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THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

**AGED CARE AND OTHER LEGISLATION AMENDMENT (ROYAL
COMMISSION RESPONSE) BILL 2022**

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Aged Care,
the Hon Anika Wells MP)

AGED CARE AND OTHER LEGISLATION AMENDMENT (ROYAL COMMISSION RESPONSE) BILL 2022

OUTLINE

The Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022 will amend the *Aged Care Act 1997* (Aged Care Act), the *Aged Care Quality and Safety Commission Act 2018* (Quality and Safety Commission Act), the *Aged Care (Transitional Provisions) Act 1997* (Transitional Act), the *National Health Reform Act 2011* (National Health Reform Act), the *Veterans' Entitlements Act 1986*, the *Military Rehabilitation and Compensation Act 2004*, and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* to implement several time critical aged care measures, many of which respond to recommendations of the Royal Commission into Aged Care Quality and Safety (Royal Commission) *Final Report: Care, Dignity and Respect* (Final Report).

Amendments relating to residential aged care funding

Schedule 1 to the Bill amends the Aged Care Act and the Transitional Act to enable the introduction of the Australian National Aged Care Classification (AN-ACC), to replace the Aged Care Funding Instrument as the residential aged care subsidy calculation model from 1 October 2022, or if the Act does not receive Royal Assent until after 1 October, a single day to be fixed by Proclamation.

Schedule 1 to the Bill responds to Recommendation 120 of the Royal Commission Final Report.

Amendments relating to star ratings

Schedule 2 to the Bill amends the Aged Care Act to introduce a new requirement for the Secretary of the Department of Health and Aged Care (Secretary) to publish information with respect to the new Star Ratings system. These amendments require the Secretary to publish information about the quality of aged care provided by residential aged care services and also the performance of approved providers of those services in relation to responsibilities and standards under the Aged Care Act.

Schedule 2 provides that the Secretary may publish the information in the form of one or more star ratings for the residential care service. The publication of Star Ratings will be based on measurable indicators of quality and available data and the publication of this information will allow older Australians and their families to make meaningful comparisons of the quality and safety of residential care services and the approved providers of those services.

Schedule 2 to the Bill responds to Recommendation 24 of the Royal Commission.

Amendments relating to code of conduct and banning orders

Schedule 3 to the Bill amends the Aged Care Act to require compliance with a Code of Conduct (Code) by approved providers and their aged care workers and governing persons. It also amends the Quality and Safety Commission Act to allow for the rules to set out the Code and gives the Aged Care Quality and Safety Commissioner (Commissioner) functions to, in accordance with the rules, take action in relation to compliance with the Code. It will also give the Commissioner powers to take

enforcement action for substantiated breaches, such as issuing a civil penalty or a banning order.

Schedule 3 to the Bill responds to Royal Commission Recommendation 77 by supporting the establishment of a code of conduct, which will apply to the personal care workforce. It also responds to Recommendation 103 by introducing banning orders as one of a wider range of enforcement powers.

Amendments relating to the extension of incident management and reporting

Schedule 4 to the Bill amends the Aged Care Act and the Quality and Safety Commission Act to extend the Serious Incident Response Scheme (SIRS) from residential care to home care and flexible care delivered in a home or community setting from 1 December 2022.

Schedule 4 to the Bill responds to Recommendation 100 of the Royal Commission Final Report.

Amendments relating to governance of approved providers

Schedule 5 of the Bill amends the Aged Care Act and the Quality and Safety Commission Act to improve the governance of approved providers. From 1 December 2022, the amendments will introduce new governance responsibilities for approved providers in relation to the membership of their governing bodies and the establishment of new advisory bodies, as well as measures to improve leadership and culture. Schedule 5 also introduces new reporting responsibilities for approved providers, which aim to help care recipients and their families to better understand the operations of providers.

These measures are aimed at improving transparency and accountability and ensuring the focus of approved providers, from the top down, is in the best interests of care recipients.

Schedule 5 of the Bill aligns with Recommendations 88 to 90 of the Royal Commission, which noted the importance of good provider governance arrangements to the provision of high quality care for care recipients.

Amendments relating to information sharing

Schedule 6 to the Bill amends the Aged Care Act, the Quality and Safety Commission Act, *Veterans' Entitlements Act 1986*, *Military Rehabilitation and Compensation Act 2004*, and *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* to facilitate greater information sharing between Commonwealth bodies across the aged care, disability and veterans' affairs sectors. It also facilitates information sharing with worker screening units in relation to non-compliance with the Code by approved providers and their workers and governing persons.

Amendments relating to the use of refundable deposits and accommodation bonds

Schedule 7 to the Bill amends the Aged Care Act and the Quality and Safety Commission Act to enable the Secretary or Commissioner to request information or documents from a provider or borrower of a loan made using a refundable

accommodation deposit or bond. The amendments create an offence for a borrower who does not comply with a request. Further, the period of liability for the existing offences for the misuse of refundable accommodation deposits and prior to an insolvency event for both providers and key personnel of providers from 2 years to 5 years.

