

EXPLANATORY STATEMENT

Issued by the authority of the Minister for Senior Australians and Aged Care Services

Aged Care Act 1997

Aged Care Legislation Amendment (Aged Care Recipient Classification) Principles 2021

Purpose

The purpose of the *Aged Care Legislation Amendment (Aged Care Recipient Classification) Principles 2021* (Amending Principles) is to amend the *Accountability Principles 2014* (Accountability Principles) and the *Classification Principles 2014* (Classification Principles), to give effect to matters set out by the *Aged Care Amendment (Classification of Care Recipients) Act 2020* (Amending Act).

The Amending Principles will amend the Accountability Principles to set out legislative provisions relating to the requirement for approved providers to allow delegates of the Secretary access to an aged care service to assess the care needs of care recipients.

The Amending Principles will also amend the Classification Principles to set out the procedures that the Secretary (or their delegate) must follow to classify a care recipient for the purposes of Part 2.4A of the *Aged Care Act 1997* (Act). The Amending Principles will also set out the classification levels and how a care recipient may be assessed and classified into each class, as well as specifying the circumstances in which a care recipient's care needs are taken to have changed significantly for the purposes of reclassification of a care recipient. The Amending Principles also set out the criteria for persons to whom the Secretary's assessment powers may be delegated.

The Amending Principles are a legislative instrument for the purposes of the *Legislation Act 2003*.

Background

The Amending Act commenced on 1 March 2021 and inserted new Part 2.4A in the Act, titled 'Classification of Care Recipients on Secretary's initiative'. Part 2.4A of the Act empowers the Secretary of the Department of Health to assess care recipients using a new assessment tool and to assign new classification levels.

Part 2.4A of the Act provides the Secretary the power to classify a care recipient for respite or non-respite care, according to the level of care the care recipient needs relative to the needs of other care recipients, in certain circumstances. The provisions in Part 2.4A of the Act allow for the Classification Principles to set out a range of matters for the purposes of the classification, or reclassification as the case may be, of care recipients. These matters include, but are not limited to:

- specifying methods or procedures that the Secretary must follow in determining the appropriate classification level for the care recipient;

- any other matters the Secretary must take into account in classifying the care recipient;
- the date on which a classification takes effect;
- specifying procedures that the Secretary must follow in assessing the level of care required by the care recipient; and
- setting out the classification levels for classifications of care recipients.

To enable the exercise of the new powers and functions under Part 2.4A of the Act, the Act includes provisions requiring approved providers of aged care to allow delegates of the Secretary access to the service to assess the care needs of care recipients.

Accordingly, section 96-2(15) of the Act permits the Secretary to delegate their powers and functions under section 29C-3 of the Act to a person who satisfies the criteria specified in the Classification Principles. If a person meets the criteria, they may assess the care recipient for the purposes of Part 2.4A of the Act.

The Australian Government funded academic studies and trials conducted between 2017 and 2020 with the aim of formulating a new residential aged care assessment, classification and funding system. As a result, a new method for classifying care recipient was developed. The new system is called the Australian National Aged Care Classification (AN-ACC). Publications relating to the development of this system include the University of Wollongong's *Resource Utilisation and Classification Study* and the Department of Health's *Trial of the AN-ACC Assessment Framework*. Both publications will be accessible at <https://www.health.gov.au> at the date the Amending Principles commence.

The changes implemented through the Amending Principles will not affect the level of care provided to care recipients, or the amount of subsidy paid to approved providers of aged care.

Authority

Section 96-1 of the Act provides that the Minister has the power to make instruments providing for matters required or permitted, or necessary or convenient, in order to give effect to the relevant Part or section of the Act. Item 1 in the table to section 96-1 of the Act provides that the Minister may make Accountability Principles providing for matters in Part 4.3 of that Act. Item 9 in the table to section 96-1 of the Act provides that the Minister may make Classification Principles providing for matters in Part 2.4A of that Act.

Reliance on subsection 33(3) of the *Acts Interpretation Act 1901*

Under subsection 33(3) of the *Acts Interpretation Act 1901*, where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend, or vary any such instrument.

