC further noted that:

> The sustainability of the aged care system will require aged care service subsidies to be directed to services that are targeted to older people in need, effective in meeting the objects of the aged care system, delivered efficiently, and are balanced by consumer contributions from those with significant means to reflect the personal benefits of the services they receive. (Tsihlis et al., 2023, p. 6)

UARC proposed that the wording of this first object should be amended to require that the Act operate in conjunction with other laws to give effect to Australia's obligations under the relevant instruments (underlining added). Accordingly, the new wording of Section 5(a), as set out next, is supported:

5 Objects of this Act

The objects of this Act are to:

(a) in conjunction with other laws, give effect to Australia's obligations under the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights 1 of Persons with Disabilities; ...

Establishing Objects for the Aged Care System

Consultation Paper No. 1 proposed a set of objects for the legislation, but not for the aged care system. UARC, in its submission, criticised this approach and drew attention to other legislative practices that set out the objects of the subject system, as well as the objects of the legislation itself. The wording of the introduction to section 5(b) in the Exposure Draft, which now refers to the objects that the aged care system is designed to achieve, is supported.

UARC also noted in its submission that, should this change be made, the new Act would not need to contain a Purpose Statement. Accordingly, the omission of such a statement in the Exposure Draft is also supported.

Amendments to the Scope of the Objects of the Aged Care System

The scope of the objects set out in Consultation Paper No. 1 was, in UARC's view, worthy of further consideration.

The first of UARC's concerns was that the sustainability of the aged care system was not recognised as a legitimate and foundational object of the system. This has now been rectified and, although UARC proposed a variation of the formulation of words that now appear in the Exposure Draft, it is prepared to support them to a point. The Exposure Draft wording of this newly added objective is:

> 5... (g) provide for sustainable funding arrangements for the delivery of funded aged care services by a diverse, trained and appropriately skilled workforce; …

The only remaining concern is the Department's proposal to tie the object of having a sustainable aged care system together with one that addresses the need for services to be delivered 'by a diverse, trained and appropriately skilled workforce' (section 5(g)). Each component has strong merit, but their force is individually diminished by tying them together. UARC would like to see a separate object for system sustainability and another for service delivery by a diverse, trained and appropriately skilled workforce.

This is the model adopted in the Statement of Principles (section 22). Section 22(6) commits to an aged care system that values workers and, in addition, sections 22(8) to

22(12) commit to a transparent and sustainable aged care system that represents value for money. The structuring of the objects should adopt the approach set out in the Statement of Principles at section 22.

The innovation object set out in section 5(h) of the Exposure Draft is strongly supported. Unfortunately, it is in tension with some of the complexity that has been introduced into the Exposure Draft in the approach taken by the Department to address constitutional limitations. These matters are discussed in the next section.

4 Ensuring Constitutional Authority While Not Distorting Good Policy

A Synopsis of the Current Situation and the Department's Initial Thinking on Additional Constitutional Authority

The Commonwealth has progressively taken responsibility for subsidising aged care services and for the associated regulation. The resultant Commonwealth aged care system, as referred to, for example, in sections 5(b) and 5(e) of the Exposure Draft, comprises a list of services for which funding may be payable under this Act, as prescribed in the Rules (section 8) and the related regulatory regime.

However, it is an inconvenient truth that there is no explicit constitutional authority for the Commonwealth Parliament to make laws for all matters covered by the Commonwealth aged care system. In contrast, the Commonwealth has clear authority, under section 51(xxiiiA) of the Constitution, for such matters as pharmaceutical, sickness and hospital benefits, and for medical and dental services.

To date, the Commonwealth's legislative cover for funding subsidised services regulated by the *Aged Care Act 1997* (Cth) has been limited to providers that are constitutional corporations. This power is available through section 51(xx) of the Constitution.

The Commonwealth Home Support Programme (CHSP), which includes many providers that have a wider range of non-corporation business structures, is outside the *Aged Care Act 1997* (Cth) and is limited to grant funding arrangements authorised by section 105C of the *Public Governance, Performance and Accountability Act 2013* (Cth). Under this Act, the Minister can make provision about Commonwealth grants – currently achieved through the Commonwealth Grants Rules and Guidelines.

The Government is seeking to apply the new legislation to all funding and regulation of subsidised aged care services that are within the Commonwealth aged care system, including the new Support at Home program that will, no earlier than 2027, also include elements of the current CHSP. The Department's Consultation Paper No. 1 drew attention to the Commonwealth's limited constitutional powers in developing the new Aged Care Act. In particular, the Department recognised the limitations of the 'constitutional corporations' power to be able to apply to a wider range of services and providers.

Consultation Paper No. 1 stated that a revised and expanded approach 'will support new aged care providers to enter markets where limited funded aged care services are currently available' (Department of Health and Aged Care, 2023a, p. 12). The external

affairs power was seen as a solution, specifically as it applied to treaties such as the *Convention on the Rights of Persons with Disabilities* and the *Covenant on Economic, Social and Cultural Rights*.

UARC's submission in response to Consultation Paper No. 1 noted that the *Covenant on Economic, Social and Cultural Rights* refers to the rights of everyone to having an adequate standard of living, to physical and mental health, and to education. While the Covenant makes specific references to women, children and young persons, there is no such reference to older persons – although they would be included in the generality of the rights of everyone.

Reliance on an Even Broader Set of Powers

In releasing the Exposure Draft in December 2023, the Department issued a further explanatory paper, *A New Aged Care Act: Exposure Draft. Consultation Paper No. 2* (Department of Health and Aged Care, 2023b). This latest document reveals further concerns that the Department holds in relation to the adequacy of its earlier proposed constitutional fix. Those concerns have led to particular forms of drafting in various sections of the Exposure Draft, as discussed below, as well as to the inclusion of an omnibus section 395, headed 'Constitutional limits', which brings together all possible constitutional powers seen as providing some form of legitimacy for the Commonwealth (through the System Governor – Department) to fund services that are listed as being included in the aged care system.

While the Commonwealth intends to rely in part on its corporations power, UARC notes that for the purpose of becoming a registered provider an entity must meet a range of suitability tests, but that the only corporate structure requirement is that: 'the entity has an ABN' (section 68(1)(a). This is a broader requirement than being a constitutional corporation. Accordingly, the Commonwealth's new Aged Care Act will also need to rely on the external affairs power (as foreshadowed in Consultation Paper No. 1) and as now proposed, a range of other powers, including the hospital benefits power and the power to make laws for people of any race. The application of these powers is summarised below, drawing on Consultation Paper No. 2.

Section 51(xx) Corporations

Provider registration for service groups, such as home care and short-term restorative care, is expected to rely on the corporations power for the first phase of reform.

Section 51(xxix) External affairs

This power will be one of two that are relied on for service types delivered in residential care homes, as enlivened by the *International Covenant on Economic, Social and Cultural Rights*.