Schedule 7 to the Bill responds to Recommendation 134 of the Royal Commission Final Report.

Amendments relating to the Independent Health and Aged Care Pricing Authority

Schedule 8 to the Bill amends the National Health Reform Act, the Aged Care Act and the Quality and Safety Commission Act to expand the functions of a renamed Independent Health and Aged Care Pricing Authority (Pricing Authority) to include the provision of advice on health care pricing and costing matters, provision of advice on aged care pricing and costing matters, and the performance of certain functions conferred in the Aged Care Act. The amendments also establish new governance arrangements for the Pricing Authority to reflect the enhanced responsibilities and integrated functions of the Pricing Authority.

Schedule 8 to the Bill responds to Recommendations 6, 11, 115 and 139 of the Royal Commission Final Report.

Amendments relating to restrictive practices

Schedule 9 to the Bill revises the strengthened arrangements on the use of restrictive practices that commenced on 1 July 2021, to address unexpected outcomes in relation to the interaction with State and Territory guardianship and consent laws.

The amendments introduce interim arrangements to address this issue until State and Territory laws can be amended. The amendments would allow for the *Quality of Care Principles 2014* (Quality of Care Principles) to make further provision for the giving of informed consent to the use of restrictive practices where a care recipient does not have capacity to consent. This would include the authorisation of a person to consent to the use of a restrictive practice on a care recipient’s behalf, where State and Territory laws do not clearly provide for a person to consent to the use of restrictive practices. To support these interim arrangements, the amendments also insert an immunity provision where approved providers have relied on the consent given by the restrictive practices substitute decision maker.

Schedule 9 to the Bill relates to Recommendation 17 of the Royal Commission Final Report.

Financial Impact Statement

MEASURE	FINANCIAL IMPACT OVER THE FORWARD ESTIMATES
Schedule 1	Nil
Schedule 2	\$200.1 million*

Schedule 3	\$105.6 million*
Schedule 4	\$125.6 million*
Schedule 5	\$27.7 million
Schedule 6	Nil
Schedule 7	Nil
Schedule 8	\$49.1 million
Schedule 9	Nil

The measures in this Bill have an estimated cost of \$508.0 million over the forward estimates.

*This reflects costs for the measure as whole, although components of measures may not be directly implemented by this Bill.

Regulation Impact Statement

Consistent with the Office of Best Practice Regulation’s Regulatory Impact Statement (RIS) requirements, the Department of Health and Aged Care certifies that a package of independent reviews undertook a process and analysis equivalent to a RIS. The certification and list of reviews are available at the end of this explanatory memorandum.

In addition, the RIS for measures which are not covered by this certification are also reproduced the end of this explanatory memorandum.

Statement of Compatibility with Human Rights

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

AGED CARE AND OTHER LEGISLATION AMENDMENT (ROYAL COMMISSION RESPONSE) BILL 2022

This Bill 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 Bill

Schedule 1 – Residential aged care funding

Schedule 1 amends the *Aged Care Act 1997* (Aged Care Act) and the *Aged Care (Transitional Provisions) Act 1997* (Transitional Act) to enable the introduction of a new residential aged care basic subsidy calculation model, the Australian National Aged Care Classification (AN-ACC) funding model. The AN-ACC funding model will replace the Aged Care Funding Instrument from 1 October 2022, or, if Royal Assent occurs after 1 October 2022, on a single day to be fixed by Proclamation. The new funding model will link calculation of a variable amount of residential aged care subsidy to each care recipient's AN-ACC classification level. It will also link calculation of a fixed amount of subsidy to the characteristics of residential aged care services. This fixed component will be the same for all residents at a residential care service and will be higher for services in remote locations and certain specialist services, in recognition of higher fixed operating costs.

Schedule 2 – Star ratings

Schedule 2 to the Bill amends the Aged Care Act to introduce a requirement for the Secretary of the Department of Health and Aged Care (Secretary) to publish information with respect to the new star ratings system. The amendments require the Secretary to publish information about the quality of aged care provided through the service, and the performance of the approved provider in relation to responsibilities and standards under the Aged Care Act. The amendments also provide that the Secretary may publish the information in the form of one or more star ratings for the residential care service. Star ratings will be based on measurable performance indicators and their publication will allow older Australians and their families to make meaningful comparisons of the quality and safety of residential care services and providers. The amendments also clarify that the Secretary may use protected information (within the meaning of the Aged Care Act) for the purposes of publishing the information or calculating a star rating for the residential care service. The amendments further provide that information that is published must not include personal information. In addition, the amendments provide that the Secretary is not liable to civil proceedings for loss, damage or injury suffered by an approved provider of a residential care service or any other person as a result of the publication of the star rating.