Documents Incorporated by Reference

The Amending Principles incorporate the following documents by reference:

- the Australian National Aged Care Classification Assessment Tool (AN-ACC Assessment Tool); and
- the Australian National Aged Care Classification Reference Manual (AN-ACC Reference Manual).

These documents will be accessible at <https://www.health.gov.au> at the date the Amending Principles commence.

Consultation

The Attorney-General's Department was consulted in drafting the Amending Principles. The aged care sector and the general public were consulted extensively between 2017 and 2020 on the development of the AN-ACC system, including the assessment and classification elements of the system that are embodied in the Amending Principles. Consultation included a formal public consultation process held from March to May 2019 which received 91 submissions, which strongly supported reform of residential aged care assessment, classification and funding arrangements. Implementing the assessment and classification elements of the AN-ACC system is also consistent with Recommendation 120 ('Casemix-adjusted activity based funding in residential aged care') of the 1 March 2021 *Final Report* of the Royal Commission into Aged Care Quality and Safety.

Commencement

The Amending Principles commence on 1 April 2021.

Regulation Impact Statement (RIS)

The Office of Best Practice Regulation (OBPR) was consulted during development of the Amending Act on the regulatory costs of implementing the assessment and classification elements of the AN-ACC system that these Amending Principles will enable. OBPR advised that a RIS was not required (OBPR ID 25927).

The Department of Health acknowledged this advice by letter to the OBPR, accessible at https://ris.pmc.gov.au/sites/default/files/posts/2020/11/m_lye_correspondence_-_shadow_assessment_-_8_october_2020.pdf at the date the Amending Principles commence. This letter noted residential aged care providers will be required to provide access to care recipients and their clinical notes, and to enable AN-ACC assessors to speak to clinical staff about care recipients' care needs if required.

Details of the Aged Care Legislation Amendment (Classification of Care Recipients) Principles 2021

Section 1 states that the name of the amending instrument is the *Aged Care Legislation Amendment (Aged Care Recipient Classification) Principles 2021*.

Section 2 states that the Amending Principles commence on 1 April 2021.

Section 3 states that the Amending Principles are made under the *Aged Care Act 1997*.

Section 4 states that each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

Schedule 1 amends the Accountability Principles and the Classification Principles.

Schedule 1—Amendments

Accountability Principles 2014

Item 1 – After Part 1

This item inserts new Part 1A—Allowing delegates of Secretary access to service to assess care needs of care recipients, after Part 1 of the Accountability Principles. New Part 1A comprises new sections 4A and 4B.

New section 4A states the purpose of new Part 1A. For the purposes of paragraph 63-1(1)(ha) of the Act, new Part 1A requires an approved provider to allow delegates of the Secretary, performing the new assessment function permitted by section 29C-3 of the Act, access to an aged care service to assess the care needs of care recipients provided with care through the service.

New subsection 4B(1) states that the section applies if two conditions are met. The first condition is that a delegate of the Secretary gives the approved provider of the service written notice that the delegate requires access to the service, on a day specified in the notice, to assess under section 29C-3 of the Act the care needs of care recipients provided with care through the service. The second condition is that the notice is given at least two days before the specified day.

New subsection 4B(2) outlines the access that an approved provider must allow to the delegate on the specified day for the delegate to make the assessments. This includes access to:

- all areas of the premises used to provide care through the service;
- staff members of the approved provider who are on those premises on the specified day;
- the care recipients whose care needs are to be assessed; and
- records relating to the care needs of those care recipients.

Classification Principles 2014

Item 2 – Before Part 1

This item inserts a new Chapter heading, Chapter 1—Preliminary, before Part 1 of the Classification Principles. Chapter 1 sets out the preliminary matters relating to the operation of both Part 2.4 of the Act (Classification of care recipients) and the new Part 2.4A of the Act (Classification of care recipients on Secretary’s initiative) inserted by the Amending Act.

Item 3 – Section 4

This item inserts a number of new defined terms into section 4 of the Classification Principles. The new terms and their definitions relate to the operation of Part 2.4A of the Act. The new terms are used by reference in other items in the Amending Principles.

