



Submission to the Department of Health and Aged Care

New Aged Care Act Exposure Draft

March 2024

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Introduction

We appreciate the opportunity to comment on the exposure draft of the new Aged Care Act and shape a system that began with recommendations from the Royal Commission into Aged Care Quality and Safety.

According to the national Eye Health Survey (2016), there are around 453,000 people with vision loss in Australia. Aside from uncorrected refractive error, which can be mitigated with prescription glasses or contact lenses, most of the vision loss is caused by conditions such as diabetic retinopathy, glaucoma, macular degeneration, and cataract, which usually occur later in life. Indeed, 80% of the world's blind are aged 50 years and older and the prevalence of blindness and vision impairment continue to increase as people move into their sixties, seventies, and eighties. Therefore, most people who require support for their vision loss will seek it through the Aged Care system.

People with vision loss experience higher rates of falls, hip fractures, and entry into residential aged care than other Australians. Recent data indicates that vision loss costs Australia up to \$27.6 billion annually.

For the first time, this new draft acknowledges people who are blind or have low vision as one of the groups for whom specific approaches may be required to deliver funded aged care services. This is a valuable step toward a system that is better equipped to facilitate cost-saving eye care and rehabilitation options.

This brief submission offers more recommendations about how the Act can deliver on the opportunities outlined in the statements of rights and principles.

Recommendations

1. The definition of care needs should be modified to acknowledge sensory difficulty as an eligibility trigger for aged care services. To align with Chapter 2 of the Act, the term “aged care needs” should be used in the definitions section.
2. Supporters and representatives should be able to nominate preferred formats for communication independently of participants.
3. Revisions to this draft should not prohibit the creation of a specialist vision service type, triggered by referral from a needs assessor.
4. The new Act should, in accordance with Right 1, explicitly allow an aged care recipient to manage their own funding, in order to facilitate the transition to a multiple provider system.
5. Recipients of funded aged care services should receive a preview of the services they've been approved to access, in order to provide input before a package is finalised.
6. The Act should stipulate that, wherever possible, the needs assessor should be a delegate of the system governor, in order to avoid problems which have occurred in the NDIS.
7. The proposed specialist vision service type and assistive technology funding streams should be available to people in residential care as well as in the new Support at Home program.
8. The Act should minimise regulatory requirements that would discourage delivery of specialist vision and eye care services in residential aged care.

Definition of Care Needs

Vision 2020 Australia's members hope that recognition in the new Act will encourage aged care providers and workers to consider and seek to address the impacts of vision loss. But one of the most common problems we see is at the entry point to the system.

Many people seek access to aged care services primarily because of a vision condition. These people don't demonstrate frailty in the way that has historically been expected of aged care recipients. They may in fact appear relatively physically healthy, yet they may be seeking assistance because they're having difficulty reading independently. Some of the first impacts of vision loss are impeded access to information and communication, which can leave people feeling isolated and helpless.

Alternatively, someone may seek aged care access because they've lost their driver's licence. They might feel underconfident about using public transport, not because of physical frailty, but rather because they are unable to read signs or see the opposite side of the road while crossing.

We've seen the power and importance of wording in other assessment systems. We're concerned that cases like those we've described may not neatly fit into prevalent understandings of "physical, mental or social" difficulty.

We argue that vision as well as hearing loss are sufficiently disruptive to justify entry into the aged care system. In fact, reaching otherwise healthy people early with funded aged care services may prevent the development of comorbidities commonly associated with blindness and low vision.

We argue that the definition of care needs in Chapter 1 of the Act should read:

"Care needs means one or both of the following apply in relation to an individual:

- (a) the individual has difficulty (whether physical, mental, social or sensory) undertaking any daily living activities;
- (b) the individual requires help from another person, or the assistance of one or more aids, to maintain their physical, mental or social capacity to function or communicate independently."

In addition, we note that Chapter 2 of the Act refers frequently to "aged care needs assessments". In order to strengthen the link between the definition in Chapter 1, and the eligibility criteria in Chapter 2, we recommend the term "aged care needs" be used consistently throughout, including in the definition in Chapter 1.

Supporters and Representatives

We're pleased to see the exposure draft offering further definition to the supporter and representative roles discussed in earlier consultations. Formalising these positions will be particularly helpful for people who are accessing the system following a deterioration in vision.

We welcome the facility for a participant to nominate more than one supporter, as described in the consultation paper. As we discussed in an earlier submission, this will allow for a participant to navigate the system with the assistance of whichever member of their family is available at the time.

However, we have some concerns regarding the provision of information for supporters and representatives. Sections 25 and 29 of the exposure draft stipulate that any information or document given to the supporter/representative of an individual must, in every respect, be in the same form, and in the same terms, as if it were being given to the individual.

This wording could result in supporters or representatives only receiving information in the format participants have requested. This would be problematic, for example, when a participant has asked for information in large print, audio, or Braille. The supporter or representative may not need the information in an alternative format, and indeed may find it more difficult or impossible to access it in that form.