The *Convention on the Rights of Persons with Disabilities* will provide the basis for the home support service group (and the future Support at Home program).

Section 51(xxiiiA) Hospital benefits

Service types delivered in a residential care home will also rely on the hospital benefits power.

UARC notes that in *Williams v Commonwealth of Australia* (2014) HCA 23, a Full Bench of the High Court gave the social welfare power (section 51(xxiiiA)) a broad and generous reading when characterising Commonwealth social welfare laws, such as those in the field of aged care. The plurality in this case reiterated the findings of a previous High Court Full Bench in *Alexandra Private Geriatric Hospital Pty Ltd v The Commonwealth* ("the Alexandra Hospital Case") [22], to say that,

> 'the concept intended by the use in [s 51(xxiiiA)] of the word 'benefits' is not confined to "a grant of money or some other commodity" and that the concept "may encompass the provision of a service or services". The Court treated this conclusion as supported, even required, by the decision in the *BMA Case*. And it was on this footing that the Court decided in the *Alexandra Hospital Case* that the payment of money to the proprietor of an approved nursing home, in respect of each qualified nursing home patient, for each day on which the patient received nursing home care in that nursing home, was provision of a "sickness and hospital benefit". As the Court pointed out [23], the benefit could be identified either as the money paid to the nursing home proprietor or as the services provided by the proprietor to the patient as the quid pro quo for the money payment made by the Commonwealth. But each description reflected the central fact that the intended ultimate beneficiary of the benefit was a particular patient: the identified patient in respect of whom a particular payment was made', per French CJ, Hayne, Kiefel, Bell, Keane JJ, at [44].

Section 51(xxvi) Special laws for the people of any race for whom it is deemed necessary

Although Consultation Paper No. 2 does not refer to the power to make laws for people of any race explicitly, it alludes to it in at least two instances. First, the Paper notes that it is not necessary for a delegate to be satisfied that a person has an ongoing need for nursing services to be able to receive service types that are delivered in a residential care home if they are an Aboriginal or Torres Strait Islander person. Second, the Paper notes that home support services to be delivered by a registered provider under the NATSIFAC (National Aboriginal and Torres Strait Islander Flexible Aged Care) program will have 'different constitutional authority' (Department of Health and Aged Care, 2023b, p. 38).

Reducing the Coherence of the Proposed Act

One overarching concern is the reliance on a number of different constitutional powers for different parts of the proposed Act. This approach is diminishing the coherence of the new legislation and is compounding its complexity. The Department itself acknowledges that compliance with constitutional constraints has required restrictions on approvals of service types or services in certain service groups and, as a result, it notes that 'this section [49] may appear quite complex' (Department of Health and Aged Care, 2023b, p. 37).

Limiting the Scope of the Aged Care System Objects

Due to the approach being taken to assert the Commonwealth's constitutional powers to make laws relating to its aged care system, certain provisions in the Exposure Draft run counter to the objects proposed for that system.

A foundation object of the aged care system under the new legislation is to assist older people to live active, self-determined and meaningful lives (section 5(b)(ii)). However, this capability and wellness approach to delivering care will be transformed in a residential care environment by subsequent sections of the proposed Act. To conform to recent interpretations of applicable constitutional powers, the Exposure Draft introduces a focus on treating sickness, thereby reverting to an earlier paradigm of medicalised aged care.

As the Consultation Paper No. 2 observes:

> The concept of a residential care home is particularly important, with service types delivered in this location relying on the hospital benefits power (see section 51(xxiiiA) of the Constitution) and the external affairs power as enlivened by the International Convention on Economic, Social and Cultural Rights (see section 51(xxix) of the Constitution) for constitutional authority. (Department of Health and Aged Care, 2023b, p. 17)

In accordance with that approach, section 48(2)(a) of the Exposure Draft has been drafted to require that a person is not eligible for residential care unless:

> (b) if the individual is not an Aboriginal or Torres Strait Islander person and the service types in the group are delivered in an approved residential care home—the individual has, by reason of sickness, a continuing need for funded aged care services (including nursing services) in those service types.

Section 7 defines sickness as meaning an infirmity, illness, disease, incapacity or impairment. While this definition could be construed in such a way as to apply to all residents, it offers a narrow, medicalised and nurse-dependant construct. The definition

of sickness should be replaced with one that is centred on supporting capability and wellness.

UARC argues that, if the Commonwealth were not constrained by reliance on the hospital benefits power of the Constitution, it could instead adopt the World Health Organization's (WHO) constitutional framing and cast aged care and support as seeking to attain and maintain, as best able, good health, where that is defined as follows: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organization, 1946). The WHO approach aligns with the proposed objects of the new Act, which embrace the opportunity to support a person's capabilities and promote wellness through living active, self-determined and meaningful lives.

Limiting the Adoption of Sound Policy Reform

A further consequence of the Exposure Draft's attempt to medicalise the aged care system is to limit the scope of the current residential care reforms.

The Royal Commission's Recommendation 25 calls for 'a new aged care program that combines the existing Commonwealth Home Support Programme, Home Care Packages Program, and Residential Aged Care Program, including Respite Care and Short-Term Restorative Care' (Royal Commission into Aged Care Quality and Safety, 2021, p. 226). In response, the then Government announced that senior Australians would have more control and flexibility to select a residential aged care provider of their choice by discontinuing the Aged Care Approvals Round (the regulated numbers of bed licences) and instead allocating packages directly to consumers from July 2024. That change is only three months away in law and has been in practice for several years.

This decision followed the Government's acceptance of the recommendations of a report into the impact of alternative models for allocating residential aged care places (Woods & Corderoy, 2020). The report recommended that places should be assigned directly to eligible consumers who would 'exercise choice and would benefit from greater provider competition and diversity of providers, services and accommodation settings' (Woods & Corderoy, 2020, p. viii).

An integral element of the recommended reforms was to amend the legislated definition of residential aged care to facilitate the delivery of subsidised full-time professional care in a more diverse range of accommodation settings (Woods & Corderoy, 2020, p. xvii). As the report argued:

> Specifically, it is suggested that consideration be given to enabling providers to offer residential aged care in seniors housing, including assisted/independent living and retirement villages, provided the residential aged care building code and accreditation requirements are met. This may start to shift current negative perceptions of residential aged care accommodation. (Woods & Corderoy, 2020, p. 152)

Contrary to this approach, the Exposure Draft is embedding a greater focus on treating a person's sickness, as discussed above. In addition, the proposed section 9(2)(b) will require that a residential care home is a place that is fitted, furnished and staffed for the purpose of providing services to persons who reside there by reason of that sickness. Unfortunately, there are several undefined terms in the Exposure Draft that have a significant bearing on whether older people will be able to exercise choice and benefit from greater provider competition and a more diverse range of preferred accommodation settings in which they will be able to receive ongoing care.

Depending on the meaning of such terms as: 'a place' (section 9(2)), 'a retirement village' (section 9(3)(b) and 'a private home' (section 9(4)(a), there is every likelihood that the Exposure Draft's revised definition of residential care will become more restrictive, not expansive as was intended by the agreed reforms.