Many of the new terms refer to assessment items in the AN-ACC Assessment Tool, which will be publicly available on the Department of Health’s website at <https://www.health.gov.au>.

The assessment items will be used by assessors to assess the level of care a care recipient will need. Each assessment item is published in academic literature (referenced in the AN-ACC Reference Manual), is clinically validated and is either in the public domain, or use under licence from the copyright holder has been arranged by the Department of Health for the purposes of conducting assessments under section 29C-3 of the Act.

The assessment items include the:

- Australian Modified Functional Independence Measure (AFM) assessment item, which measures care burden and is administered by direct observation and/or communication with the care recipient and/or their carer. The AFM Australian Functional Measure is based on the Functional Independence Measure.
- Australia-modified Karnofsky Performance Status (AKPS) assessment item, which measures the care recipient’s overall performance status or ability to perform their activities of daily living.
- Behaviour Resource Utilisation Assessment item, which measures the implications of the care recipient’s behaviour for carers and service providers, in terms of the levels of monitoring and supervision required.
- Braden Scale assessment item, which measures the care recipient’s risk of developing a pressure sore by examining six subscales.
- De Morton Mobility Index (DEMMI) assessment item, which measures the mobility of older people across clinical settings.
- Rockwood Frailty Score assessment item, which measures the care recipient’s frailty.
- Resource Utilisation Group – Activities of Daily Living (RUG) assessment item, which is a 4-item scale measuring motor function with activities of daily living for bed mobility, toileting, transfer and eating. It provides information about the care recipient’s functional status, the assistance they require to carry out these activities and the resources needed for the care recipient’s care.

New definitions such as ‘*medical practitioner*’, ‘*occupational therapist*’, ‘*physiotherapist*’ and ‘*registered nurse*’ refer to the ‘*National Law*’.

The National Law has the same meaning as in the *My Health Records Act 2012*. In section 5 of that Act, the National Law means:

- (a) for a State or Territory other than Western Australia—the Health Practitioner Regulation National Law set out in the Schedule to the *Health Practitioner Regulation National Law Act 2009* of Queensland, as it applies (with or without modification) as a law of the State or Territory; or
- (b) for Western Australia—the *Health Practitioner Regulation National Law (WA) Act 2010* of Western Australia, so far as that Act corresponds to the Health Practitioner Regulation National Law set out in the Schedule to the *Health Practitioner Regulation National Law Act 2009* of Queensland.

A ‘*police report*’ is defined to have the same meaning as in the *Aged Care Quality and Safety Commission Rules 2018* (Commission Rules). Section 4 of the Commission Rules provide that a police report means a report about a person’s criminal conviction record that is issued by:

- (a) the Australian Federal Police; or
- (b) the police force or police service of a State or Territory.

A ‘*serious offence conviction*’ has the same meaning as in the Commission Rules. Section 4 of the Commission Rules provides that a person has a serious offence conviction if the person has been:

- (a) convicted of murder or sexual assault; or
- (b) convicted of, and sentenced to imprisonment for, any other form of assault.

The term ‘*significant*’ is defined with reference to new section 4A (see Item 4 below). A care recipient mentioned in an item of the table in new section 4A has ‘*significant*’ compounding factors if the compounding factors for the care recipient, considered together, indicate that the care recipient has significantly higher care needs relative to the needs of other care recipients mentioned in that item.

Item 4 – At the end of Part 1

This item inserts new sections 4A and 4B into the Classification Principles.

Compounding factors

New section 4A sets out the meaning of the term ‘*compounding factors*’. The table in section 4A sets out the compounding factors for care recipients. Compounding factors are considered at Step 5 of the procedure for determining the appropriate classification level for non-respite care for a care recipient under new section 32 of the Classification Principles (see Item 6 of the Amending Principles).

Compounding factors differ depending on various matters, including whether a care recipient is independently mobile, is mobile only with assistance, or is not mobile.

Consideration is also given to a care recipient's cognitive ability and function, and risk of pressure sores.

