

Position Statement by the National Ageing Research Institute

Final NARI Response to the Exposure Draft of the Aged Care Act 2023

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About the National Ageing Research Institute (NARI)

NARI has over 40 years' experience researching matters related to ageing and aged care in Australia and is the only independent research institute in Australia solely dedicated to ageing research. Our vision is a world where older people are respected, healthy and included. We are a national leader in ageing research, producing work of international significance to apply to real lives, particularly in falls and balance, pain, dementia, physical activity, healthy ageing, psychosocial and mental health, elder abuse and health systems evaluation. We create and share knowledge to make a difference for older people. This submission draws upon our expertise and our desire to contribute to a positive reform agenda for a high-quality aged care sector in Australia.

As Australia's leader in research on ageing and aged care, NARI has consistently called for a stronger evidence base to underpin the care of older people. In our previous submissions we have called for a reform agenda that goes beyond ensuring adherence to minimum quality standards and considers how quality can be improved through promoting and implementing aged care models that afford engagement and enablement of aged care users. We have also advocated for care that acknowledges the needs of all people in caring relationships. The evidence-informed models of care we have developed promote the rights of older people consistent with the UN Convention on the Rights of Older Persons. **This includes the right to human and community connection, relationship-centred care, a safe and comfortable environment, holistic integrated healthcare, and a capable and resourced workforce with strong leadership and effective governance.**

NARI's Submission

NARI welcomes the release of the Aged Care Act Exposure Draft which proposes to replace today's current aged care legislation, particularly the Aged Care Act 1997 (which largely focuses on the regulation and payment of providers) and the Aged Care Quality and Safety Commission Act 2018.

NARI recognises the hard work and dedication of the Federal Government of Australia in bringing about these much-needed reforms to aged care. The comments within this

submission are aimed to guide the revision of the Exposure Draft to meet the care needs of Australians as they move through their later lives.

Whilst a good start, the current Exposure Draft of the Act needs to be strengthened to deliver on the promise of dignity for older people. Please note, the limited timeframe for the consultation means that the feedback provided here does not include comments from aged care consumers who contribute to and inform our policies. We have selected thirteen key issues with the current Exposure Draft that draw on our collective expertise as leaders in research with and for older people and their communities.

NARI: Key issues with the Aged Care Act Exposure Draft

1. The Act should further define “high quality care” to include that it is evidence-informed or evidence-based

The Royal Commission into Aged Care Quality and Safety¹ (hereafter termed ‘the Royal Commission’) found variability and inconsistency in available aged care data. This was one of the reasons it was difficult to uncover substandard care in Australia’s aged care system. The Commissioners stated, ‘there have been missed opportunities in research and innovation in the aged care sector which has resulted in it being behind the research, innovation and technological curves.’ Although one of the objectives of the new Act is to ‘*promote innovation in the Commonwealth aged care system based on research and support continuous improvement in the Commonwealth aged care system*’ (Chapter 1: Part 1), the only apparent mechanism for this is through the complaints functions of the Aged Care Quality and Safety Commission (ACQSC) (p. 142). Under the proposed new Act, the ACQSC Commissioner has the function to build the capability of registered providers to develop a culture of learning and innovation to deliver quality care. Engagement with research and researchers could improve this.

The Act could be strengthened by stating that older people have the right to evidence-based care that maximises their quality of life and reduces their risk of experiencing adverse events and iatrogenic conditions. Providing financial incentives to aged care providers to partner with researchers for research, quality improvement, and evaluation purposes would strengthen the capability of the sector and raise awareness among registered providers and aged care workers of evidence-informed care.

As part of the Commonwealth Government's reform agenda to place older people at the heart of the aged care system, aged care providers will be required to adopt a range of best practice strategies to promote consumer engagement. This engagement should be extended to consumers' engagement in and with research. Currently the lived experiences of older people are underrepresented in research, particularly the voices of older people living in residential aged care homes.