- Is 'a place' a separate part of a hospital, health service or retirement village such as a separate floor or wing or other spatially identifiable area? Or is it the specific unit/dwelling in which the person resides, provided it is fitted, furnished and staffed to provide the required services? UARC notes that the units in many retirement villages are already being built to Class 9c building standards that apply to residential care homes.

- Is 'a retirement village' a complex of units and other buildings that is regulated under the retirement village legislation of the respective states and territories? Or is it to be defined more generically as including a range of seniors housing, social housing and independent living units that operate outside of that legislation? UARC notes that there are significant variations across the different jurisdictional regulatory regimes that will add further complexity. But the Commonwealth could also take up the opportunity to work with the states and territories to improve the national consistency of this regulation.

- Is 'a private home' to be defined as a home (unit/dwelling) that a person owns? If so, why should a person's ownership of their residence be a determining factor as to whether or not they are able to receive ongoing and complex care akin to residential care where they currently reside. UARC notes that there are many forms of ownership and tenancy across the diversity of places that older people call their private home.

The current drafting of section 67(1)(b) compounds the likely complexity of section 9 – possibly unintended. Section 67 requires that the Commissioner, when deciding whether to register a provider, must also decide whether to approve any of the provider's residential care homes. Given the potential fluidity of places in which residential care will be delivered, the section may be better drafted to separate these two functions of the Commissioner.

In recent years, the states and territories have demonstrated that there are strong medical, personal welfare and efficiency benefits from providing an increasing range of medical and other health services to people in their homes. Notably, there are no constitutional constraints on these jurisdictions in flexibly adopting such policies and programs as Hospital in the Home and End of Life packages for people wishing to die at home.

In the case of Hospital in the Home, the NSW Health website notes:

> The care received through a Hospital in the Home service is comparable with the care received in a hospital. Some of the benefits for patients include:
>
> - ability to remain in the comfort of own home
> - not having to adjust to the hospital's routine - they can eat their own food, watch TV when they want and sleep in their own bed
> - reduced risk of adverse events from hospital admission
> - family and friends can visit when it suits the patient rather than the hospital routine. (NSW Health, 2021)

In terms of palliative care, there is substantial evidence that complex intensive care (within clinical limits) is being successfully delivered to Australians, including older people and particularly when they are reaching the end of life in locations and settings other than ‘residential aged care’ as currently defined (McCaffrey et al., 2013).

Older people should be able to choose to stay at home or move into retirement villages, independent living units, serviced apartments and other innovative seniors living arrangements that have the capability of offering continuity of care in settings that reflect their needs and preferences. Many such options could enable them to benefit from personal and community networks of care and support, not only when their needs are low, but also as those care needs increase – potentially including end-of-life care in their home. Depending on the definition of the terms discussed above, the new legislation could force older people to move again if their care needs exceed those that their retirement village (or other seniors living) was legally able to provide to them in the unit/dwelling in which they currently live, even if it was built to Class 9c standards and the required level of staffing could be made available. The same would apply if their partner’s needs increased and they wished to continue living together.

Contrary to the provisions in the Exposure Draft, the Government has been turning much needed attention to reducing the institutional qualities of current residential aged care. For instance, the Commonwealth has invested in guidelines for designing residential aged care settings that are more community-like and home-like and in smaller scale (Carnemolla et al., 2021). The Exposure Draft should be drafted in a manner that acknowledges the sound policy of enabling higher care to be provided in the very home settings within the community that these recent 2023 Aged Care Design Guidelines (Seemann et al., 2023) are designed to emulate.

Given the Government's focus on care at home (and hospital at home) models, higher care models should be able to be delivered anywhere a person lives – provided that it is a safe environment in which to receive and deliver care and support. Having the option to remain at home, in a familiar environment that can be individualised and customised for an older person's aged care needs, provides the benefit of increased health-related quality of life (Carnemolla & Bridge, 2016), as well as the potential for care savings (Carnemolla & Bridge, 2019).

In summary, the proposed constitutional approach to be adopted should not erect a barrier to Australians' preferences for less institutional/congregate care settings. The new legislation should not thwart the opening-up of residential care to better respond to older persons' accommodation preferences through the abolition of aged care approval rounds and bed licences. And it should not undermine the intention of object 5(h) of the aged care system to: 'promote innovation in the Commonwealth aged care system based on research and support continuous improvement'.

Alternative Constitutional Approaches – An Agenda for the Near-Medium Term

UARC recognises that the Commonwealth is faced with few options in the immediate future to provide workable solutions to its lack of constitutional authority over its aged care system. Nonetheless, the consequent complexity and constraints on implementing good policy should be tolerated for as little time as possible.

UARC's September 2023 submission to Consultation Paper No. 1 (Tsihlis et al., 2023) discussed the value of the Government seeking a referral of powers from the states and territories under section 51(xxxvii) of the Constitution, or even some form of national uniform legislation. While each could be seen as a potential dilution of the principle of subsidiarity at the expense of greater centralism, the two options involve achieving similar co-operative federalist objectives, albeit by different federalist processes.

Mirror legislation

With mirror legislation, the Commonwealth would seek the agreement of the states and territories to co-operate on developing nationally agreed legislation, noting that they would ultimately retain control over the legislation enacted in their own jurisdiction. In the case of gun control in 1996, the Commonwealth took the lead in negotiating and drafting a National Firearms Agreement, but because gun regulation is a state power, it was necessary for all states and territories to enact the Agreement into legislation.

One potential limitation of this approach, as has been evidenced by the mirror Work Health and Safety and the Uniform Evidence Acts over the last decade or so, is that subsequent uncoordinated amendments in various states have resulted in this nationally uniform mirror legislation developing some cracks over time.

Referral of powers

The alternative is for the referral of state powers to the Commonwealth. The Constitution, at section 51(xxxvii), provides for:

> Matters referred to the Parliament of the Commonwealth by the Parliament or Parliaments of any State or States, but so that the law shall extend only to States by whose Parliaments the matter is referred, or which afterwards adopt the law.

Under this approach, the states would enact legislation referring their power over a set of legislatively specified provisions, or over aged care as a subject matter of general responsibility, in either case being otherwise outside the reach of Commonwealth power (as prescribed elsewhere under section 51), to the Commonwealth. The Commonwealth would then be able to govern that field (concurrently with the referring jurisdictions and prevailing where state law is inconsistent) until the referral legislation expires. Examples of referred powers include industrial relations (laws applying to workplaces), family law and national terrorism – while noting that Western Australia has refrained from referring its powers on various occasions.

UARC strongly recommends that the Government commit to consulting with the states and territories on the adoption of a more suitable and stable aged care constitutional solution in the near-medium term. Such a commitment would allay the concerns of many stakeholders that parts of the new Act will entrench retrograde limitations on the reforms that need to be undertaken and on the wellbeing of older Australians.