However, in some instances, a supporter or representative may need information delivered in an alternative format, where the participant does not. People who are blind or have low vision should be equipped to assist their family members through accessing aged care services in the same way as a person without a disability could.

To resolve this problem, we suggest that:

1. Sections 25 and 29 of the Act be clarified through an explanatory note, specifying that this section refers to the content of information, and not the mode of its delivery, and
2. An additional subsection be added to stipulate that supporters and representatives may request information in alternative formats.

Assessment Pathway

Because vision loss, even within the Aged Care context, is comparatively uncommon, we've found assessors typically have little awareness of vision rehabilitation supports. This creates a barrier for people seeking help, who may not themselves always understand the available options.

We believe the simplest solution is for delegates to approve access to a specialist vision service when vision impairment is flagged at the assessment stage. This service type, which would be grant-funded, would provide a mix of services including orientation and mobility instruction, occupational therapy, orthoptics and assistive technology trials.

Crucially, needs and classification assessments described in the draft would not be required to establish which, or how much, of each specialist vision service is necessary. However, the generalist assessor would still establish whether a person requires a more traditional service mix, such as cleaning, gardening, and support work. This approach will ensure triggered early intervention supports for people with vision impairment, while minimising the need for training assessors, or the frequent reassessments we've seen in other systems.

In our proposed assessment pathway for a person with vision loss:

1. Vision loss is flagged at the assessment stage.
2. The assessment establishes funding and classification for service groups and service types as usual, and
3. The assessor refers the person to a specialist vision service, which will provide vision rehabilitation training and support.

Nothing in the current draft appears to prohibit this approach, but given that key elements of the Act are yet to be drafted and that this consultation will inspire further revisions, we suggest that in redrafting, the Department should avoid introducing elements that would disallow triggered access to grant-funded programs providing specialist supports such as we're proposing for people with vision loss.

Access to Decision Makers

One of the long-standing issues for NDIS participants with vision impairment has been the lack of access to the people making decisions about them. Assessments are often carried out by Local Area Coordinators, who then provide the reports that NDIA delegates use to decide funding packages. This situation, where participants and decision makers never meet and only interact through an intermediary, is widely considered to be one of the major causes of the high number of reassessments and appeals in the scheme, which was one of the first priorities of NDIS Minister Bill Shorten.

The recently completed Independent Review of the NDIS recommended an approach where Agency delegates directly delivered assessments and worked closely with participants to establish plans. We believe a system that allows packages to be developed through direct interactions between the delegate and the participant would minimise honest errors and misunderstandings.

The exposure draft requires the System Governor to inform a person about what services they've been approved to access within 14 days of the decision. They're also told how they can request reconsideration of that decision, though the detail of this process isn't included in the current draft.

We propose that following the approval decision, recipients of Aged Care services should be sent a "preview" of the service types they'll be allowed to access, and offered the option of raising a concern directly with the delegate.

This would increase the transparency of the process, and help people feel that they've had an opportunity to be heard. Most importantly, it would allow for the prompt resolution of miscommunications or human errors which otherwise would result in stress for participants and high administrative costs for Government.

Choice and Control in Support at Home

Without the presence of another disability, people who are blind or have low vision are typically cognitively capable and eager to maintain control over their lives. In the NDIS, for example, most participants with visual impairment as a primary disability are either self-managed or plan-managed, both options which allow greater flexibility in how funds are used.

There are likely to be some cultural differences in Aged Care recipients, who will be less accustomed to using assistive technology to navigate information about budgets and services. However, current Aged Care recipients tell us that they face unnecessary limitations on the services they can access, and who delivers them.

For example, Home Care packages are currently held by a "lead provider", which subcontracts specialist providers when they can't deliver a specific service type. This has led to instances where the lead provider:

1. Refused to fund specialist vision services such as orientation and mobility, due to a lack of knowledge of its benefits.
2. Refused to allow a client to access support workers with specialist knowledge of vision loss from other service providers, because they delivered this service type.

3. Refused to allow a client to use allied health services from multiple providers.

While lead providers sometimes effectively connect people with services they need, in these instances they impede choice, and prevent access to services that would improve independence, in favour of higher frequency supports.

We understand the current intention is to introduce a multi-provider model following the integration of CHSP into the new Support at Home program in 2027. This should be considered a necessary aspect of implementing the “independence, autonomy, empowerment and freedom of choice” promised in the Statement of Rights, and especially in Right 1.

In order for a multiple provider system to work well, participants in the new program must be able to take control of their own funding, without the assistance of a lead provider. Currently, there is no reference in the Act to self-management, and thus no obligation to deliver this key aspect of genuine control.

We contend that Care partners should deliver the connection functions that were once offered by lead providers, and that a person should be able to choose which providers they use for different service types. The goal should be automated payment from the participant’s funds to the provider, with no intermediary. Participants, their supporters and representatives should be given information about their funds and how they’re being spent.