Schedule 3 – Code of conduct and banning orders

Schedule 3 to the Bill amends the Aged Care Act to require compliance with a Code of Conduct (Code) by approved providers and their aged care workers and governing persons. It also amends the *Aged Care Quality and Safety Commission Act 2018*

(Quality and Safety Commission Act) to allow for the rules to set out the Code and gives the Aged Care Quality and Safety Commissioner (Commissioner) functions to, in accordance with the rules, take action in relation to compliance with the Code. It will also give the Commissioner powers to take enforcement action for substantiated breaches, such as issuing a civil penalty or a banning order.

Schedule 3 to the Bill responds to Royal Commission into Aged Care Quality and Safety (Royal Commission) Recommendation 77 by supporting the establishment of a code, which will apply to the personal care workforce. It also responds to Recommendation 103 by introducing banning orders as one of a wider range of enforcement powers for the Commissioner.

Schedule 4 – Extension of incident management and reporting

Schedule 4 to the Bill amends the Aged Care Act to extend the Serious Incident Response Scheme (SIRS) from residential care to home care and flexible care delivered in a home or community setting from 1 December 2022. This Schedule introduces new responsibilities for approved providers of home care, and flexible care delivered in a home or community setting to manage incidents, including through implementing and maintaining an incident management system that complies with requirements set out in the *Quality of Care Principles 2014* (Quality of Care Principles).

The definition of a reportable incident will also be extended to home and community care settings, so that home care and flexible care providers operating in these settings will be required to notify the Commissioner of these incidents. Protections against retribution or vilification for individuals reporting such incidents will also extend to reportable incidents in these settings.

Schedule 4 to the Bill also amends the Quality and Safety Commission Act to expand the Commissioner's powers to deal with incidents that are reported by Commonwealth grant funded aged care service providers, and authorise these providers to collect, use and disclose information relevant to their obligations in relation to the SIRS for the purposes of the *Privacy Act 1988*.

Schedule 5 – Governance of approved providers

Schedule 5 to the Bill amends the Aged Care Act and the Quality and Safety Commission Act to improve the governance of approved providers of aged care. From 1 December 2022, the amendments will introduce new governance responsibilities for approved providers in relation to the membership of their governing bodies and the establishment of new advisory bodies, as well as measures to improve leadership and culture. These measures are aimed at improving transparency and accountability, and ensuring the focus of approved providers, from the top down, is on the best interests of care recipients.

Schedule 5 also introduces new responsibilities for approved providers to annually give information to the Secretary. This new responsibility is intended to operate in conjunction with Schedule 3 to the Aged Care Amendment (Implementing Care Reform) Bill 2022 (Implementing Care Reform Bill), which introduces a requirement for the Secretary to publish specified information. These amendments aim to help care recipients and their families better understand key details of a provider's operations. The amendments will also require approved providers to notify the Commission of

changes to key personnel and will replace the current disqualified individual arrangements with a suitability test for key personnel, consistent with the arrangements under the National Disability Insurance Scheme (NDIS).

Schedule 6 – Information sharing

Schedule 6 to the Bill amends the Aged Care Act, the Quality and Safety Commission Act, *Veterans' Entitlements Act 1986*, the *Military Rehabilitation and Compensation Act 2004*, and the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* to facilitate greater information sharing between Commonwealth bodies across the aged care, disability and veterans' affairs sectors and with worker screening units in relation to non-compliance with the Code by approved providers and their workers and governing persons.

Schedule 7 – Use of refundable deposits and accommodation bonds

Schedule 7 to the Bill amends the Aged Care Act to enable the Secretary or Commissioner to request information or documents from a provider or borrower of a loan made using a refundable accommodation deposit or bond. The amendments create an offence for a borrower who does not comply with a request. Further, the period of liability for the existing offences for the misuse of refundable accommodation deposits prior to an insolvency event for both providers and key personnel of providers will be extended from 2 years to 5 years.

Schedule 7 also amends the Quality and Safety Commission Act to enable the Commissioner to issue an infringement notice for a borrower who commits an offence for failing to comply with a request under these amendments. The reforms implemented under Schedule 7 to the Bill will form part of the second phase of a three phase plan to implement a new financial and prudential monitoring, compliance and intervention framework for the aged care sector.

Schedule 8 – Independent Health and Aged Care Pricing Authority

Schedule 8 to the Bill amends the *National Health Reform Act 2011* (National Health Reform Act) and the Aged Care Act to expand the functions of a renamed Independent Health and Aged Care Pricing Authority (Pricing Authority) to include the provision of advice on health care pricing and costing matters, provision of advice on aged care pricing matters and the performance of certain functions conferred in the Aged Care Act. The amendments also establish new governance arrangements for the Pricing Authority. The new governance arrangements will reflect the enhanced responsibilities and integrated functions of the Pricing Authority.

Schedule 8 also amends the National Health Reform Act, the Aged Care Act and the Quality and Safety Commission Act to ensure appropriate use and disclosure of information required for the Pricing Authority to perform its new functions.

Schedule 9 – Restrictive practices

Schedule 9 to the Bill revises the strengthened arrangements on the use of restrictive practices that commenced on 1 July 2021, to address unexpected outcomes in relation to the interaction with State and Territory guardianship and consent laws. The proposed amendments introduce interim consent arrangements until State and Territory laws can be amended to address these issues.