A further benefit of this approach would be the opportunity it provides for the Government to work concurrently with the states and territories to improve the national consistency of regulatory regimes that inter-relate with aged care, several of which have been referred to elsewhere in this submission.

5 Defining Quality Care

In its previous submission on the foundations of the new Aged Care Act, UARC noted that:

> Quality care is when what is delivered meets the standard associated with the purpose in an appropriate manner. This then leads to a related issue of quality care being defined as 'high' introducing the notion of a scale of high to low. UARC takes the position that quality (appropriate) care should not be described as 'high' or 'low', but rather it is an absolute, i.e. care is either appropriate and meets the criteria of quality care, or it is not. Quality care must also be safe. (Tsihlis et al., 2023, p. 14)

Contrary to UARC's view, section 19 of the Exposure Draft sets out a definition of what is required to achieve 'high quality care'. Further, section 99 makes clear that this is an aspirational target that providers should strive towards, but that achievement is not a necessary condition of registration. Specifically, section 99 of the Exposure Draft provides that it is a condition of registration for registered providers in certain categories to 'demonstrate the capability for, and commitment to, continuous improvement towards the delivery of high quality care' (underlining added).

UARC stands by its earlier position and considers that the characteristics of care, such as those listed in section 19, should not be intended as aspirational standards that are to be worked towards but are unable to be benchmarked. Rather, they should be the accepted standards of quality and safe care that must be delivered. For example, it could be argued that care which 'puts the individual first' in subsection (a) and prioritises 'the timely and responsive delivery of the service to the individual' in subsection (c)(ii) would be the expected care for every person to receive no matter the circumstances of service delivery. Rather than being considered 'high' quality care that providers should strive to achieve, these basic characteristics of quality care should be delivered to all persons and funded according to an efficient cost of that care.

Cohesion with the Strengthened Aged Care Quality Standards

Further, the *Strengthened Aged Care Quality Standards Final Draft* released in November 2023 does not use the term 'high quality care' (Department of Health and Aged Care, 2023d). In UARC's view this is significant, as the benchmark for compliance that providers are incentivised to adhere to, and continually improve on, are these specific measures. These Final Draft Standards define 'quality care' as:

Care and services that:

- keep older people safe from preventable harm
- are person-centred, provided with kindness and compassion, responding to the holistic needs of the older person and aiming to improve their wellbeing
- are inclusive, culturally safe, trauma aware and healing informed
- are effective, providing the right care to meet the older person's needs goals and preferences
- are smoothly coordinated when care is provided by the workforce, health professionals and external providers. (Department of Health and Aged Care, 2023d, p. 54)

UARC strongly supports the references throughout the Standards to providing 'quality care', not 'high quality care'. The term 'high quality care' in the Act is therefore in tension with the Standards.

A further ambiguity between high quality care and quality care has been introduced in the release of the *Strengthening Aged Care Quality Standards Guidance* consultation, which closes on 30 April 2024. In the glossary, the definition for 'quality of care' rightly matches the wording within the Standards. The definition of 'continuous improvement' also mentions that a provider 'supports the workforce to improve and innovate in providing safe and quality care and services' (Aged Care Quality and Safety Commission, 2024a, p. 8).

However, at the beginning of the guidance document for each Standard there is an introductory statement which introduces the concept of 'high quality safe care', without differentiating it from 'quality care', as follows:

> This material is not a prescriptive guide. When we assess provider conformance against the Aged Care Quality Standards we won't expect that every provider will necessarily be taking each of the described actions. The actions you take to deliver high quality safe care will depend on the circumstances of your service and the needs of the people in your care. The material in this document can be used as a guide to achieving quality care outcomes in your organisation. (Aged Care Quality and Safety Commission, 2024b, p. 3)

In each Standard, the focus on high quality care differs. In Standards 1, 2, 3, 4, 6 and 7, it is the above message, though more generally the phrase 'quality care' is used in the documents.

The guidance for *Draft Standard 5: Clinical Care* refers to high quality clinical care in some specific action points – Action 5.4 Comprehensive Care, Action 5.6 Cognitive Impairment, and Action 5.7 Palliative and End-of-life Care (Aged Care Quality and Safety Commission, 2024c). This could indicate that it is in specific contexts of clinically focused care that the notion of 'high' quality is to be delivered. For these clinical outcomes, it may be possible to achieve 'high' versus 'not high' quality care that can be measured objectively, although no further guidance on this is provided. Further, the concept of delivering clinical care that is not high quality should be unacceptable.

The WHO also uses the phrase ‘quality care’ to describe health services which should be:

- **Effective** – providing evidence-based healthcare services to those who need them;
- **Safe** – avoiding harm to people for whom the care is intended; and
- **People-centred** – providing care that responds to individual preferences, needs and values.

To realize the benefits of quality health care, health services must be:

- **Timely** – reducing waiting times and sometimes harmful delays;
- **Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;
- **Integrated** – providing care that makes available the full range of health services throughout the life course;
- **Efficient** – maximizing the benefit of available resources and avoiding waste. (World Health Organization, 2024)

Cleland et al. (2021) reviewed the literature on what defines quality of care for older people in aged care and found that:

> In Australia, quality of care has typically been measured using processes, organisational outcomes and clinical care measures, for example, pressure injuries, unplanned weight loss and use of physical restraints. Although these measures are important aspects of physical health, the use of clinical care measures fails to assess wider attributes of quality of care that might impact on an individual’s health and well-being. In 2015 the Australian government introduced consumer-directed care to improve the quality of care by providing older people and their families increased choice and flexibility about their care. (Cleland et al., 2021, p. 765)

UARC considers that achieving quality care requires more than ‘ticking the box’ as care delivered in a clinical setting. As discussed earlier, UARC considers that the *Strengthened Quality Standards* capture what is intended as being quality care in a holistic sense.

Revising Section 19 and Section 22

UARC notes that one means of overcoming the disparity between the Standards and the Act would be to import the definition of quality care from the Standards to replace the wording of section 19, and to then benchmark continuous improvement activities against the Standards. Such an approach would streamline the process whereby compliance obligations already exist and can be built upon. However, as is noted next, UARC also recognises the merit of much of the current wording of section 19 and considers that it is appropriate as a basis for defining quality care.