2. The definition of 'High quality care' in the Act should include 'physical health'

The proposed definition for High Quality Care' prioritises:

kindness, compassion and respect for life experiences, self-determination, dignity, quality of life, mental health and wellbeing of the individual (Part 2: Division 2, p.27).

We note there is nothing in the definition of high-quality care that incentivises care for an individual to maintain and manage a physical health condition. Older people in residential care homes often have multiple chronic conditions. An analysis of records from 9,436 aged care residents from 68 residential care homes in New South Wales and the Australian Capital Territory from 2014 to 2017 found 93% of aged care residents had some form of cardiovascular disease, with hypertension the most common (62%) and 61% had arthritis² Parkinson's disease is also a significant condition, affecting 5-8% of residents³. Moreover, almost one third of aged care residents have diabetes⁴. Each of these physical health conditions requires ongoing management. For example, aged care residents with diabetes are at risk of diabetes-related complications due to potential over or undertreatment resulting in hypoglycemia and hyperglycemia. Being nice to them does not go far enough. The Royal Commission heard that residential aged care providers often fail to deliver, facilitate, or coordinate care to meet the complex care needs of these residents¹. The Royal Commission strongly recommended that providers have knowledge and skills to deliver dementia care and palliative care, in particular¹. Whilst we do not want the Act to dilute the importance of care that is characterised by kindness, compassion, respect for life experiences, self-determination, dignity, quality of life, mental health, and wellbeing, it is essential that providers have the clinical expertise to support the management of complex health conditions.

3. The definition of 'High quality care' in the Act should be more inclusive of cultural and linguistic diversity.

We note that in the Exposure Draft of the Act there is limited mention of cultural and linguistic needs in the definition of high-quality care. The findings of the Royal Commission (executive summary, page 97) highlight the importance of care that '*address physical, social, psychological, cultural and spiritual needs, supporting people to function independently for as long as possible*'¹. We would therefore advocate for greater inclusiveness of the needs of culturally diverse seniors. Specifically, we suggest that the words 'culture and faith' be included in the current definition in Chapter 1, Part 2, Division 2, Section 19, pp. 27-28 as follows:

- (i) *kindness, compassion and respect for life experiences, culture and faith, self-determination, dignity, quality of life, mental health and wellbeing of the individual*
(Part 2: Division 2, p.27).

Further reflecting the rights of culturally and linguistically diverse seniors and their community to have a voice in the development and implementation of aged care services, we recommend that the following wording is updated to focus on partnership as well as true co-design and importantly include culturally and linguistically diverse seniors, their families and communities (underlined);

- (viii) implementing inclusive policies and procedures, in partnership with and through co-design with Aboriginal or Torres Strait Islander persons and culturally and linguistically diverse families and communities to ensure that culturally safe, culturally appropriate and accessible care is delivered to those persons at all times, which incorporates flexibility and recognises the unique experience of those persons.

4. The Act should not conflate person-centred care with consumer-directed care

The Exposure Draft defines an aspiration for 'a person-centred aged care system' (p. 33). While NARI acknowledges the strengthening of assessment processes and consumer protections, we remain concerned that the Act's continued reliance on a market-driven model conflates person-centred care with consumer choice or consumer-directed care.

Evidence suggests market forces often fail to deliver care aligned with individual needs, particularly in underserved communities or for marginalized groups. Additionally, framing care as a "consumption" transaction undervalues the vital human connection between caregivers and older individuals, who themselves contribute significantly as caregivers within their communities.

To facilitate person-centred care, we urge the consideration of further measures, including addressing limitations in "thin markets," funding dedicated services or targeted community programs, and ensuring that consumer choice operates within a system that prioritises individual needs and fosters meaningful relationships in care delivery.