Each item of the table to new section 4A sets out the compounding factors corresponding to the relevant level of mobility and level of cognitive ability of the care recipient. The compounding factors will be determined as a result of the assessor assessing the care recipient in accordance with the assessment items in the AN-ACC Assessment Tool (as those assessment items are defined in Item 3 of the Amending Principles).

Palliative care plan

New section 4B sets out the requirements for a palliative care plan. A palliative care plan is considered at Step 1 of the procedure for determining the appropriate classification level for a care recipient for non-respite care under new section 32 of the Classification Principles.

The requirements for a palliative care plan include that it was prepared within 3 months before the care recipient entered the residential care service. The plan must be prepared by a medical practitioner or registered nurse from a specialist palliative care team, primary care team or hospital discharge team, independently of the residential care service.

The plan must state the Australian Health Practitioner Regulation Agency registration number, practice address, and contact details for the medical practitioner or registered nurse who prepared the plan. The plan must also include the care recipient's Australia-modified Karnofsky Performance Status score, a statement by a medical practitioner of the care recipient's prognosis of life expectancy, and whether the care recipient is in a stable, unstable, deteriorating or terminal palliative phase.

The medical practitioner providing the statement regarding the care recipient's prognosis of life expectancy is not required to be the same medical practitioner who prepared the palliative care plan.

Item 5 – Before Part 2

This item inserts a new Chapter heading, 'Chapter 2—Classification of care recipients under Part 2.4 of the Act' before Part 2 of the Classification Principles. The new Chapter heading will assist to distinguish matters in the Classification Principles that deal with classification of care recipients under Part 2.4 of the Act from matters that deal with classification of care recipients under the new Part 2.4A of the Act.

Item 6 – After Part 10

This item inserts new Chapter 3—Classification of care recipients under Part 2.4A of the Act, consisting of new Parts 11 to 14. Parts 11 to 14 set out the new scheme to classify aged care recipients for the purposes of Part 2.4A of the Act.

New Part 11—Classification of care recipients (new sections 30 to 33) sets out the provisions relating to the classification of care recipients.

New section 30 states that, for the purposes of section 29C-2 of the Act, Part 11 specifies the procedure the Secretary must follow in determining the appropriate

classification level for a care recipient for respite care or non-respite care, and the day on which a classification of a care recipient takes effect.

Determining appropriate classification level – respite care

New section 31 provides that, for the purposes of subsection 29C-2(3) of the Act, the procedure set out in subsection 31(2) is specified to determine the appropriate classification level for a care recipient for respite care.

The Secretary must take the steps outlined in new subsection 31(2), using the assessment of the care needs of the care recipient made under section 29C-3 of the Act for the purposes of classifying the care recipient.

Step 1: Work out whether the care recipient is independently mobile, is mobile only with assistance or is not mobile.

Step 2: Determine that the appropriate classification level for the care recipient is as follows:

- (a) if the care recipient is independently mobile—Respite Class 1; or
- (b) if the care recipient is mobile only with assistance—Respite Class 2; or
- (c) if the care recipient is not mobile—Respite Class 3.

The care recipient’s De Morton Mobility Index (DEMMI) score (see Item 3 and the AN-ACC Assessment Tool) is used to work out the care recipient’s status as independently mobile, mobile only with assistance, or not mobile.

Determining appropriate classification level – non-respite care

New section 32 provides that, for the purposes of subsection 29C-2(3) of the Act, the procedure set out in subsection 32(2) is specified to determine the appropriate classification level for a care recipient for non-respite care. The Secretary must take the steps outlined in new subsection 32(2) to determine the appropriate classification level for a care recipient for non-respite care, using the assessment of the care needs of the care recipient made under section 29C-3 of the Act for the purposes of classifying the care recipient.

Step 1: If the Secretary has assessed the care recipient as having palliative care status, then proceed to Step 6, as Steps 2 to 5 do not apply to the care recipient.

A care recipient will have palliative care status if the requirements of new subsection 36(2) are met. That is, a care recipient must be assessed as having a palliative care status if the care recipient entered the residential care service with a palliative care plan that meets the requirements of section 4B and, according to the plan, the care recipient has:

- a prognosis of a life expectancy of 3 months or less on the day the care recipient entered the residential care service; and
- an Australia-modified Karnofsky Performance Status score of 40 or less.