If the Department chooses to keep the current wording of section 19 as the definition of 'quality care', UARC suggests that the following sections be amended for clarity and consistency in the Act, including section 22 on the Statement of Principles:

- **Section 19(c)(v)** be amended to remove the words 'if they are living in an approved residential care home'. Improvements to physical and cognitive capacity are just as important in a home or community setting as in residential aged care.
- **Section 19(c)(ix)** be amended to reflect the comprehensive wording in section 19(c)(viii) that applies to partnerships with Aboriginal and Torres Strait Islander persons and incorporate the wording of section 22(4) so that it also applies to people with diverse life experiences. The revised wording would state 'implementing inclusive policies and procedures, in partnership with the needs of the individual, regardless of the individual's location, background and life experiences to ensure that accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed care is delivered to those persons at all times'. It would be expected that all members of the workforce adhere to these measures regardless of their lived experience of diversity.
- **Section 19(c)(x)** be amended to state 'bilingual aged care workers and interpreters being made available as needed by the individual', rather than 'as requested by'. Persons needing language assistance should not have to become aware of the potential availability of that help and then initiate steps to make a request.
- **Section 22(3)(d)** to be amended to remove the words 'except where it is the individual's choice to access palliative care and end-of-life care'. UARC is strongly of the view that maintaining or improving an individual's 'physical, mental, cognitive and communication capabilities to the extent possible' should remain a goal for the system to achieve if it is to be 'person centred' and allow for dignity and quality of life at all stages of a person's life.

6 Rights of Older Persons and the Significance of Consumer Choice

UARC strongly supports the rights-based, person-centred approach taken by the Exposure Draft of the proposed Act. In doing so, we wish to restate a view, made in our September 2023 submission, that older people should expect their rights to be clearly enunciated and upheld, those rights should be balanced with the rights of other individuals, and that there should be clear pathways for complaints.

UARC is concerned that, in its present iteration, the Statement of Rights as drafted in section 20 lacks the necessary force to adequately protect the human rights of older Australians. Further, the effectiveness of the Statement is diluted by the absence of any positive duty imposed on providers. At present, the approach is 'remedial' in that compliance with rights is only examined after a breach has occurred.

UARC supports the view expressed by COTA et al. (2024, p. 8) that as well as having a complaints pathway, a positive duty should be embedded in the legislation. This approach would mean that providers were under a legal duty to be proactive and ensure meaningful measures were in place to deliver rights-based care. The inclusion would require mechanisms to ensure compliance review and enforcement. Accordingly, these areas require further interrogation to determine what elements must be proven to establish a breach, what is the nature of the liability arising from the breach, and what penalties are appropriate. The legislation should include giving the relevant authority the power to perform these functions.

UARC notes that section 23 places an obligation on Government decision-makers to have regard to the Statement of Principles when exercising powers under the Act. However, the absence of any review mechanisms to challenge decisions made that do not comply with the principles is a serious omission. Further, the enforceability of the Statement of Principles is diminished significantly by section 23(2) and (3), which state that 'nothing in this Division creates rights or duties that are enforceable by proceedings in a court or tribunal' and 'a failure to comply with this Division does not affect the validity of any decision, and is not a ground for the review or challenge of any decision'.

UARC supports the inclusion of consumer choice, ensuring the autonomy of persons to make decisions concerning their own lives, and allowing them to do so considering any risks associated with those choices. We reiterate our comments provided in UARC's September 2023 submission that there needs to be a clear articulation of the intersection between the duty of care on providers and the dignity of risk – hence, there needs to be

greater clarification around the liability of providers and responsible persons where they enable people under their care to engage with activities that allow for their self-determination, though carrying a degree of risk.

While we are in agreement with the nature of liability under Chapter 3, Part 5, more clarification is required concerning the general defence of 'reasonable excuse' for those providers and responsible persons found liable under those sections. UARC would welcome the opportunity to comment further on what circumstances might be considered 'reasonable' in the context of serious failures, as we query whether these provisions go far enough to protect older Australians.

The use of restrictive practices is a topic that requires further critical review under the proposed Act. Much of the detail is to be provided in the Rules, which are yet to be released. In UARC's view, the use of restrictive practices should be subject to a high degree of regulation and review, including the statutory requirement on providers to maintain and review behaviour support plans. UARC welcomes the opportunity to review the forthcoming Rules with respect to restrictive practices, for instance, the monitoring and review of restrictive practices in section 17(g) and the outcomes of discussions with states and territories concerning substitute decision-makers.

7 Supporters and Representatives

The inclusion of supported decision-making principles is a welcome addition to the proposed Aged Care Act. The following analysis identifies some concerns with the revised proposal in the Exposure Draft and Consultation Paper No. 2, and reiterates that there is an opportunity for these aged care issues to drive the implementation of nationally uniform Supporter, Guardianship and Attorney legislation that would be easy to understand and bring together the current fragmented approach (Tsihlis et al., 2023, p. 25).

Consistency in Language

UARC notes that page 29 of Consultation Paper No. 2 refers to the terms 'cognitive capabilities', 'legal capacity', 'ability to make decisions' and 'decision-making capability'. To avoid confusion and conflation of these terms, it is suggested that consistent and clearly defined language be used.

The Role of Supporters and Representatives

As UARC discussed in its submission to the first consultation, given that capacity is decision-specific, a person may benefit from a supporter nominee to assist them to make some decisions, but a representative may need to be involved for other, more complex decisions. The two roles can co-exist contemporaneously. It is therefore recommended that section 374(5) of the Exposure Draft be struck out. In like manner, the mirror provision in section 376(7) should also be struck out.

Further, cultural norms and family structures that involve shared decision-making among family members would be better reflected in allowing for people in both 'supporter' and 'representative' roles to be recognised. As a recent article in the *Australian Journal of General Practice* explains:

> Recognising culture, the collective nature of family and community decision making for a person, the ways to uphold respect for Elders and a trauma-informed approach are fundamental to the care of older Aboriginal and Torres Strait Islander people with cognitive impairment and dementia. (LoGiudice et al., 2023, p. 505)

A related concern is that the Consultation Paper proposes that there may be multiple supporters or representatives acting at the one time, though not both in each category. This too could cause conflict in terms of who has the ultimate decision-making power.

For representative appointments, clarity on this could come from the use of the words 'jointly' (in that decisions must be made together and the parties must agree), or 'jointly and severally' (allowing for decisions to be made separately or together). This would also allow for streamlining with some of the language used in existing forms for the Appointment of Enduring Guardians.

Existing Legally-Appointed Nominees

The role of people who hold an existing Appointment of Enduring Guardian comes into some doubt under section 28 of Chapter 1 of the Exposure Draft, which states: 'A person must not make a decision under, or for the purposes of, this Act on behalf of an individual unless the person is appointed as a representative of the individual under section 376'.

The additional administrative burden of applying for an administrative appointment when existing Guardianship legislation covers provisions over where a person lives and what care or personal care services they receive, such as in New South Wales, is expected to cause uncertainty among legal professionals and the community. The need to update details if circumstances change, such as a revocation of an existing document, also creates doubt as to how quickly this information would be recognised by the aged care provider. Additionally, the Consultation Paper states:

> If someone is applying to be appointed as an individual's representative and they are already appointed:
>
> - as a Guardian under a law of the Commonwealth, or a State or Territory
> - by a court or tribunal and have power to make decisions for the person
> - as an enduring power of attorney, or
> - as a nominee of the older person for the purposes of the NDIS or Services Australia
>
> then the System Governor must appoint them as the older person's representative, unless there is a good reason not to. (Department of Health and Aged Care, 2023b, p. 29)

Contrary to achieving cohesion with existing state and territory laws, UARC considers that this provision will instead cause greater confusion as different people may already be holding these roles. For example, in New South Wales a person may have appointed a different Enduring Guardian and Enduring Power of Attorney, and they are held in completely separate forms, serving their own purpose. A Guardianship appointment is generally for medical and lifestyle decisions, whereas an Attorney's responsibilities apply to legal and financial decisions. While other states combine both areas of decision-making into a single form, multiple people may still hold Attorney or Guardianship roles.

