RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Submission: *A New Aged Care Act: the foundations*

A Department of Health and Aged Care consultation paper

September 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 21,000 physicians and 9,000 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including geriatric medicine, general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to continue progress towards improving health and wellbeing services to older people. We know that older people are a large and growing demographic, a significant proportion of whom have complex and co-morbid conditions. We trust our feedback will inform the development of the Exposure Draft of the Bill for a new Aged Care Act.

Our submission reflects thoughtful consideration of the consultation paper questions by our specialist physicians. Input has come from key experts in areas such as geriatrics, internal and general medicine, rehabilitation medicine, occupational and environmental medicine, and public health medicine. We greatly appreciate and acknowledge the expert advice provided by the Australian and New Zealand Society of Geriatric Medicine (ANZSGM) with this submission.

Key RACP recommendations

The RACP recommends the new Aged Care Act should give sufficient consideration to:

1. **First Nations people.** Consistent recognition is required throughout the Legislation and Rules of the unique position, strengths and needs of First Nations people.
2. **Aged care workers**. To improve quality of care, the rights of workers must be centrally embedded in this Act.
3. **Models of care.** Co-funded arrangements between Commonwealth and State/Territory Health Departments that support the delivery of multidisciplinary outreach models of health care into residential aged care facilities, in line with Recommendation 58 of the Royal Commission into Aged Care Quality and Safety.
4. **Transition Care Program.** Provision of an unlimited Transition Care Program (TCP) system available from hospital. This would help the transition between hospital and community or residential aged care.
5. **Prevention.** The need for embedding explicitly that the approach to aged care must be preventative and proactive, supporting early intervention.
6. **Functional ability.** An Object should be added regarding functional ability, so aged care providers are encouraged to ensure that when considering service needs functional ability is assessed and then improved or maintained.
7. **Provisions for those below the arbitrary age-based eligibility of 65 years with high care needs.** This is a large group and includes people with earlier ageing issues. Their outcomes can become worse in the face of insufficient service provision and ineligibility for services these people need.

RACP consultation question responses

On the proposed structure, purpose and constitutional foundation of the new Act

1. Do you think the aged care legislative framework will be more accessible and transparent if there is a single piece of primary legislation and one set of Rules?

Our members agree that a single piece of primary legislation and one set of Rules is preferrable.

Additional comments:

- Clarity and a navigable structure will be essential to its functionality.
- Consistent recognition is required throughout the Legislation and Rules of the unique position, strengths and needs of First Nations people.
- Cultural awareness should be an inclusive term that is applied in practical and sensitive ways to facilitate effective care provision to our diverse Australian community.

2. Would you prefer to access separate topic-based subordinate legislation (like the current Quality of Care Principles 2014 and the Subsidy Principles 2014)?

Access to a separate topic-based subordinate legislation is preferrable.

Additional comments:

- An amalgamated source document increases awareness and accessibility and application.
- It is essential to consider the ease of updating and amending these regulations in any scenario.

3. What else would you like to see included in the Objects of the new Act?

Our members suggest these considerations:

- **The objects should be framed as higher standards**. For example, the proposed object "*ensure people accessing funded aged care services are free from mistreatment and neglect, and harm from poor quality or unsafe care*" could be reframed as "*People **should** have access to best practice services, facilities and care. This includes ensuring etc…"*
- **Include the work, health, wellbeing and safety of the health and aged care workforce** and the provision of effective return to work programs, consistent with the RACP Health Benefits of Good Work program.
- **Embed the critical role of functionality for older people in the objects**. The new Aged Care Act must be patient-centred and explicitly embed the importance of facilitating the functionality of older people, ie. "do with, rather than for" the older person.
    - An Object is needed that will encourage aged care providers to ensure that when considering service needs functional ability is assessed, and then improved and/or maintained where possible.
    - The proposed objects have a focus on service provision and access to services, but should also include the need for aged care to focus on the maintenance or improvement of the functional ability of older people. Such an Object would reflect existing aged care programs, such as short-term restorative care, transition care, and allied health and therapy and meet Recommendation 1 (p.205) from the Royal Commission "to ameliorate age-related deterioration in their social, mental and physical capacities to function independently".
    - A focus just on access to, and delivery of services (as in the existing Objects), ignores the fact that function can often be improved to some extent (or at least maintained through appropriate interventions), which gives older people a greater sense of empowerment, and may even lessen the need for services.
    - The 'environment' can be modified to support remaining functional deficits, through aids (e.g., walking frames) and through the creation of aged friendly spaces. The expertise of physiotherapists, occupational therapists, exercise physiologists, and allied health assistants is important here.
- **Recognise that accessing services and being able to navigate the aged care system is impacted by technology/computer expertise and having the requisite equipment.** The second to last Object could incorporate this issue.
- **The approach to aged care must be preventative and proactive, supporting early intervention.** This is a significant systemic problem. Issues such as frailty, and other problems which can affect or deteriorate the health and function of older people in the community should be part of the focus of the legislation. The legislation should acknowledge the role of aged care medical providers (geriatricians, rehabilitation medicine physicians and general practitioners) with an early detection focus to maintain older people's quality of life.
- **Provision of services should not be limited to care supports but also include equitable access to specific restorative therapy programs as an important component of maintaining independence.** These should be specifically aimed at restoring and maintaining function and independence. They are separate to Health-funded hospital inpatient rehabilitation programs related to specific events, eg. stroke or a fractured hip.

4. Do you think it is a good idea to include a 'Purpose Statement' in the new Act, as well as objects provisions? What do you think the purpose of the new Act should be?

Our members agree with the inclusion of a Purpose Statement.

Additional comments:

- The Purpose Statement, where it refers to aged care services, should include the necessary descriptor, ie. *"must be provided in a healthy and safe workplace for the aged care workforce".*

This is integral to raising the standard of aged care services and should be listed as a specific obligation of aged care providers.
- The proposed Purpose Statement could read as being all about meeting needs through service provision. However, there should also be a focus on the maintenance or improvement of the functional ability of older people.

5. Do you have any other feedback on the proposed structure of the new Act?

Our members note that they are seeing more people with developmental disabilities living to older ages. Recognition of, and provision for, older people with disabilities and their needs within the new Act should not be overlooked.

On the Statement of Rights

6. Do you support a Statement of Rights being included in the new Act?

Our members agree with including a Statement of Rights.

7. Are there any rights that you think we have missed that should be included?

Our members provided the following for consideration:
- Include reference to the rights of those persons who lack capacity to make decisions in the first proposed 'right' (page 15), regarding supported decision-making and a person's rights.
- Include the explicit right to equitable and timely access to healthcare services (including oral health) through pathways that are not discriminative or prohibit, for example, where people lack technological expertise.
    - Unmet healthcare needs in older people can lead to further decline in function and loss of independence. It is essential that older people receive aged care services appropriate to their assessed needs in a timely fashion, and that best meets their preferences in their setting.
- Include the right of aged care residents to be cared for in a healthy and safe environment.
- Include the right to accessible ***quality*** health care is fundamental.
- Include the right to an independent, safe and clear complaints process as part of the draft Right (10) *to be supported to exercise their rights, voice opinions and make complaints without fear of reprisal, and have complaints dealt with fairly and promptly*.

Additional comments:
- We draw attention to need to ensure there is more than a complaints process, there is recognition of the need for in-built system safeguarding of older people if they disclose abuse.
- The processes for anyone concerned about abuse to report must be made clear and promoted through education and information channels.

8. Are there any rights that you think should be worded differently?

- Page 16:
    - #7. A definition of "restrictive practices" should be included.
    - #8 refers to access to aged care services, however this overlooks other services such as tertiary care, which proved to be a significant issue during the COVID-19 pandemic.