The amendments allow for the Quality of Care Principles to make further provision for the giving of informed consent to the use of restrictive practices in circumstances where a care recipient does not have capacity to consent themselves. This includes authorising a person to consent on a care recipient's behalf, where State and Territory laws currently do not provide for a person to be given authority to consent to the use of restrictive practices. These arrangements are designed to ensure that providers will be able to meet the strengthened requirements on the use of restrictive practices in all jurisdictions.

Human rights implications

Schedule 1 - Residential aged care funding

This schedule to the Bill engages the following human rights:

- the right to an adequate standard of living in article 11(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and articles 25 and 28 of the Convention on the Rights of Persons with Disabilities (CRPD);
- the right to health in article 12(1) of the ICESCR and articles 23(1)(c) and 25 of the CRPD; and
- the right to social security in article 9 of the ICESCR and article 28 of CRPD.

Right to an adequate standard of living

The right to an adequate standard of living, including adequate food, water and housing, and to the continuous improvement of living conditions is contained in article 11(1) of ICESCR. Articles 25 and 28 of the CRPD also require countries to take appropriate measures to ensure clean water services and public housing programs for people with disability. Schedule 1 promotes the right of those receiving care to an adequate standard of living by providing for the subsidised provision of aged care accommodation and services on the basis of need. This includes ensuring higher subsidies are paid in respect of the costs of aged care accommodation for those with less assets and or lower incomes.

The new arrangements for calculating residential aged care basic subsidy will better match the amount of basic subsidy paid for provision of residential aged care to the real costs of meeting the care recipient's needs in their residential aged care setting. This is because the calculation method will reflect both the individual characteristics of the care recipient and the characteristics of the service where the care is delivered. As such, the new arrangements for calculation of residential aged care basic subsidy promotes the rights of those care recipients to an adequate standard of living.

Right to health

The right to health is contained under article 12 of the ICESCR and article 25 of the CRPD. These articles refer to the right of individuals, including persons with disability, to the highest attainable standard of physical and mental health. Schedule 1 promotes the right to health by providing for the subsidised provision of aged care accommodation and services on the basis of need. The subsidisation of aged care service will ensure consumers are able to access health facilities and goods, including essential medications and services and other health services.

The new arrangements for calculating residential aged care basic subsidy will better match the amount of basic subsidy paid for provision of residential aged care to the real costs of meeting the care recipient's needs in their residential aged care setting.

This is because the calculation method will reflect both the individual characteristics of the care recipient and the characteristics of the service where the care is delivered.

As such, the new arrangements for calculation of residential aged care basic subsidy will better facilitate access to health services to promote the enjoyment of the highest attainable standard of physical and mental health by care recipients.

Right to social security

The right to social security including social insurance is contained in article 9 of the ICESCR. Schedule 1 to the Bill promotes the right of those receiving care to social security, by providing for the subsidised provision of aged care accommodation and services on the basis of need. This includes ensuring higher subsidies are paid in respect of the costs of aged care accommodation for those with fewer assets and or lower incomes.

The new arrangements for calculation of residential aged care basic subsidy will better match the amount of basic subsidy paid for provision of residential aged care to the real costs of meeting the care recipient's needs in their residential aged care setting. This is because the calculation method will reflect both the individual characteristics of the care recipient and the characteristics of the service where the care is delivered. As such, the new arrangements for calculation of residential aged care basic subsidy aim to maintain the right to social security by providing a minimum essential level of benefits to all older persons, so as to enable them to acquire at least essential health care, basic shelter and housing, water and sanitation and foodstuffs.

Schedule 2 – Star ratings

This schedule to the Bill engages the following human rights:

- the right to health in article 12(1) of the ICESCR and article 25 of the CRPD; and
- the right to access information in article 21 of the CRPD;

Right to health

The right to health is contained under article 12 of the ICESCR and article 25 of the CRPD. These articles refer to the right of individuals, including persons with disability, to the highest attainable standard of physical and mental health. Schedule 2 promotes the right to health by providing older Australians, their families and carers with standardised information on the quality of residential aged care services through the Star Ratings. Quality Indicators measure aspects of service provision which contribute to the quality of care and services for care recipients and as part of Star Ratings will support provision of information on the quality of clinical care in services. Service Compliance Ratings arise from the requirement of every aged care provider to meet government regulations and standards. Compliance is the process of ensuring providers meet these requirements, and taking action when they do not. This is to protect and maintain the safety, health, wellbeing, and quality of life for people using aged care services. Staffing levels, presented through Care Minutes, are vital to the quality of the care residents receive. Findings from Consumer Experience Interviews, detailed in Consumer Experience Reports, will provide information on resident's views on the quality of care and services in residential aged care facilities.