UARC recommends that a hierarchy be put in place to allay concerns or potential conflicts between appointees, preferably with existing Guardians being given

precedence as this better fits the current system. Consultation with the states and territories on the transfer of powers over aged care would afford the Commonwealth a further opportunity to work with those jurisdictions on improving national consistency on this matter.

Administrative Powers

There appear to be far-reaching administrative powers to be given to the System Governor, such as the power to make, revoke or cancel appointments in Chapter 8, Part 4 (Appointment of supporters and representatives) of the Exposure Draft.

The powers proposed to be held by the System Governor are similar to those that only a Tribunal would be able to make and would be supported in doing so by adequately trained staff who specialise in Guardianship orders.

The System Governor's powers would include appointing a representative who would have substitute decision-making powers without the older person's consent. In addition, section 382(2) allows for the System Governor to suspend an appointment of an individual in a circumstance where 'the System Governor reasonably believes that the supporter or representative has caused, or is likely to cause, physical, sexual, financial, psychological or emotional abuse or neglect to the individual'.

UARC notes that these instances under Guardianship frameworks would usually involve a hearing process in a Tribunal setting to establish evidence from the parties involved. It is unclear what processes would be used by the System Governor to investigate claims of this serious nature.

Notification Requirements

A high administrative burden and complex system of applications, revocations, suspensions and notification requirements could cause greater confusion and conflict in appointments than the existing system incurs. For instance, section 31(1) states that a supporter or representative of an individual has a duty to inform the System Governor if 'an event or change or circumstances happens' that could be likely to affect matters such as 'the ability of the System Governor to contact the supporter or representative for the purposes of this Act'.

There may be unintended consequences from imposing these restrictions in the legislation, which may come to mean that appointees must notify every time they are going on an overseas holiday, for example, and ensure that alternate arrangements are in place during that time.

Restrictive Practices Consent

UARC notes the statement that there is continued work with states and territories on establishing clear arrangements for appointing a 'restrictive practices substitute decision-maker' under state and territory consent and guardianship laws. UARC would welcome the opportunity to comment on this issue when further guidance is released.

Role of Representatives when the Older Person has Decision-Making Capacity

Section 30(2)(b)(ii) of the Exposure Draft permits a representative to act in situations where 'it is possible for the individual to do the thing but the individual does not want to do the thing themselves'. UARC submits that a representative should only take over the decision-making role when the older person does not have the capacity to make the particular decision, and therefore proposes that this sub-section be struck out.

Allowing a representative to make decisions when the older person has capacity is contrary to the stated objects of the Act, which include to: assist older people to live 'self-determined' lives; 'put older people first'; support older people to 'effectively participate in society on an equal basis with others, thereby promoting positive community attitudes to ageing' and; ensure older people are free from mistreatment and harm. Allowing a representative to make decisions when the older person has capacity is also inconsistent with representative-based decision-making as a 'last resort' role (as explained on page 28 of Consultation Paper No. 2). An older person who has capacity to make a decision should be involved in that decision.

Informally, a person can still choose to have input and involvement by someone they trust, as commonly happens now. However, as a matter of law, substitute decision-making in UARC's view should be reserved for situations where a person does not have the capacity to make a particular decision, and there should be an obligation to support an older person's decision-making as much as possible. This latter position aligns with human rights perspectives on the rights of people with disability.

The fact that older people are often sidelined in decision-making is all the more reason for the law not to entrench that practice. For example, audits of advance care directives have found that many so-called directives are written by someone other than the older person (Detering et al., 2019). This creates a risk that the documented preferences are not actually those of the older person, thus undermining respect for their human rights.

If the Government chooses to retain section 30(2)(b)(ii), UARC makes the following recommendations to ensure the wishes of the older person are upheld:

1. The delegation of consent to make a decision would need to be context-specific rather than a blanket delegation.

2. For an older person who is still capable of making a decision, that person should be made aware of all the consequences of a decision to be made by the delegated representative before the decision is made.

In essence, the older person should be fully informed to the extent they wish on the particular matter to be decided on.

Clarification on whether the intention of the duties in section 30(3) are intended by the Government to be fiduciary in nature would be useful, as if so, this would give rise to more stringent obligations to act in good faith and in the best interests of the principal. This would bring the Act into further harmony with the principles underpinning Attorney and Guardianship legislative frameworks.

8 Complaints Handling

The establishment of a Complaints Commissioner is a welcome step towards improving the current system of managing complaints in aged care. It will provide appropriate avenues for older persons who feel that their rights have not been upheld.

However, although the Department's current proposal places the Complaints Commissioner into a Senior Executive Services position within the ACQSC, UARC agrees with the view raised in the *Key Issues Paper* released by COTA et al. (2024, p. 13) that a separate statutory appointment would be favourable to avoid potential conflicts of interest.

The diagram on page 24 of Consultation Paper No. 2 offers a broad overview of how complaints will be managed and possible pathways for regulatory action. However, more detail would be helpful in the 'restorative outcomes' section to assess whether these methods would be effective. The terms 'better communication' and 'fixing the problem', although basic and necessary steps to resolution for a complainant, do not offer any insight into measurable steps to be taken to resolve an issue, such as set timeframes for investigation and resolution or obligations on keeping the complainant updated on the progress of their complaint.

UARC's submission to the previous Consultation Paper No. 1 made three recommendations for inclusion in the legislation on complaints handling:

1. Detailed risk-assessment guidelines governing the process used by bodies such as the ACQSC when responding to a complaint. UARC also recommends such guidelines being published and shared with complainants to increase transparency and trust in the system.
2. Clear pathways for complainants to escalate unresolved internal complaints and unsatisfactory outcomes from early resolution. This could include, for example, mediation and reconciliation pathways, so that any unresolved matters are not channelled back to the early resolution process.
3. Provisions specifically outlining the methods and protocols that regulators should adopt when exercising their power. (Tsihlis et al., 2023, p. 10-13)

Section 183 of the Exposure Draft provides a broad overview of what aspects of complaints handling may be considered by the Rules. However, UARC awaits the publication of these processes with great interest in order to provide further commentary and recommendations.