Step 2: Work out whether the care recipient is independently mobile, is mobile only with assistance, or is not mobile.

The care recipient's De Morton Mobility Index (DEMMI) score is used to work out the care recipient's status as independently mobile, mobile only with assistance, or not mobile.

Step 3: If the care recipient is mobile only with assistance, work out whether the care recipient has higher cognitive ability, medium cognitive ability, or lower cognitive ability.

The care recipient's AFM cognition score is used to work out whether the care recipient has higher cognitive ability, medium cognitive ability, or low cognitive ability.

Step 4: If the care recipient is not mobile:

- (a) work out whether the care recipient has higher function or lower function; and
- (b) if the care recipient has lower function—work out whether the care recipient has higher pressure sore risk or lower pressure sore risk.

The care recipient's RUG total score is used to work out whether the care recipient has higher function or lower function. The care recipient's Braden total score is used to work out whether the care recipient has a higher pressure sore risk or lower pressure sore risk.

Step 5: If the care recipient is any of the following, determine whether the care recipient has significant compounding factors:

- (a) is independently mobile; or
- (b) is mobile only with assistance and has higher cognitive ability or medium cognitive ability; or
- (c) is not mobile and has higher function; or
- (d) is not mobile, has lower function and has higher pressure sore risk.

The care recipient's De Morton Mobility Index (DEMMI) score is used to work out the care recipient's status as independently mobile, mobile only with assistance, or not mobile.

The care recipient's AFM cognition score is used to work out whether the care recipient has higher cognitive ability, medium cognitive ability or low cognitive ability.

The care recipient's RUG total score is used to work out whether the care recipient has higher function or lower function.

The care recipient's Braden total score is used to work out whether the care recipient has a higher pressure sore risk or lower pressure sore risk.

The compounding factors that apply are worked out using the table in new section 4A (see Item 4).

Step 6: Determine the appropriate classification level for the care recipient.

The classification level for care recipients is set out in a table in new subsection 32(3), with the appropriate classification determined as follows:

- Class 1: has been assessed as having palliative care status;
- Class 2: is independently mobile, and does not have significant compounding factors;
- Class 3: is independently mobile, and has significant compounding factors;
- Class 4: is mobile only with assistance, and has higher cognitive ability, and does not have significant compounding factors;
- Class 5: is mobile only with assistance, and has higher cognitive ability, and has significant compounding factors;
- Class 6: is mobile only with assistance, and has medium cognitive ability, and does not have significant compounding factors;
- Class 7: is mobile only with assistance, and has medium cognitive ability, and has significant compounding factors;
- Class 8: is mobile only with assistance, and has low cognitive ability;
- Class 9: is not mobile, and has higher function, and does not have significant compounding factors;
- Class 10: is not mobile, and has higher function, and has significant compounding factors;
- Class 11: is not mobile, and has lower function, and has lower pressure sore risk;
- Class 12: is not mobile, and has lower function, and has higher pressure sore risk, and does not have significant compounding factors; and
- Class 13: is not mobile, and has lower function, and has higher pressure sore risk, and has significant compounding factors.

The compounding factors that apply to the care recipient are set out in the table under new section 4A (see Item 4). A care recipient has significant compounding factors if their compounding factors, considered together, indicate the care recipient has significantly higher care needs relative to the needs of the other care recipients mentioned in the relevant item in the table under section 4A (see Item 3).

Use of computer programs to make decisions

In order to operationalise the classification of care recipients as set out in Steps 1-6 above, a computer program will be used to assist the Secretary to classify a care recipient into the appropriate class.

The computer program will receive and process the data in completed electronic copies of the AN-ACC Assessment Tool that assessors submit through a securely encrypted electronic channel, to calculate the corresponding classification level.

Section 29C-8 of the Act relevantly provides that the Secretary may arrange for the use, under the Secretary's control, of computer programs for making decisions on the classification of care recipients under section 29C-2. This provision provides that a decision made by the operation of a computer program under such an arrangement is taken to be a decision made by the Secretary.