Right to access information

The right to access information is contained in article 21 of the CRPD, which provides that appropriate measures should be taken to ensure people with disabilities can exercise their right to freedom of expression and opinion, including being provided with information in accessible formats, in a timely manner, without additional cost.

Schedule 2 to the Bill will promote the right to access information by requiring the Secretary to publish information about the quality of residential care services and the performance of approved providers in relation to their aged care responsibilities and standards in a way that is easily accessible by the public. This will provide older Australians, including those with disability, and their families with meaningful information about the quality and safety of residential care provided through a service.

Schedule 3 - Code of conduct and banning orders

This schedule to the Bill engages the following human rights:

- the right to protection from exploitation, violence and abuse in article 20(2) of the ICCPR and article 16(1) of the CRPD;
- the right to health in article 12(1) of the ICESCR and articles 23(1)(c) and 25 of the CRPD;
- the right not to be subjected to cruel, inhuman or degrading treatment in article 7 of the ICCPR and article 15 of the CRPD;
- the right to privacy in article 17 of the ICCPR and article 22 of the CRPD;
- the right to freedom of opinion and expression in articles 19 and 20 of the ICCPR; and
- the right to work and rights at work in articles 4 and 6 of the ICESCR.

Right to protection from exploitation, violence and abuse

Schedule 3 promotes the right to be protected from exploitation, violence and abuse under article 20(2) of the ICCPR and article 16 of the CRPD by implementing a Code and obligations for approved providers and their aged care workers and governing persons to comply with the Code. The Schedule also introduces additional functions to enable the Commissioner to take action in relation to compliance with the Code. This is designed to improve the safety and wellbeing of care recipients, including those with disability, through regulating compliance with the Code. The introduction of banning orders for individuals will further promote this right by restricting or prohibiting aged care workers and governing persons who are unsuitable from working or otherwise being involved in the aged care sector.

Right to health

The right to health under article 12 of the ICESCR and article 25 of the CRPD refers to the right of individuals, including persons with disability, to the highest attainable standard of physical and mental health. Schedule 3 promotes the right to health by strengthening regulation of inappropriate conduct by those engaged in providing aged care services and by ensuring that unsuitable people who may present a risk to aged care recipients are not engaged in the provision of their care.

Right not to be subjected to cruel, inhuman or degrading treatment

Schedule 3 promotes the right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment under article 15 of the CRPD and article 7 of the ICCPR by imposing certain responsibilities on providers and individuals who are

engaged in aged care services, and by allowing for appropriate regulation of their conduct.

Schedule 3 requires approved providers, governing persons of approved providers and aged care workers to comply with the Code and gives the Commission powers to regulate compliance. The Code will be based on the NDIS Code of Conduct and will include a requirement to provide care in a safe and competent manner, free from all forms of violence, discrimination, exploitation, neglect, abuse and sexual misconduct.

Schedule 3 also allows for civil penalties to be issued where an approved provider that is a corporation, or one of their aged care workers or governing persons, fails to comply with the Code. Schedule 3 also allows for the temporary or ongoing banning of aged care workers and governing persons who pose a risk to aged care recipients.

Right to privacy

Schedule 3 engages the right to privacy under article 17 of the ICCPR and article 22 of the CRPD. Schedule 3 requires the Commissioner to maintain a register of banning orders, with the register to contain specified information including the name of the person against whom the order was made, the details of the order and other information specified in the rules. The Rules may also make provision for correction of information in the register (consistent with an individual's ability under Australian Privacy Principle 13 to request correction of their personal information), as well as making the register wholly or partly publicly available, or specified information in the register publicly available. The Bill also specifies the details of additional information which should be included on the register of banning orders in relation to each individual against whom a banning order has been made at any time, when it should be included, and how the information included in the register can be accessed and corrected. There is also an additional obligation on the Commissioner to make sure the register is kept up to date.

By specifying the types of information that will be included in the register and explicitly requiring the Commissioner to keep the register up to date means that the limitations on the right to privacy are only so far as are legitimate and necessary for the purposes of ensuring the safety and well-being of care recipients.

The right to privacy can be permissibly limited to achieve a legitimate objective and where the limitations are lawful and not arbitrary. The term 'unlawful' in article 17 of the ICCPR means that no interference can take place except as authorised under domestic law. Additionally, the term 'arbitrary' in article 17(1) of the ICCPR means that any interference with privacy must be in accordance with the provisions, aims and objectives of the ICCPR and should be reasonable in the particular circumstances.

All personal information, including sensitive information, acquired under or for the purposes of the Quality and Safety Commission Act or the Aged Care Act is protected information. It is an offence, punishable by 2 years imprisonment, to use or disclose protected information other than as authorised by law, including in accordance with the *Privacy Act 1988*.

To the extent that Schedule 3 limits the right to privacy, these limits are reasonable and proportionate because they only enable the collection, use and disclosure of

personal information in accordance with the permissions set out under the relevant secrecy provisions. The limitation of privacy rights in limited circumstances and for limited purposes is directly connected to the Bill's legitimate purpose in promoting the rights of aged care recipients to be protected from violence, exploitation and abuse, and their right to the highest attainable standard of health and an adequate standard of living.