Section 96 of the Exposure Draft requires registered providers to:

(a) implement and maintain a complaints and feedback management system in accordance with any requirements prescribed by the rules; and

(b) manage complaints and feedback in accordance with that system and any other requirements prescribed by the rules;

Consultation Paper No. 2 also mentions that 'the details of these requirements will be consulted on separately' (Department of Health and Aged Care, 2023b, p. 53). While the principles of adopting best-practice around complaints handling and creating a positive culture around this are sound, there are distinct gaps which hinder the opportunity for UARC to provide detailed feedback on the proposed mechanisms.

The financial services industry is one example where details on complaints timeframes available through internal dispute resolution processes are tightly regulated, and the guidelines are readily available to the public through the Australian Securities & Investments Commission's Regulatory Guides. The *Corporations Act* itself also includes specific timeframes in relation to contacting complainants, such as section 1056A in relation to death benefit decisions. The Australian Financial Complaints Authority has also published its corresponding Rules which clearly set out its decision-making approach, time limits for complaints and the types of remedies available (Australian Financial Complaints Authority, 2024).

Similar levels of detail could be provided in the context of complaints relating to aged care. The complaints handling processes should be easy for consumers to understand from the outset if a problem arises, and then should be similarly easy to navigate.

UARC would welcome the opportunity to provide feedback on the specifics of the proposed complaints processes when this information becomes available. A transparent approach and clear resolution pathways are elements that UARC considers would be key to restoring trust in the complaints system.

9 Whistleblower Protections

UARC is pleased that the Department has taken the approach of allowing for anonymous disclosures by whistleblowers and has adopted the 'reasonable grounds of suspicion' test that a person or entity has contravened as a provision of the new Act. The Exposure Draft provisions in Chapter 7, Part 5 are an improvement on the proposals made in Consultation Paper No. 1.

UARC notes with some concern that the definition of 'aged care worker', as a category of persons who can receive a protected disclosure under section 10(4), is broad and includes 'an individual employed or otherwise engaged (including as a volunteer) by the registered provider'. An extra protection appears in section 360 with the aim of ensuring that aged care workers who make disclosures are not victimised. While aged care workers on the 'front line' may be best placed to pick up on potential breaches of the Act by providers, appropriate supports and education would need to ensure that this potential burden does not act as a deterrent to people entering the aged care workforce or coming in as volunteers.

10 Provider Governance – Responsible Persons and Statutory Liability

UARC agrees with the increase in penalties for 'responsible persons' of aged care providers as a positive step in ensuring compliance from a top-down approach to prevent serious failings in management that lead to a care recipient's death, severe injury or illness. The term, as defined in section 11, appears to cover board members and management involved in 'planning, directing or controlling the activities' of the registered provider and includes, for those who deliver funded aged care services, 'any person who has responsibility for overall management of the nursing services' delivered.

As stated in this submission under 'Rights of Older Persons and Consumer Choice', how this is balanced with the concepts of dignity of risk and allowing care recipients to have greater choice about their care and activities in daily life does require further clarification. At a minimum, it should be acknowledged that there are competing priorities between preventing harm and allowing people to engage in activities that promote dignity of risk if that is their choice.

UARC understands that it will be left to the courts to decide if section 121(7), which details the possibility of five years imprisonment, 1000 penalty units, or both, for responsible persons who are found at fault for death, serious injury or illness, is invoked. The definition of a 'reasonable excuse' as a defence will similarly be tested in litigation within the aged care context. However, as mentioned earlier in this submission, further guidance would be appreciated.

The positive duty to take due diligence to comply with section 120, which is a duty to 'not cause adverse effects to the health and safety of individuals to whom the provider is delivering funded aged care services', is considered sound. In UARC's view, a key provision is section 121(d), which is 'responding in a timely way to that information' regarding incidents and risks in the provider's operations. These matters aside, the cultural shift in aged care that the proposed Act seeks, by way of improving overall quality of care outcomes, should not be overshadowed.

In UARC's understanding, a registered provider's statutory obligations and liability under voluntary assisted dying (VAD) legislation is a carve-out and sits within the jurisdiction of the states and territories. Currently, VAD is legal in all the states, but not in the ACT or NT. Obligations for providers within state VAD frameworks also vary as the specific provisions differ. In preparation for the new Act, UARC recommends that there be adequate education and materials made available to providers in order to ensure that they understand their obligations under the new Aged Care Act and make clear the

distinction between those obligations and the relevant VAD frameworks. The provisions on statutory duty and compensation in Chapter 3, Part 5 are a positive step forward in ensuring that those in provider management positions are actively engaged with due diligence processes and with providing quality and safe care more broadly. As mentioned above, however, UARC would like clarification of the balance between these provisions and consideration of the dignity of risk.

Transparency in Reporting

From a public interest perspective, this opportunity to revise the Aged Care Act could generate greater trust in the aged care system through increased transparency of information. A key element will be publishing more information on the performance of providers that are receiving public subsidies, such as when questions are raised as to their compliance record and how this aligns with public-facing information such as Star Ratings that can impact on people's choice of provider.

UARC recognises that the sector is already required to report many elements of its operations, financial performance and serious incidents. UARC also considers that the cost of collecting and reporting information should be less than the administrative and public interest benefits of that information. However, the examples mentioned later in this section do suggest there is further scope for disclosure in this instance.

Section 86.1 of the *Aged Care Act 1997* (Cth) includes information that is acquired under the Act and 'relates to the affairs of an approved provider'. Unless authorised by law, section 86.2 states that the penalty for a person who 'makes a record of, discloses or otherwise uses the information' is two years imprisonment. Under section 38 of the *Freedom of Information Act 1982* (Cth), these sections of the Aged Care Act fall into the 'secrecy provisions', therefore rendering them exempt from disclosure.

The Royal Commission into Aged Care Quality and Safety recommended that this secrecy provision for aged care provider matters be removed (Recommendation 88. Royal Commission into Aged Care Quality and Safety, 2021, p. 265-266). However, in the July 2023 progress report on the implementation of Royal Commission's recommendations, the only reference was that this matter will be addressed in the new Aged Care Act (Office of the Interim Inspector-General of Aged Care, 2023).

Section 322 of the Exposure Draft includes a definition of protected information, which is 'information whose disclosure could reasonably be expected to prejudice the financial interests of an entity; and is not public; and is not readily discoverable'. This does raise concerns about the breadth of information that may be protected by this subjective test, as arguably, any information that paints a provider in a negative light could be said to prejudice their financial interests. The following examples illustrate this point:

- Complainants making freedom of information requests to follow up a complaint that has been delayed within the Aged Care Quality and Safety Commission and seeking reasons for this; or
- Where a whistleblower has made a disclosure that eventuates in findings and further investigation, and this would be expected to have an impact on a provider's compliance record or Star Rating.

Such information, in UARC's view, should warrant a greater consideration of what is in the public interest to be disclosed so as to promote transparency of processes where this is needed. Reporting should be accurate, timely and as transparent as possible, thus enabling consumers to exercise informed choice when selecting their providers.