Section 29C-8 of the Act also provides that the Secretary may, under section 29C-2, substitute a decision for a decision the Secretary is taken to have made if the Secretary is satisfied that the decision made by the operation of the computer program is incorrect, for example, in response to the findings of periodic or ad hoc verification testing. Section 29C-8 does not limit any other provision of the Act that provides for the review or reconsideration of a decision.

The use of a computer program is consistent with the principles and guidance set out in the Administrative Review Council's 2004 report *Automated Assistance in Administrative Decision Making* for the following reasons:

- The methods and procedures in Part 11 of the Amending Principles detail factors that the decision-maker must take into account in classifying care recipients.
- These factors include using as inputs diverse and unbiased datasets, as collected by the Secretary or delegate under section 29C-3 of the Act, that do not treat persons differently based on age or any other protected attributes such as disability.
- Given the nature of the factors, a computer program can be programmed to apply the requirements of the Act and Principles made under the Act in a logical manner, as opposed to a decision that requires an inherently human weighing of factors – for example, a public interest test.
- Subsection 29C-8(3) and Part 6.1 of the Act provide mechanisms to substitute and review a decision made with a computer program in a particular matter, if the computer program malfunctions or makes an erroneous decision.

New section 33 provides that, for the purposes of subsection 29C-2(6) of the Act, a classification of a care recipient under Part 2.4A of the Act takes effect on the day the classification under section 31 or section 32 is made.

New Part 12—Assessments of the level of care needed (new sections 34 to 37) sets out the provisions relating to assessments of the level of care needed.

New section 34 states that, for the purposes of section 29C-3 of the Act, Part 12 specifies the procedures the Secretary must follow to make assessments of the level of care needed by a care recipient (relative to the needs of other care recipients), and the circumstances in which recipients of respite care are taken to have been assessed.

New section 35 states that, for the purposes of subsection 29C-3(2) of the Act, the assessment procedure for respite care is that the Secretary must complete the

De Morton Mobility Index assessment item in accordance with the part of the AN-ACC Reference Manual that relates to that assessment item.

New section 36 states that, for the purposes of subsection 29C-3(2) of the Act, the assessment procedure set out in new subsections 36(2) and 36(3) is specified for a care recipient being provided with non-respite care.

New subsection 36(2) provides that, if the care recipient entered the residential care service with a palliative care plan that meets the requirements of section 4B of the Classification Principles (see Item 4) and the plan has been given to the Secretary and, according to the plan, the care recipient had:

- a prognosis of a life expectancy of 3 months or less on the day the care recipient entered the residential care service; and
- an Australia-modified Karnofsky Performance Status score of 40 or less;

then the Secretary must assess the care recipient as having palliative care status.

New subsection 36(3) provides that, if any of the following circumstances apply to the care recipient, the Secretary must complete the AN-ACC Assessment Tool in accordance with the AN-ACC Reference Manual:

- (a) the care recipient did not enter the residential care service with a palliative care plan that meets the requirements of section 4B; or
- (b) the care recipient entered the residential care service with a palliative care plan that meets those requirements but the plan has not been given to the Secretary; or
- (c) the care recipient entered the residential care service with a palliative care plan that meets those requirements but, according to the plan, did not have:
 - (i) a prognosis of a life expectancy of 3 months or less on the day the care recipient entered the residential care service; and
 - (ii) an Australia-modified Karnofsky Performance Status score of 40 or less.

New section 37 sets out, for the purposes of subsection 29C-3(3) of the Act, the circumstances in which recipients of respite care are taken to have been assessed.

Subsection 29C-3(3) of the Act provides that, if the approval of a care recipient under Part 2.3 of the Act covers the provision of respite care and the circumstances specified in the Classification Principles apply, an assessment of the care recipient's care needs made under section 22-4 of the Act for the purposes of the approval is taken to be an assessment of the level of care needed by the care recipient under this section, and the assessment is taken to have been made for the purposes of classifying (or reclassifying) the care recipient under Part 2.4A of the Act for respite care.