Additional comments:
- *Conflicting rights*. It is important that a rights based Act addresses where there are conflicting rights, such as when individuals' rights collide. For example, this may occur when one person's right to freedom of movement intersects with restrictive practices.
- *The rights of aged care workers.* These need to be supported to have a workplace free from violence or harms and a workplace where restrictive practices are minimised to encourage growth in the aged care workforce.

9. We consider it critical that person-centred complaints pathways are available for older people to seek early resolution of concerns about their rights. This is because the ideal scenario is where the registered provider or if necessary, the Commission can address risks early, instead of using enforcement mechanisms after harm has already occurred. Do you think we have the balance right?

Our members support this approach.

Additional comments:

- Besides the Code of Conduct or the Quality Standards that may have been breached, there are other existing laws and approved codes (for example, Work Health and Safety) to which aged care services may be held accountable.
- Although it is stated that all registered providers will be expected to implement a complaints and feedback management system, the strategy of mediation could be included in the wording.

On the Statement of Principles

10. Do you support a Statement of Principles being included in the new Act as well as a Statement of Rights?

Our members support a Statement of Principles being included.

Additional comments:

- Noting the merit of and circumstances that have seen the need for a rights-based approach, we would like to see consideration given to building in the principles of a values-based approach, which allows then for negotiation, cooperation and compromise when needed. This offers scope in places such as rural, regional, remote communities where rigid compliance may not be a practical. For this reason, we suggest the Department examine any potential pitfalls in a rights based approach and make mitigating provisions.

11. Are there any principles that you think we have missed that should be included?

Our members suggest the following for consideration:

- The principle of needing to ensure a healthy and safe workplace for the aged care workforce. Workers have a right to a workplace free from violence and harms, and it is the inherent balance between conflicting rights that needs to be addressed, ie. if workers' rights are not addressed, workforce shortages may persist, and quality of care may not improve.
- The principle of needing to support and sustain a skilled aged care workforce as a key component of a high performing aged care system. To improve quality of care, the rights of workers must be centrally embedded in the Act.
- The principle of providing support to carers. The carer role is pivotal for the care of the older person. Carers need to be supported and enabled to sustain their own health. This might include mechanisms to identify carer stress or burn out.

12. Are there any principles that you think should be worded differently?

- Clarify the term *care leavers* in Principle 4.
- Remove "which are not unlimited" in Principle 9 (*The aged care system should fund aged care services, which are not unlimited …*) as it is understood that there are pragmatic constraints within the operating environment.

On high quality care

13. Are there any changes you would make to the proposed definition of high-quality care?

Our members suggest the following for consideration:

- The definition should include timely access to appropriate health care. It should also be provided wherever practical in the setting preferred by the older person.

- High quality care also includes having the expertise to identify when an older person receiving aged care or being assessed for eligibility might benefit from further health assessment.
- The definition and description must refer to the aged care workforce.
  - High quality care relies on a high degree of workforce participation – effective return to work programs and processes for the aged care workforce are contributing factors.
  - Training and accreditation of aged care workers is essential to high quality care. This includes workers being able to identify when there is a need for further health care.

14. Outside of the new regulatory model, are there any other initiatives that you would like to see addressed in the new Act to encourage registered providers to aim higher and deliver high quality care?

Our members suggest the following for consideration:

- **Aged care workers**. The training of aged care workers should be part of the Act. In the definition of high quality care, it is omitted. We note Recommendations 14, 78 and 114 of the Royal Commission into Aged Care Quality and Safety for reference.
- **Integrated care.** The benefits of an integrated care approach to care that considers the whole person in context and in their environment is important. This would better reflect a patient-centred approach.
- **Models of care.** Co-funded arrangements between Commonwealth and State/Territory Health Departments that support the delivery of multidisciplinary outreach models of health care into residential aged care facilities, in line with Recommendation 58 of the Royal Commission into Aged Care, are vital. Many jurisdictions are already successfully delivering these models of care however these often rely on short term funding arrangements. Specialist healthcare teams accessible from State health systems are urgently needed to bolster health care delivery in residential aged care facilities.
- **Clinical governance**. Responsibility for clinical governance needs to be clarified. The discussion document is unclear on this.
- **Complaints management.** Wording that promotes managing adverse outcomes or complaints from a "just culture" based approach (eg. Safer Care Victoria). In this framework, a systemic approach is adopted rather than a blaming approach to resolve situations. A just culture encourages balanced accountability and applies systems-thinking principles to adverse patient safety events.
- **Therapy programs.** The provision of prescribed restorative therapy programs should be included in the new Act. They should be automatically available as part of the care support packages under the Act. Currently therapy programs are not available under the Act and require specific ACAT approval. This creates inequity in access, delays and additional costs. Definitions of 'services' provided under the Act should specifically include access to prescribed restorative therapy programs. Restorative therapy programmes should be available both in the community and in residential care facilities.

On the proposed approach to penalties and compensation pathway

15. Do you support inclusion of the new statutory duty of care in the new Act?

Our members support the inclusion of the new statutory duty of care.

Additional comments:

- Workers have not been mentioned, in contrast to the Work Health and Safety Act 2011 (Commonwealth) in which there is a requirement for employers to train and educate.
- There is an implicit duty of care to all health professionals. Further clarification of the duty within the new Act is needed.

16. Do you think the new duty could result in any unintended consequences?

Our members provided the following as potential unintended consequences:

- Aged care providers may become increasingly unwilling to provide care to older people with certain challenging behaviours, such as due to Behavioural and Psychological Symptoms of Dementia (BPSD) or schizophrenia. Our members note there are already significant delays in

most jurisdictions with the transition of patients with challenging behaviours from hospital to aged care facilities, leading to substantial unnecessary acute and subacute hospital bed occupancy. The Commonwealth-funded Specialist Dementia Care Units have not ameliorated this situation.

- If a statutory duty of care were applied in the Act to individual aged care workers, this might discourage workforce participation in the aged care sector, which already faces substantial workforce shortages.
- There may be attempts to hide breaches.
- Consider the benefits of a "Just Culture" styled approach (in Q14 above).

17. Do you support related duties being placed on responsible and governing persons of aged care providers?

Our members supports this, providing the duties are clear, unambiguous and do not conflict with other duties relevant to the provision of healthcare services.

18. Do you think a related duty should be placed on aged care workers?

Our members did not have a clear view but offer these comments:

- It is noted that the Royal Commission did not include this as part of its Recommendation 14. A possible reason is the effect such a statutory duty might have on discouraging retention and recruitment in the aged care workforce.
- If a related duty is placed on aged care workers, this assumes that aged care workers have the necessary experience, qualifications, skills and training. The quality of aged care training should be reviewed in light of any new related duty.
- Any imposed duties should be clear, unambiguous and not conflict with other relevant duties.

19. Do you think a separate duty should be placed on organisations that provide enabling services and/or facilitate access to aged care workers? What should be the extent of such a duty?

Our members offer these comments:

- Caution may be warranted as it would be difficult to ensure organisations can operate a system with the same level of safeguards and oversight as offered by other aged care providers. Older people should be made aware of the fact that safeguards and oversight is limited.
- This could be seen as consistent with the wording of the Royal Commission's Recommendation 14. Such a duty should specify that organisations that provide enabling services and/or facilitate access to aged care workers must ensure that the services or workers are fit for purpose.
- The separate duty might be analogous to the Work Health and Safety Act 2011 (Commonwealth).
- The duty should apply to the organisation. The organisation has the same duty as the person providing care on behalf of that organisation. More duties may complicate the understanding of the duties.