Specialist Service Provision in Residential Aged Care

A study commissioned by the Department of Health found high rates of eye disease in residential aged care facilities, which were often under-diagnosed and untreated. The study found that more than 70% of residents had some evidence of eye disease, over 60% had some degree of age-related macular degeneration (the leading cause of blindness in people over 50); and a quarter were found to have low vision.

People with vision loss in residential aged care are receiving very little support targeted specifically toward vision rehabilitation. This is partly because of the way funds are held, which looks likely to be retained in the new legislation. The Department’s consultation paper suggests that funds for participants in residential care “will still flow directly to the registered provider that the individual has chosen to deliver their funded aged care services”. This appears to be based on the assumption that a provider can and will provide all the supports a resident requires.

In our experience, residential care providers have little understanding of vision loss and associated support needs. While providers are encouraged to provide allied health services, in practice these are usually very generalist, so that they can reach the highest possible volume of clients. Catering to such specific needs would typically require the subcontracting of a specialist service provider for a small number of residents. There is little motivation to undertake this effort.

Due to cultural perceptions about the impact of vision loss, there are many people for whom a change in vision is the primary motivator for entering residential care. Others who acquired their vision loss earlier in life and are currently supported by the NDIS or the Disability Support for Older Australians program, may at some point choose to transition into residential care, and therefore lose access to those funding streams.

Without training, a resident will likely struggle to navigate their facility. Providers may be reluctant to allow people to move around freely, correctly perceiving a heightened risk of falls, but failing to

introduce any supports to mitigate this. In fact, orientation and mobility instruction has proven very effective in introducing strategies for safe indoor navigation that don't rely on sight.

Orthoptists, meanwhile, play a valuable role in prescribing low vision aids, and specialist occupational therapists help people develop new ways of performing familiar tasks.

Comparatively low-cost aids and equipment can make a huge difference for people with permanent vision loss. Adaptive and task-specific lighting can be very helpful to residents in their rooms, for reading, writing, and a variety of other simple activities. While we hope ultimately to see such features routinely integrated into facility design, at this stage they're usually not available.

We don't see a way to quickly motivate providers to ensure delivery of these support types. To enable the maximum possible independence, people with vision loss who live in residential aged care facilities should be allowed access to service types including assistive technology funding, and specialist blindness and low vision services. This shouldn't be precluded by any changes to the current draft, or by any elements in the yet to be drafted chapter on classification.

Optometry in Aged Care

As previously noted, vision loss is associated with a range of adverse and costly health outcomes, but 90 per cent of vision loss in Australia is preventable or treatable. In part, eye conditions are underdiagnosed in residential care because optometrists are finding it increasingly difficult to access facilities. The domiciliary loading benefits designed to encourage this practice aren't sufficient to offset the cost of service delivery.

The current draft has created some confusion around whether optometrists would be subject to new reporting obligations if they continued to deliver Medicare-funded services in aged care facilities. While we strongly support a more robust process for managing complaints and reportable incidents, we also believe every effort should be made to avoid introducing additional obstacles to optometrists visiting residential care facilities, especially noting that optometrists are already subject to other regulatory and reporting requirements.

A growing number of optometrists are delivering low vision optometry services as registered aged care providers. This method of service delivery allows for longer engagements with patients than are typically possible through Medicare, and encourages provision of innovative service models where the optometrist leads a team of allied health professionals in collaborative vision rehabilitation.

It has been suggested that optometrists seeking to deliver aged care services would register under Category 4, as described in the Department's proposed new regulatory model. This would impose additional regulatory requirements, many of which seem to duplicate those optometrists are already beholden to via AHPRA.

The case study of optometry is an important reminder of the opportunity to simplify auditing and compliance processes as we transition to new legislation. Many vision service providers work across the NDIS, aged care, the Department of Veteran's Affairs, and, in the case of optometry, Medicare. These are all systems that impose significant and often duplicative administrative burden. While regulatory alignment is largely out of scope for this consultation, the exposure draft makes no mention of exempting providers from registration obligations when those obligations are functionally duplicated by another system. We strongly encourage the Department to add a provision that would allow the System Governor or the Commissioner to exempt providers from certain requirements of registration in specific circumstances.

About Vision 2020 Australia

Vision 2020 Australia is the national peak body for the eye health and vision care sector. Working with and representing almost 50 member organisations, we focus on supporting policy and funding changes to prevent avoidable blindness, enhance eye care delivery and better meet the needs of people who are blind or living with low vision.

Our members span a wide range of areas and engage in local and global eye health and vision care, health promotion, low vision support, vision rehabilitation, eye research, professional assistance, and community support. This means that the work we do in developing sector-supported policy and advice brings a diverse range of expertise and perspectives to bear, and that the perspectives and experiences of both service users and service providers are at the heart of our work.

Avoidable blindness and vision loss in Australia, and our region, can be prevented and treated by working in partnership across government, non-government, private and community sectors. People of all ages who are blind or vision impaired will benefit from these partnerships, with improved access to services that support their independence and community participation.

For further information about this submission, please contact Vision 2020 Australia via email, 