The circumstances specified in new section 37, which will determine whether subsection 29C-3(3) will apply, are that the assessment of the care recipient's care needs mentioned in paragraph 29C-3(3)(a) of the Act was completed using the

De Morton Mobility Index assessment item in accordance with the part of the AN-ACC Reference Manual that relates to that item.

New Part 13—Classification levels (new sections 38 to 40) specifies the classification levels for care recipients.

New section 38 states that, for the purposes of section 29C-5 of the Act, Part 13 sets out classification levels for classifications of care recipients.

New section 39 states that, for the purposes of subsection 29C-5(1) of the Act, the classification levels for respite care are Respite Class 1, Respite Class 2, and Respite Class 3.

New section 40 states that, for the purposes of subsection 29C-5(1) of the Act, the classification levels for non-respite care are: Class 1; Class 2; Class 3; Class 4; Class 5; Class 6; Class 7; Class 8; Class 9; Class 10; Class 11; Class 12; and Class 13.

New Part 14—Reclassification of care recipients (new sections 41 to 43) sets out the provisions relating to the reclassification of care recipients.

Under section 29D-1 of the Act, the Secretary may reclassify a care recipient for respite care or non respite care if an approved provider that is providing that kind of care to the care recipient requests, in writing, that the Secretary reclassify the care recipient. However, the Secretary must not reclassify a care recipient unless the Secretary is satisfied that the care needs of the care recipient have changed significantly.

New section 41 provides that, for the purposes of subsection 29D-1(3) of the Act, Part 14 specifies the circumstances in which the care needs of a care recipient are taken to have changed significantly.

New section 42 specifies that, for the purposes of a reclassification of a care recipient for respite care, the care needs of the care recipient are taken to have changed significantly if, since the day the existing classification of the care recipient took effect, the condition of the care recipient has changed from:

- (a) the care recipient being independently mobile to being mobile only with assistance; or
- (b) the care recipient being independently mobile to being not mobile; or
- (c) the care recipient being mobile only with assistance to being not mobile.

Section 43 specifies that for the purposes of a reclassification of a care recipient for non-respite care, the care needs of the care recipient are taken to have changed significantly if, since the day the existing classification of the care recipient took effect:

- (a) the condition of the care recipient has changed from:
 - (i) the care recipient being independently mobile to being mobile only with assistance; or

- (ii) the care recipient being independently mobile to being not mobile; or
- (iii) the care recipient being mobile only with assistance to being not mobile; or
- (b) the care recipient has been an in-patient of a hospital for a total of at least 5 days; or
- (c) the care recipient has been an in-patient of a hospital for a total of at least 2 days and was administered general anaesthetic while an in-patient; or
- (d) for a care recipient with an existing classification level of Class 9, Class 10, Class 11, Class 12 or Class 13—at least 6 months have passed; or
- (e) for a care recipient with an existing classification level of Class 2, Class 3, Class 4, Class 5, Class 6, Class 7 or Class 8—at least 12 months have passed.

The classification levels for non-respite care (see Part 11 and Part 13) are defined such that, generally, care recipients in Class 2 to Class 8 may be expected to be less frail and need less care than care recipients in Class 9 to Class 12, who in turn may be expected to be less frail and need less care than care recipients in Class 1.

As such, proportionately to the different levels of frailty and care needs of care recipients in these classification levels, a 12 month period applies before the care needs of a care recipient in Classes 2 to 8 are taken to have changed significantly, and a 6 month period applies for care recipients in Classes 9 to 12. Care recipients in Class 1, who must have palliative care status, are not expected to be the subject of a request for reassessment, as the care recipient's palliative care status should not change during the period of their residency in the residential care service.

Depending on the outcomes of a new assessment under section 29C-2 to inform the Secretary's new classification decision, the Secretary may decide to maintain the care recipient's existing classification level or determine a different classification level.

Item 7 – Part 15

This item repeals Part 15, and substitutes a new Part 15—Criteria for delegates.

New Part 15 (sections 44 to 45) sets out the provisions relating to the criteria for the delegates to whom the Secretary's assessment powers may be delegated.