5. The Act should better recognise the important role of informal carers

Informal carers contribute an estimated 1.9 billion hours of unpaid care annually⁵, playing a critical role in supporting older Australians to navigate the aged care system. However, without adequate support, they risk experiencing psychological distress, financial hardship, social isolation, and compromised health⁶. The Royal Commission recommended that a new Act should establish rights for carers and access to supports commensurate with need, including carers' need for social participation¹. Unfortunately, the Exposure Draft falls short of this recommendation, and the existing Carers Recognition Act (2010) lacks tangible protections. We urge the inclusion of carer rights within the Act, guaranteeing the reasonable provision of support based on assessed needs. This could include financial assistance, respite services, and access to training and resources. Without such measures, the burden of compensating for gaps in the aged care system will continue to fall on overwhelmed and financially strained carers.

6. The Act should adopt language that promotes a shift in the culture of aged care from dependency to enablement

The rules listing the service type to be delivered in a residential aged care home are: (a) *services for the care of persons who are experiencing sickness;*

(b) *services incidental or conducive to the care of persons who are experiencing sickness*

We understand the importance of 'sickness' for ensuring compliance with the Australian Constitution and potentially accessing specific health funding. However, using this term exclusively risks perpetuating a dependency-focused culture. It may also negatively impact the self-perception and well-being of residents who do not identify as "sick", and reinforce a medicalised view of ageing, neglecting the potential for continued personal growth and independence. To promote a holistic view and cater to diverse needs, we recommend amending clause 6 (Division 2: Section 8) to include terms like 'disability,' 'functional impairment,' and 'support needs'.

7. The Act should regulate for improved access to allied health care

The Royal Commission (2021, p.66) stated '*people in aged care have limited access to services from allied health professionals, including dietitians, exercise physiologists, mental health workers, occupational therapists, physiotherapists, podiatrists, psychologists, speech pathologists and specialist oral and dental health professionals*¹. Lack of access to allied health care hinders the implementation of multidisciplinary and restorative care models. While the new Australian National Aged Care Classification (AN-ACC) funding model has its benefits, its current structure creates barriers due to limitations in addressing specific needs beyond basic care. To truly ensure quality care, the Act should consider expanding its definition to include the provision of necessary medical, nursing, and allied health services based on individual needs. However, it is crucial to acknowledge the need for adequate resources and robust enforcement mechanisms to support this expansion.

8. The Act should strengthen the definition of diversity to ensure it meets the cultural, spiritual, emotional and practical needs of culturally and linguistically diverse older Australians

Diversity is poorly defined within the Exposure Draft. Diversity is reflected in a person's culture, ethnicity, sociocultural milieu and individual preferences etc and these complexities have to be carefully considered. Projections suggest that the Australian 'mosaic' in the future will be increasingly diverse. The new Act should ensure that it captures/cateters for older people of the future as well as now. It should also be flexible enough to ensure services are tailored to meet the cultural, spiritual, emotional and practical needs of culturally and linguistically

diverse older Australians and their supporters should be a cornerstone in quality care. Supporters and representatives in the context of cultural and linguistically diverse (CALD) families may still require additional navigational support of the aged care system highlighting the importance of ethnospecific providers who can help facilitate understanding and trust in the system to enable uptake of appropriate services. We are concerned that a single-entry point into the aged care system may still represent an overwhelming barrier to those from CALD backgrounds.

9. The Act should strengthen the complaints process

Chapter 5 of the Exposure Draft describes the proposed governance of the aged care system, including the roles and functions of the System Governor, Aged Care Quality and Safety Commission (ACQSC), the ACQSC Commissioner, and the Complaints Commissioner. NARI welcomes the proposed changes designed to strengthen the powers of the ACQSC but are concerned that the complaints process could be undermined by the Complaints Commissioner having to be an employee of the ACQSC. We recommend the Complaints Commissioner assists the ACQSC Commissioner in the performance of the Commissioner's complaints functions but have direct independent statutory authority and functions. We support a governance model where the Complaints Commissioner is appointed by, and responsible to, the minister and with powers to compel information, participation in the complaints process and certify enforceable undertakings. We recommend that the Act has clear timelines and performance indicators for all aspects, including receipt, action, and resolution of complaints. An important component of the system is the New Aged Care Discrimination Commissioner whose role and functions should be integrated into the new Act.