20. Do you have any further feedback on the proposed approach to compensation?
No comment

On disclosure protections for whistleblowers

21. What challenges could there be with the proposed whistleblower framework, and do you have any proposed solutions?
No comment

22. What other barriers are there to people disclosing information about what they observe in the aged care system, and how can these best be overcome?
No comment

On the proposed approach to embedding supported decision making

23. What are your views on the proposed nominee framework?

Our members offer these comments:

- **Defining capacity to appoint a nominee**. Consideration should be given to the need for a definition on capacity to appoint the nominee regarding situations where there is no enduring power of attorney or guardianship order.
- **Alignment with other nominee arrangements**. There is support for aligning the framework with existing nominee arrangements in other schemes and considering a person's existing representatives for decision-making under other laws.
- **More than one nominee**. The framework should allow for a person to have more than one representative nominee, or more than one supporter nominee.

24. What challenges could there be with the proposed framework, and do you have any proposed solutions?

Our members offer these comments on potential challenges:

- As noted above, it would be helpful to be clear how many representatives there can be, and provisions for joint representatives / people sharing the role.
- Under the proposed framework it will be possible for a person to have someone appointed as their representative for the purposes of the Act, and a different person appointed as their Enduring Power of Attorney/Guardian under State legislation. Where those two different representatives to form different views about what kind of services the older person should receive, it is not clear how these disagreements would be resolved. Situations in which these kinds of disagreements arise frequently lead to older people becoming 'stranded' in a hospital bed far longer than is clinically necessary, placing burden on facilities, and exposing the older person to an increased risk of harm and distress.
- The Act must clearly provide for substituted decision making where supported decision making is not feasible, and where decisions that are contrary to the older person's expressed wishes might need be made. This is acknowledged in the consultation paper but it is included almost as a footnote. However this is a relatively common scenario in the practice of geriatric medicine.
- Conflicts between family members or persons of interest may arise, in which case it should be clear which person is the nominee and then that person should be the main channel of communication to avoid conflict. Delegation may be possible but must be presented in writing and with consent from the decision maker (either the older person or legally appointed representative).
- Clarity should be given on how this will work in relation to State/Territory Guardianship provisions.

25. Are there any other duties or obligations you think should be put on appointed nominees?
No comment

26. When do you consider a supporter nominee would be most useful to a recipient of aged care services? For example, to convey decisions, understanding processes, receiving and explaining correspondence in a way which is understood by the older person.

Our members offer these comments on when a supporter nominee would be most useful:

- An older person should be asked if they wish to have a supporter nominee at the earliest opportunity and if they wish them present for any and all discussions every time.
- The supporter nominee can assist with navigating a complex system and advocating for the older person, as well as assisting with information sharing.

27. What kind of information do you think support nominees should receive?

Our members suggest the following:

- Information about the level of care to be received, information about providers, information about available services, and client finance statements.
- The nominee duties and responsibilities and the extent of their scope in making or helping make decisions.
- The same information as 'regular representatives' are provided with under the existing arrangements (My Aged Care); all duplicate correspondence unless the consumer opts out.

28. Are there any categories of information that support nominees should not receive?

Our members suggest the following:

- Information at the discretion of the consumer, on an 'opt out' basis. When nominating a support person, the older person should be asked if there is any information that should not be shared with the nominee.

29. How can the Department best support the transition from current My Aged Care (MAC) arrangements to the new nominee arrangements? Are there any implementation issues you are concerned about?

Our members make the following suggestions:

- This can be done through clear communications to stakeholders providing sufficient lead time, wide publication of new arrangements, global information via television and online as well as other means including social media and streaming platforms.
- If possible, regular representatives and authorised representatives under the current MAC arrangements could be automatically transitioned as supporter nominees and representative nominees (respectively) under the new arrangements. The risk of not automatically transitioning representatives in this fashion is that very large numbers of aged care recipients will be left without the support they rely on to navigate the aged care system, resulting in significant harm to older people when they are unable to access the services they need, and potentially avoidable hospital presentations.
- If automatic transitioning is undertaken, all existing MAC clients should be notified in writing of the transition and the effect this will have on their own representatives and be provided with avenues to notify the relevant authority if they do not wish existing representatives to transition to equivalent roles under the new scheme. Representatives of existing MAC clients should also be notified of the change and its effects in writing.