11 References

Aged Care Quality and Safety Commission. (2024a, January). *Draft Glossary of Terms: Guidance Material for the Strengthened Aged Care Quality Standards for Review and Discussion*. https://www.agedcarequality.gov.au/sites/default/files/media/guidance-material-glossary-of-terms.pdf

Aged Care Quality and Safety Commission. (2024b, January). *Draft Standard 1: The Person. Guidance Material for the Strengthened Aged Care Quality Standards for Review and Discussion*. https://www.agedcarequality.gov.au/sites/default/files/media/guidance-material-for-the-strengthened-aged-care-quality-standards-standard-1.pdf

Aged Care Quality and Safety Commission. (2024c, February). *Draft Standard 5: Clinical Care. Guidance Material for the Strengthened Aged Care Quality Standards for Review and Discussion*. https://www.agedcarequality.gov.au/sites/default/files/media/guidance-material-for-the-strengthened-aged-care-quality-standards-standard-5.pdf

Australian Financial Complaints Authority. (2024, January 1). *Complaint Resolution Scheme Rules*. https://www.afca.org.au/media/1759/download

Carnemolla, P., & Bridge, C. (2016). Accessible housing and health-related quality of life: Measurements of wellbeing outcomes following home modifications. *ArchNet-IJAR: International Journal of Architectural Research, 10*(2), 38-51.

Carnemolla, P., & Bridge, C. (2019). Housing design and community care: How home modifications reduce care needs of older people and people with disability. *International Journal of Environmental Research and Public Health, 16*(11), 1951.

Carnemolla, P., Debono, D., Hourihan, F., Hor, S., Robertson, H., & Travaglia, J. (2021). The influence of the built environment in enacting a household model of residential aged care for people living with a mental health condition: A qualitative post-occupancy evaluation. *Health & Place, 71*, 102624.

Cleland, J., Hutchinson, C., Khadka, J., Milte, R., & Ratcliffe, J. (2021). What defines quality of care for older people in aged care? A comprehensive literature review. *Geriatrics & Gerontology International, 21*(9), 765–778.

COTA (Council on the Ageing), OPAN (Older Persons Advocacy Network), AIR (Association of Independent Retirees), Carers Australia, Dementia Australia, EAAA (Elder Abuse Action Australia), FECCA (Federation of Ethic Communities' Councils of Australia), NAPWHA (National Association of People with HIV Australia), LGBTIQ + Health Australia, National Seniors Australia, PICAC (Partners in Culturally Appropriate Care) Alliance, & RSL (Returned and Services League of Australia). (2024, January 17). *Aged Care Exposure Draft: Key Issues Paper*. https://cota.org.au/publication/aged-care-act-exposure-draft-key-issues-paper/

Department of Health and Aged Care. (2023a, September 28). *A New Aged Care Act: The Foundations. Consultation Paper No. 1*. https://www.health.gov.au/sites/default/files/2023-09/the-new-aged-care-act-the-foundations-consultation-paper.pdf

Department of Health and Aged Care. (2023b, December 14). *A New Aged Care Act: Exposure Draft. Consultation Paper No. 2*. https://www.health.gov.au/sites/default/files/2024-02/a-new-aged-care-act-exposure-draft-consultation-paper-no-2.pdf

Department of Health and Aged Care. (2023c). *Aged Care Taskforce*. https://agedcareengagement.health.gov.au/taskforce/

Department of Health and Aged Care. (2023d, November). *Strengthened Aged Care Quality Standards – Final Draft*. https://www.health.gov.au/resources/publications/the-strengthened-aged-care-quality-standards-final-draft

Department of the Attorney-General. (2024). *Royal Commissions – Royal Commission into Aged Care Quality and Safety*. https://www.royalcommission.gov.au/aged-care

Detering, K. M., Buck, K., Ruseckaite, R., Kelly, H., Sellars, M., Sinclair, C., Clayton, J. M., & Nolte, L. (2019). Prevalence and correlates of advance care directives among older Australians accessing health and residential aged care services: Multicentre audit study. *BMJ Open, 9*(1), e025255.

Exposure Draft, Aged Care Bill 2023 (Cth), https://www.health.gov.au/resources/publications/exposure-draft-aged-care-bill-2023?language=en.

LoGiudice, D., Hughson, J., Douglas, H., Wenitong, M., & Belfrage, M. (2023). Culturally safe, trauma-informed approach to cognitive impairment and dementia in older Aboriginal and Torres Strait Islander people. *Australian Journal of General Practice, 52*(8), 505–511.

McCaffrey, N., Agar, M., Harlum, J., Karnon, J., Currow, D., & Eckermann, S. (2013). Is home-based palliative care cost-effective? An economic evaluation of the Palliative Care Extended Packages at Home (PEACH) pilot. *BMJ Supportive & Palliative Care, 3*(4), 431-435.

NSW Health. (2021). *Hospital in the Home (HITH).* https://www.health.nsw.gov.au/Performance/Pages/hith.aspx

Office of the Interim Inspector-General of Aged Care. (2023, July). *Progress Report: Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety*. https://www.health.gov.au/sites/default/files/2023-10/progress-report-implementation-of-the-recommendations-of-the-royal-commission-into-aged-care-quality-and-safety.pdf

Royal Commission into Aged Care Quality and Safety. (2021). *Final Report: Care, Dignity and Respect. List of Recommendations*. https://www.royalcommission.gov.au/system/files/2021-03/final-report-recommendations.pdf

Seemann, N., Fuggle, L., Week, D., Westera, A., Morris, D., Loggie, C., Thompson, C., Fildes, D., Grootemaat, P., Lambourne, S., Goodenough, B., & Gordon, R. (2023). *Final Report on the Development of the Draft National Aged Care Design Principles and Guidelines*. Department of Health and Aged Care; Centre for Health Service Development; Australian Health Services

Research Institute. https://www.health.gov.au/sites/default/files/2023-09/final-report-on-the-development-of-the-draft-national-aged-care-design-principles-and-guidelines.pdf

Tsihlis, E., Lin, J., Woods, M., Sutton, N., Debono, D., Carnemolla, P., Lorber-Kasunic, J., Brown, D., Ries, N., & Parker, D. (2023). *A New Aged Care Act: A Submission on the Foundations of the New Aged Care Act. Consultation Paper No. 1*. UARC, The University of Technology Sydney. https://www.uts.edu.au/sites/default/files/2023-09/UARC_Response_Foundations_New_Aged_Care_Act_Consultation_September_2023.pdf

Woods, M., & Corderoy, G. (2020, January 30) *Impact Analysis: Alternative Models for Allocating Residential Aged Care Places. Final Report*. https://www.health.gov.au/resources/publications/final-report-impact-analysis-alternative-models-for-allocating-residential-aged-care-places?language=en

World Health Organization (1946). *Constitution*. https://www.who.int/about/accountability/governance/constitution

World Health Organization. (2024). *Quality of Care*. https://www.who.int/health-topics/quality-of-care#tab=tab_1