Right to freedom of opinion and expression

Article 19 of the ICCPR provides that everyone shall have the right to hold opinions without interference and the right to freedom of expression, including the freedom to seek, receive and impart information and ideas of all kinds. This right extends to a right to seek, receive and impart information and the Human Rights Committee in its General Comment 34 has outlined that article 19(2) embraces a right of access to information held by public bodies, regardless of the form in which the information is stored, its source and the date of production.

Schedule 3 provides that the rules relating to the proposed register of banning orders may allow only part of the register or specified information to be made public. If the rules restrict publication to only part of the register or specified information, this will interfere with the right to freedom of expression under article 19(2). The objective of these provisions is to protect personal information from being shared. This is a legitimate objective that falls within the permissible purposes of protecting the rights and reputations of others. Further, this limitation is sufficiently narrow so as to achieve the objective of protecting the rights and reputations of others in a manner which balances those rights with the right to freedom of expression.

Under article 19(3), to constitute a permissible limitation on article 19(2), this interference must be according to law and necessary (that is, reasonable, necessary and proportionate) for one of the purposes set out in article 19(3).

Article 19(3) of the ICCPR provides that this right may be subject to certain restrictions by law that are necessary for the respect of the rights and reputation of others the protection of national security, public order or of public health or morals. Any interference would be 'lawful' because it is provided for in legislation.

Right to work and rights at work

Article 6(1) of the ICESCR protects the right to work, which includes 'the right of everyone to the opportunity to gain [their] living by work which [they] freely [choose or accept]'. The UN Committee on Economic Social and Cultural Rights has stated that the right in article 6(1) includes the right not to be unjustly deprived of work, and that this includes security against unfair dismissal.

Under Article 4 of the ICESCR, limitations to the right to work are permitted in so far as they are compatible with the nature of the right and 'solely for the purpose of promoting the general welfare in a democratic society'. The UN Committee has stated that such limitations must be proportionate and the least restrictive alternative where several types of limitations are available.

Schedule 3 places reasonable limits on the right to work by providing that the Commissioner may make a banning order prohibiting or restricting a former,

prospective or current aged care worker, or governing person, of an approved provider that is a corporation, from being involved in providing all or specified types of aged care or engaging in specified activities of the provider. These powers are reasonable and proportionate to ensure the health, safety and well-being of those receiving care. It is anticipated that the power to make a banning order will only be exercised in the most serious circumstances.

Schedule 3 contains important safeguards for the rights of a person who is subject to a banning order by ensuring the person is notified in writing that an order is being considered, and inviting the person to make written submissions, which the Commissioner must consider. An individual the subject of a banning order also has the ability to seek to have the banning order revoked or varied. Further, the Commissioner's decisions in respect of the imposition of a banning order are reviewable decisions.

The Schedule therefore places reasonable, necessary and proportionate limitations on the right to work that ensure the protection of vulnerable recipients of aged care services from misconduct and abuse.

Schedule 4 – Extension of incident management and reporting

This schedule engages the following human rights:

- the right to protection from exploitation, violence and abuse in article 16 of the CRPD;
- the right to health in article 12(1) of the ICESCR and articles 23(1)(c) and 25 of the CRPD;
- the right not to be subjected to cruel, inhuman or degrading treatment in article 7 of the ICCPR and article 15 of the CRPD; and
- the right to privacy in article 17 of the ICCPR.

Right to protection from exploitation, violence and abuse

The right to protection from exploitation, violence and abuse is contained in article 16 of the CRPD. Schedule 4 promotes this right by requiring approved providers of home care and flexible care delivered in a home or community setting to implement appropriate measures to respond to incidents, such as promoting the physical, cognitive and psychological recovery of persons, including persons with disability, in home care or flexible care delivered in a home or community setting, where those persons become victims of exploitation, violence or abuse.

Right to health

The right to health is contained under article 12 of the ICESCR and article 25 of the CRPD. These articles refer to the right of individuals, including persons with disability, to the highest attainable standard of physical and mental health. Schedule 4 to the Bill promotes the right to health by providing greater protections in respect of the physical and mental health of individuals, including persons with disability, in receiving aged care services in home and community settings. The SIRS will introduce reporting requirements in relation to instances of abuse and neglect and will introduce more robust requirements for governance systems to ensure better reporting, management and prevention of instances of abuse and neglect in home and community aged care environments.

Right not to be subjected to cruel, inhuman or degrading treatment

The right not to be subjected to torture or cruel, inhuman or degrading treatment is contained in article 15 of the CRPD and article 7 of the ICCPR. Schedule 4 to the Bill promotes this right by requiring providers to identify, manage and resolve abuse or neglect of aged care recipients, including care recipients with disability. The reporting, incident management and follow-up actions that are required as part of the SIRS are designed to improve the quality and safety of the care provided and to reduce the risk of such incidents occurring.