10. The Act should strengthen requirements for aged care providers to employ enough staff with the skills and time to care

The Royal Commission made 12 recommendations specifically designed to increase the capacity of the aged care workforce to deliver high quality and safe aged care¹. The Commissioners stated, '*there are many ingredients that enable the provision of high quality and safe aged care, but it cannot be achieved without having enough staff with the skills and time to care*'¹. We do not believe the proposed new Act goes far enough to ensure providers have enough staff with the skills and time to care. Specifically, the Act should additionally

legislate for all workers engaged by providers who are involved in direct contact with people seeking or receiving services in the aged care system undertake regular training about managing complex health conditions such as dementia, depression, diabetes, heart failure, and on strategies to optimise older peoples' functional and cognitive abilities and provide end-of-life care. Given the importance of relational care, we also recommend mandatory education about supported shared decision-making.

The proposed database of workers will not ensure aged care workers have the requisite capabilities to deliver this care. The proposed new Act simply requires providers to ensure their employees are *well-skilled and empowered and able to develop and maintain a relationship with the individual*. A caring workforce with interpersonal skills is important, but so too is their capability to understand needs and deliver complex care, particularly in residential care homes.

Whilst the new Act will legislate for the presence of a Registered Nurse on site and on duty at all times at an approved residential care home (with exemptions), it is silent on the number of staff required. The Royal Commission heard strong evidence about the association between the number of staff and quality care in residential care homes⁷. Leaving it up to registered providers to determine the appropriateness of aged care workers' qualifications, skills and experiences and what constitutes safe staffing levels is problematic. We suggest the Act be strengthened to require providers to submit data on staffing ratios (not just the availability of a Registered Nurse), and on their workforce knowledge and skills.

11. The Act should regulate for the rights of older people to maintain connection with family and friends at all times

NARI strongly supports the rights of older people to safe visitation by family members or friends where they live, as articulated in the Statement of Rights. Our program of research on social isolation and the impact of volunteer visits on aged care residents' mental health clearly demonstrate the importance of older people being able to maintain connection with family and friends. We have concerns that this right could be undermined by public health orders and varying interpretations of what constitutes safe visitation. We endorse COTA's position on this issue as outlined in their Key Issues Exposure Paper.

12. The Act should regulate for supported shared decision-making and a national approach to decision-making as it relates to the rights of older people

Regulating for Supporters and Representatives who will be appointed by the System Governor does not guarantee that decisions made with and on behalf of older people will be done in a way that upholds older peoples' rights. The current legislation related to medical treatment decision making varies from state to state. NARI is concerned that this appointment will not be feasible in the context of this variation. Moreover, whilst the intent is to ensure Supporters and Representatives are available to support older people make decisions that affect them, the process outlined does not require them to show how they have an older person's best interests in mind or that they understand how to engage in supported shared decision-making process. NARI suggests the Act strengthen regulation about what applicants have to do in order to demonstrate their suitability, the timeliness of the System Governor's response and how this proposed change aligns with or affects current state and federal legislation.

13. The Act should clearly reference how it will (or will not) support people under 65 years old

The new Act should provide guidance and legislation on the Royal Commission target of 'no people under the age of 65 living in residential aged care by 2025'. Additionally, NARI recommends specific attention to detail on how the new Act will work with the NDIS legislation, particularly for people with younger onset dementia, who may be currently receiving NDIS funding, and who may access aged care funding in the future. In addition, NARI suggests that the new Act could also include more detail about how the aged care system integrates with the healthcare and disability systems, to minimise barriers for accessing services.

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