On the proposed approach to embedding supported decision making

30. Do you support the proposed eligibility requirements under the new Act?

Our members offer provisional support, noting these issues:

- The eligibility requirements should be monitored and reviewed once operationalised.
- An arbitrary age cut-off does not support the principle of individualised, person-centred care. Members draw attention to the arbitrariness of the age-based determination when there is a large group of older persons not yet 65 years with high care needs and/or ageing related disability, for whom there are no specific provisions. Such people would be best cared for in residential aged care. However, in the face of lack of alternatives, they are stranded in hospital for prolonged periods. There are many in that close to 65-year age bracket who have ageing related health problems (eg. early onset dementia or stroke) or who have cancer and a declining health trajectory and are not easily supported by the Disability sector.

31. Do you have any concerns about people under 65, unless homeless or First Nations and over 50, being excluded from entering funded aged care services?

Our members draw attention to the following situations and groups of people with significant health care needs for whom there is poor systemic care provision:

- In rural and remote areas the eligibility requirements may not be practical.
- As described in the Q30, there are those people not yet 65 with high care needs that could be met in residential facilities but in the face of no alternatives, must remain in hospital to receive the right level of care. Examples of such conditions include early onset

dementia, stroke, or cancer. However, there are other conditions with a declining health trajectory for whom the Disability sector (defined generally as static and unchanging) does not serve these people well, in the face of declining health and increasing care needs as their disease progresses. This is a large group which our members encounter and includes people with earlier ageing issues, whose situation becomes worse in the face of poor service provision and ineligibility to the services they need.

- For those deemed not appropriate for the NDIS due to very high level of care needs that cannot be provided outside of aged care, there is poor systemic provision. In these cases, access to residential aged care facilities (or similar styled facilities) is paramount.
  Illustrative example
  An illustrative situation where it might be appropriate for people under age 65 to access funded aged care services, in particular residential aged care is that of an adult with a pervasive neurodevelopmental disorder (such as Down's Syndrome, Trisomy 21), with an ageing carer (usually a parent) who themselves require residential aged care. Such a person might not have a life expectancy greater than 65 years, might be subject to a greater rate of some aspects of physiological ageing (for example, people with Down's Syndrome have a relatively high chance of developing Alzheimer's Disease by around the age of 50), and might have been cared for their entire lives by the older carer, sometimes without assistance from formal care services or disability agencies. With advancing age and the advent of frailty and medical comorbidities, if the carer themselves needs to be admitted to a residential aged care facility, this can be very problematic for the younger disabled person. It may be highly distressing for both parties to be forced to live separately, and it may be reasonable in some circumstances for both to reside in an aged care home.

32. Are there other things you would like to see changed about entry arrangements for the aged care system?

Our members offer the following comments:

- An unlimited Transition Care Program (TCP) system would help the transition between hospital and community/residential aged care.
  - The intersection between hospital and residential aged care is a very important one, and increasingly so as the health needs of older people is becoming more complex.
  - This has the potential to effect health outcomes for older people. There are insufficient numbers of TCP beds.
- The role of Aged Care Assessment Teams (ACATs, or their equivalent under the new Act) should remain with State/Territory Health Departments and should maintain strong links with local geriatric multidisciplinary services. The ACAT teams have the clinical skills to determine who would benefit from further health care assessment and management and can facilitate this. They also play a role in helping people navigate the aged care system.

We trust these thoughtful comments and advice from experts in aged care will be taken up in the development of the new Act. The RACP is always available for any additional expert advice.

As the Legislation and associated Rules and Regulations are developed, the RACP and our member expertise would be important to any steering committee and advisory group, and we would be pleased to participate.

Please contact us via email policy@racp.edu.au for any assistance.