Under Schedule 4, an approved provider has a responsibility to manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system. Regardless of whether a serious incident is an alleged, suspected or a known occurrence, these incidents are reportable incidents for the SIRS. This promotes article 15 of the CRPD and article 7 of the ICCPR by ensuring that individuals, including persons with a disability, who are subjected to cruel, inhuman or degrading treatment have the incident promptly reported and impartially examined by the relevant authorities. Further, the Schedule extends protections for people who report abuse or neglect in relation to reportable incidents occurring in relation to care provided by approved providers in a home or community care setting.

These changes are designed to ensure those who witness or suspect that cruel, inhuman or degrading treatment is occurring do not face repercussions, such as civil or criminal liability, for reporting the incidents. This also promotes article 15 of the CRPD and article 7 of the ICCPR by ensuring that persons are not prevented from reporting cruel, inhuman or degrading treatment, and therefore allowing such treatment to continue without investigation or remedial action.

The protection against arbitrary or unlawful interference with privacy, including in respect of persons with disability, is contained in article 17 of the ICCPR and article 22 of the CRPD. Article 17 of the ICCPR provides that no one shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour or reputation, and that everyone has the right to the protection of the law against such interference or attacks. Article 22 of the CRPD outlines a similar right.

Right to privacy

Schedule 4 engages the right to privacy under Article 17 of the ICCPR. The right to privacy can be permissibly limited to achieve a legitimate objective and where the limitations are lawful and not arbitrary. The term ‘unlawful’ in article 17 of the ICCPR means that no interference can take place except as authorised under domestic law.

Additionally, the term ‘arbitrary’ in article 17(1) of the ICCPR means that any interference with privacy must be in accordance with the provisions, aims and objectives of the ICCPR and should be reasonable in the particular circumstances.

Schedule 4 to the Bill limits the right to privacy by requiring approved providers to collect and record information about incidents and to disclose a subset of that information about reportable incidents in notifications to the Commissioner. The

Commissioner will review and store information about reportable incidents of which the Commissioner is notified. The Commissioner may also collect information collected by providers for the purposes of their compliance and monitoring functions, and disclose relevant information to other bodies where it is appropriate to their functions, for example, to police if the incident may be criminal in nature, or the Australian Health Practitioner Regulation Agency if the incident may involve a breach of professional standards.

The objective of these amendments is to ensure appropriate actions are taken to address and prevent incidents, including serious incidents, from occurring to consumers. This is a legitimate objective that falls within the permissible purposes of protecting the rights and reputations of people and protecting public health.

These amendments are also reasonable, necessary and proportionate to achieving this objective since they will ensure personal information acquired is protected information under the Aged Care and Commission Act. Personal information handled under the expanded SIRS is subject to the protected information provisions under Part 6.2 of the Aged Care Act and Part 7 of the Quality and Safety Commission Act, as well as the general protections relating to personal information under the *Privacy Act 1988*. The existing penalties for misuse and unauthorised disclosure of protected information and personal information will protect and ensure safe handling of the information collected.

Schedule 5 – Governance of approved providers

This schedule of the Bill engages the following human rights:

- the right to the presumption of innocence in article 14(2) of the ICCPR; and
- the right to self-determination in article 1 of the ICCPR and article 1 of the ICESCR.

Right to privacy

Article 17 of the ICCPR provides that no one shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour or reputation, and that everyone has the right to the protection of the law against such interference or attacks. Article 22 of the CRPD outlines a similar right. Although the United Nations Human Rights Committee has not defined ‘privacy’, it should be understood to comprise freedom from unwarranted and unreasonable intrusions into activities that society recognises as falling within the sphere of individual autonomy.

Schedule 5 limits the right to privacy under article 17 of the ICCPR by requiring approved providers to satisfy themselves that their key personnel are suitable to be involved in the provision of aged care on an annual basis, and to keep records of this consideration. This assessment may require the provider to keep records of personal information about their key personnel, such as police checks, or evidence of work experience or training. The Commissioner may also view these records as part of their monitoring and investigation functions to ensure compliance with the new responsibility.

The right to privacy under article 17 can be permissibly limited to achieve a legitimate

objective and where the limitations are lawful and not arbitrary. The term ‘unlawful’ in article 17 of the ICCPR means that no interference can take place except as authorised under domestic law. Additionally, the term ‘arbitrary’ in article 17(1) of the ICCPR means that any interference with privacy must be in accordance with the provisions, aims and objectives of the ICCPR and should be reasonable in the particular circumstances. The Committee has interpreted ‘reasonableness’ to mean that any limitation must be proportionate and necessary in the circumstances.

The objective of this provision is to ensure that key personnel of approved providers are suitable to be involved in the provision of aged care. This is a legitimate objective that falls within the permissible purposes of protecting the rights of those receiving care and protecting public health.