New section 44 states that, for the purposes of subsection 96-2(15) of the Act, Part 15 specifies the criteria for persons to whom the Secretary's powers and functions under section 29C-3 of the Act (to assess the level of care needed by recipients of respite care and non-respite care) may be delegated.

New section 45 provides that the following criteria must be met for persons to whom the Secretary's assessment powers may be delegated:

- (a) the person is a registered nurse, occupational therapist or physiotherapist; and
- (b) the person has at least 5 years of clinical experience in the delivery of aged care services or related health services as a registered nurse, occupational therapist or physiotherapist (as the case requires); and

- (c) a police report issued for the person within the last 24 months does not record that the person has a serious offence conviction in Australia; and
- (d) if, at any time after turning 16, the person has been a citizen or permanent resident of a country other than Australia—the person has made a statutory declaration that the person does not have a serious offence conviction in that country.

In section 45, occupational therapist, physiotherapist and registered nurse refer to the National Law (see defined terms in Item 3), with the practical effect that delegates must be registered to practise within the scope of their registration through their name appearing on the Australian Health Practitioner Regulation Agency's Register of practitioners (accessible at the date the Amending Principles commence at <https://ahpra.gov.au>).

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*

Aged Care Legislation Amendment (Aged Care Recipient Classification) Principles 2021

This legislative instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the legislative instrument

The purpose of the *Aged Care Legislation Amendment (Aged Care Recipient Classification) Principles 2021* (Amending Principles) is to amend the *Accountability Principles 2014* (Accountability Principles) and the *Classification Principles 2014* (Classification Principles), to give effect to matters delegated by the *Aged Care Amendment (Classification of Care Recipients) Act 2020* (Amending Act).

The Amending Act commenced on 1 March 2021 and inserted new Part 2.4A in the *Aged Care Act 1997* (Act), titled ‘Classification of Care Recipients on Secretary’s initiative’. Part 2.4A of the Act empowers the Secretary of the Department of Health to assess care recipients using a new assessment tool and to assign new classification levels. The Act provides for the Accountability Principles and the Classification Principles to set out matters to enable exercise of the new powers and functions in Part 2.4A.

The Amending Principles will amend the Accountability Principles to set out legislative provisions relating to the requirement for approved providers to allow delegates of the Secretary access to an aged care service to assess the care needs of care recipients.

The Amending Principles will amend the Classification Principles to set out the procedures that the Secretary (or their delegate) must follow to classify a care recipient for the purposes of Part 2.4A of the Act. The Amending Principles will also set out the classification levels and how a care recipient may be assessed and classified into each class, as well as specifying the circumstances in which a care recipient’s care needs are taken to have changed significantly for the purposes of reclassification of a care recipient. The Amending Principles also set out the criteria for persons to whom the Secretary’s assessment powers may be delegated.

The changes implemented through the Amending Principles will not affect the level of care provided to care recipients, or the amount of subsidy paid to approved providers of aged care.

Human rights implications

The Amending Principles engage the following human rights as contained in article 11 and article 12(1) of the *International Convention on Economic, Social and Cultural Rights* (ICESCR) and articles 25 and 28 of the *Convention of the Rights of Persons with Disabilities* (CRPD):

- the right to an adequate standard of living, including with respect to food, clothing and housing, and to the continuous improvement of living conditions; and
- the right to the enjoyment of the highest attainable standard of physical and mental health.

The UN Committee on Economic Social and Cultural Rights has stated that the right to health is not a right for each individual to be healthy, but is a right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

The new scheme for the classification of care recipients will more accurately classify care recipients and, in doing so, better target the level of care required to meet their needs. This is because the assessment process to classify a care recipient will utilise clinically validated methods to determine the level of a care recipient's functioning.

As such, the new classification scheme aims to enhance the standard of living of care recipients in residential aged care services.

Conclusion

The Amending Principles are compatible with human rights as it promotes the human right to an adequate standard of living and the highest attainable standard of physical and mental health.

Senator the Hon Richard Colbeck, Minister for Senior Australians and Aged Care Services