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Submission: New Aged Care Act: Draft Exposure Bill

February 2024

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 21,500 physicians and almost 9,000 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including rehabilitation medicine, geriatric medicine, palliative medicine, general medicine, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, paediatrics and child health, sexual health 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, the medical profession 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.

Executive summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to participate in shaping the new Aged Care Act and would like to assist the Department of Health and Aged Care with its refinement. The Act is important to address the needs of older people and the quality and timeliness of access to services, particularly health care. Medical and health care is a critical part of the reform of aged care and is vital to older people.

The RACP is the source of expert interdisciplinary specialty knowledge and experience. This submission is the result of contributions from geriatric medicine, palliative medicine, rehabilitation medicine, public health, general and acute care medicine. In preparing this submission, we received valued input from our affiliated Specialty Society, the Australian and New Zealand Society of Geriatric Medicine (ANZSGM).

As experts in medical health care, we ask the Department, as part of its transformational change for improving aged care, to consider incorporating the following important recommendations and suggestions.

Recommendations

1. **Specific reference to health care.** We suggest that the Act has more direct, specific reference to health care, and not just “care”, in ways that we note in this submission and our previous submission (September 2023). We feel this is important given the value of health care to older people and this would also help to emphasise a person-centred orientation in aged care.
2. **Inclusion and recognition of functional ability.** We suggest that an Object 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 (refer to our RACP submission (September 2023) for more detail). We feel that functional ability is a significant omission and necessary to include in the Act.
3. **Inclusion of timeliness of access to health care and services**. We suggest that timely access to appropriate health care is included in the Act, as this is an important older person’s right.
4. **Involvement and engagement with the RACP.** We suggest that the RACP and our expert members be part of the advisory and review processes regarding health care to ensure the legislation meets the needs of older people and will work as intended.

Additional Feedback

Chapter 1 – Introduction

Part 1 – Preliminary

Objects of the new Act

Given the findings of the Royal Commission into Aged Care Quality and Safety, a foundational piece of legislation must have specific inclusions and statements to safeguard the health care of older people. If the legislation is to be fully person-centred, we suggest the following need to be addressed in the Objects under Section 5 of the Act:

- **Functional ability**[1], that is assessed by aged care providers and then improved or maintained wherever possible – suggest insert within Object (b) as an additional subpoint.
- There are limited statements in the Act to ensure that **aged care services include** not only care and accommodation but also **access to therapy programs for restoration and maintenance of function**. All Objects/Standards refer to ‘care services’, but not access to therapy services as part of that care.
- Ensuring equitable access to **culturally safe environments** for older individuals from **First Nations** and **culturally and linguistically diverse (CALD) backgrounds**. The importance of

[1] The World Report on Ageing and Health defines healthy ageing as ‘the process of developing and maintaining functional ability that enables wellbeing in older age’. The World Health Organization (WHO) encourages strategies to help develop and maintain older people’s functional abilities. See WHO World report on ageing and health, 2015.

this inclusion is relevant when many older Australians revert to a primary (often non-English) language because of dementia or other neurodegenerative conditions, limiting their ability to communicate their needs.

Part 2 – Definitions and key concepts

High quality care

Section 19 (v) supporting the improvement of the individual's physical and cognitive capacity, where the individual chooses to, including by keeping the individual mobile and engaged if they are living in an approved residential care home.

- This item reads as though it is tied to residential care.
- We suggest an amendment to recognise that supporting the improvement of an individual's physical and cognitive capacity should equally apply to older people who are living in the community. This would reinforce the right of an older person to support for the improvement or maintenance of functional ability.

Section 19 (viii) implementing inclusive policies and procedures, in partnership with Aboriginal or Torres Strait Islander persons, family and community 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.

- We suggest this item should also include Australians from CALD backgrounds, recognising that the needs of CALD individuals go beyond access to bilingual staff (refer 19(x)).
    - Many older people from CALD backgrounds have profound social isolation due to migrating to Australia and often leaving their wider social networks and extended family networks in their countries of origin.
    - Older people from refugee/asylum seeker communities have fled traumatic situations in their countries of origin that can increase vulnerability to conditions like post-traumatic stress disorder (PTSD) which may exacerbate conditions like Behavioural and Psychological Symptoms in Dementia (BPSD).

We suggest that Section 19 also include specific reference to:

- Respecting an older person's preference regarding preferred place of care and preferred place of death. We suggest that there be requirements to explore whether older people have an Advance Care Directive and, if not, to support them in making one.
- Maintaining ongoing sufficient funding, provided by the Commonwealth Government as needed, for specialist palliative care outreach services in the aged care sector.
- Ensuring aged care staff are appropriately trained and have access to ongoing education in the provision of palliative care and end of life care.

We also suggest more explicit linking of Part 3 on Aged Care Rights and Principles (which recognises the right of individuals to culturally safe care and equitable access to palliative care) to the provisions in Section 19 on providing high quality care.

Part 3 – Aged care rights and principles

Aged care rights

- **Timely access to appropriate health care** is an older person's right and should be included in the Act.[2]
- Whilst the safety, health, wellbeing and quality of life of older people is acknowledged as key areas it is important to also include the **obligation on aged care providers to facilitate timely access to appropriate health care**, including primary, specialist and allied health care.
- Timely health care should also be provided, wherever practical, in the preferred place of the older person.

Equitable access to health care

- Although there is mention of equitable access to palliative care and end of life care (Part 3, Section 20(2)(b)), there is no mention of other forms of health care. We suggest an amendment

[2] RACP Submission. A New Aged Care Act: the foundations (2023). URL:https://www.racp.edu.au//docs/default-source/advocacy-library/submission-to-a-new-aged-care-act-the-foundations.pdf?sfvrsn=706fd71a_4

to include 'equitable access to health care including rehabilitation, palliative care and end of life care'.

Aged care principles: Statement of principles

- We suggest a small amendment for Section 22(3)(d) to ensure older people who wish to access palliative care at home, in residential aged care or hospice settings can do so. The current wording is ambiguous and may lead to unnecessary transfers between care and healthcare settings and care teams. We suggest the following:
  - Section 22(3)(d): *maintain and improve the individual's physical, mental, cognitive and communication capabilities to the extent possible, except where it is the individual's choice to access palliative care and end-of-life care* [**INSERT in their preferred place of care**]; *and…*

Part 4 – Supporters and representatives

We suggest this section include some additional considerations:

- Supporter(s)/representative(s) should undergo rigorous assessments of mental and physical capacity, similar to requirements for Working with Children Checks, supported by references such as a Criminal Record Check and others involved in their care.
- It is important to include that the people appointed as supporter(s)/representative(s) declare any conflicts of interest.
- For older people with cognitive impairment who do not have appropriate documents appointing supporter(s)/representative(s) but may wish to do so – ie. how is their reduced capacity considered to allow for their want to be respected.
- Some older people may wish to appoint representative(s) but have someone else make decisions for them, as this is acceptable practice in some cultures that family members will make decisions for an older person, even when the older person has capacity to make their own decisions. It is worth adding the proviso that in such circumstances the older person retains the ability to object to/override any decision made by the supporter(s)/representative(s) should they wish to do so.

Appointment of supporter(s) and representative(s)

Prohibiting the simultaneous appointment of both supporter(s) and representatives(s) seem unnecessarily restrictive. Having both supporter(s) and representative(s) can be beneficial:

- For complex situations, collaborating is more effective.
- An older person's needs can be multifaceted, spanning medical, family, and social aspects, often requiring support that extends beyond the capabilities of a single supporter or representative.
- An older person may regard supporter(s) as performing an important review function when appointed in conjunction with representative(s) (i.e. supporter(s) may, in a sense, hold representative(s) "to account" for decisions).
- Recognising that supporter(s) and representative(s) have other commitments and may not be available when required, so having more than one allows the appropriate support is available for an older person and maximises an older person's self-determination.
- Consideration of particular circumstances, such as if there is a conflict of interest, a dispute, or any indication of elder abuse, with clear guidelines in place to navigate such situations.

Support for providers

We believe that registered providers will require:

- Clear definitions and expectations of supporter(s) and representative(s) for older people.
- The establishment of a communication system facilitating interactions between providers, supporter(s) and representative(s).
- Guidelines to address disputes or complications that may arise during interactions, ensuring smooth collaboration and effective decision-making.

Penalty of supporter(s) and representative(s)

- Non-compliance with duties as supporter(s)/representative(s) should be deemed a serious matter. We feel an initial warning should be issued, followed by information outlining their duties, and if a re-occurrence occurs there should be immediate cessation of their roles. We feel there

needs to be accountability and standards for those entrusted with supporting and representing older people.

Chapter 2 – Entry to the Commonwealth aged care system

- Entering the aged care system should be a streamlined and straight-forward process, based on a single, simple application for funded aged care services. We feel this should remain with qualified and experienced multidisciplinary Aged Care Assessment Teams (ACAT), and not outsourced to Regional Assessment Services.

Chapter 7 – Managing information

Safeguarding of older people

- We suggest inclusion of a section specifically stating how older people will be safeguarded if they disclose abuse (which may be emotional or financial)/neglect/violence. A disclosure of abuse/neglect/violence may be dismissed if the person has cognitive decline as the person may not be believed. Training and education of people who interact with older people needs to be thorough.
- Any information disclosed needs to be easy to find and explicit, including details of steps, contacts, responsibilities and safety.

Other comments

Restorative care/reablement

There is no explicit mention of an approach which encompasses rehabilitation/restorative care/reablement for older people.

- Without explicit mention of rehabilitation/restorative care/reablement, aged care will likely continue to be oriented to task-based activities, rather than working alongside older people to rehabilitate/re-enable them with activities of daily living to support their quality of life.
- Without this, the Act will not facilitate a change in the way aged care services could be delivered. Currently, there is only mention of short-term restorative care and transition care services. Rehabilitation and reablement and are not mentioned.
- International trends promote functional ability (eg. the WHO[3]).

Governance

- It is proposed that the governance arrangements will include a System Governor, Inspector-General of Aged Care, Aged Care Quality and Safety Commissioner, National Aged Care Advisory Council, Aged Care Quality and Safety Advisory Council and Council of Elders. We feel that there should be clear information regarding responsibilities and accountabilities, as well as how is it proposed that they will work collaboratively in the complex aged care system.

Closing remarks

The RACP notes the provision for independent review of the new Act in five (5) years and suggests that qualitative and quantitative formative evaluation processes be established for this review. The RACP and our members would also welcome the opportunity to be part of the advisory and review process regarding health care.

We welcome the Department's consideration of our recommendations and look forward to working with the Department further to achieve improvements in aged care. If you wish further information or to engage with us, please contact the RACP Policy and Advocacy unit via policy@racp.edu.au We look forward to hearing from you.

[3] World Health Organization World report on ageing and health, 2015.