This provision is also reasonable, necessary and proportionate to achieving this objective, since the handling of a key personnel’s personal information is subject to the protected information provisions in Part 6.2 of the Aged Care Act, the information sharing and confidentiality provisions in Part 7 of the Quality and Safety Commission Act, as well as the general protections under the *Privacy Act 1988*. The existing harsh penalties for misuse of personal information will protect and ensure safe handling of the information collected.

Right to the presumption of innocence

Article 14(2) of the ICCPR recognises the right to the presumption of innocence, and provides that everyone charged with a criminal offence shall have the right to be presumed innocent until proven guilty according to law. This right is engaged when legislation creates an offence of strict liability because the defendant may be found guilty, or an element of an offence may be proven against the defendant, without the prosecution being required to prove fault. Strict liability offences will not necessarily be inconsistent with the presumption of innocence where they are reasonable, necessary and proportionate in pursuit of a legitimate objective.

Schedule 5 creates an offence of strict liability that applies to an individual who is a key personnel of an approved provider if that individual does not notify the approved provider of a change of circumstances relating to suitability matters within 14 days. The Schedule also creates offences of strict liability that apply to corporations, but these offences do not engage any human rights.

The offence of strict liability in respect of the offence for an individual who is a key personnel is reasonable, necessary and proportionate in pursuit of the regulatory regime governing key personnel. It will ensure that individuals who are key personnel of an approved provider are suitable to be involved in the provision of aged care. This is because the information being made available to approved providers by their key personnel will enable the approved provider to reconsider suitability, and if necessary manage the situation, including by notifying the Commissioner. If notified, this will also ensure the Commissioner is supported in carrying out their functions to protect and enhance the safety, health, wellbeing and quality of life of aged care recipients. Applying strict liability to this offence will help to deter non-compliance with this requirement, and individuals who are key personnel will be on notice that this requirement must be complied with. The offence has been considered in light of the *Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement*

Powers, and carries a maximum penalty of 30 penalty units without the possibility of imprisonment. Accordingly, the application of strict liability to these offences is not inconsistent with the presumption of innocence.

Right to self-determination

Article 1(1) of the ICCPR recognises the right to self-determination and provides that all peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development. Article 1(1) of the ICESCR also outlines this right. The UN Committee on the Elimination of Racial Discrimination has stated that the right to self-determination involves 'the rights of all peoples to pursue freely their economic, social and cultural development without outside interference'.

Schedule 5 engages this right, as introduces a new responsibility under subsection 63-1D(2), that approved providers must ensure that a majority of the members of the governing body of the provider are independent non-executive members; and at least one member of the governing body of the provider has experience in the provision of clinical care. This responsibility may impact Aboriginal Community Controlled Organisations delivering aged care services.

An Aboriginal Community-Controlled Organisation delivers services, including aged care services, that build the strength and empowerment of Aboriginal and Torres Strait Islander communities and people. Often such organisations are required to be:

- incorporated under relevant legislation and not-for-profit;
- controlled and operated by Aboriginal and/or Torres Strait Islander people;
- connected to the community, or communities, in which they deliver the services; and
- governed by a majority Aboriginal and/or Torres Strait Islander governing body.

Therefore, subsection 63-1D(4) provides that these responsibilities do not apply at a particular time, if that provider is a kind of body known as an Aboriginal Community Controlled Organisation. This provision promotes the right to self-determination for Aboriginal and Torres Strait Islander peoples, acknowledging that such people must be able to exercise meaningful control over their affairs and preserve their group identity and culture.

Schedule 6 – Information sharing

This schedule engages the following human rights:

- the right to privacy in article 17 of the ICCPR and article 22 of the CRPD; and
- the right to freedom of opinion and expression in articles 19 and 20 of the ICCPR

Right to privacy

The protection against arbitrary or unlawful interference with privacy, including in respect of persons with disability, is contained in article 17 of the ICCPR and article 22 of the CRPD. Schedule 6 limits the right to privacy by facilitating information sharing between Commonwealth departments and authorities that have powers and

functions relating to aged care and veterans' care to receiving Commonwealth bodies that have powers and functions relating to persons with disability, including the NDIS Quality and Safeguards Commission, the National Disability Insurance Agency and the Department of Social Services. The limitation on the right to privacy is necessary, reasonable and proportionate to achieve the legitimate objective of facilitating the sharing of regulatory information about the conduct of providers of care, support, treatment and other services across the care sector with the appropriate Commonwealth bodies. The intention is to enable Commonwealth departments and authorities to more efficiently share information to better carry out their respective purposes, including responding promptly to cross-sector risks regarding providers to ensure the better protection of the safety of recipients of care and support, including persons with disability.

Schedule 6 also limits the right to privacy by providing an additional purpose of the NDIS Worker Screening Database to include sharing of information in that database with the Commissioner and the Secretary for the purposes of assisting them in the performance of their functions or powers. The limitation on the right to privacy is necessary, reasonable and proportionate to achieve the legitimate objective of facilitating the sharing of information about workers in the NDIS sector who may also be aged care workers. This will enhance the safety, health and well-being of care recipients to ensure that workers who are not appropriately cleared in one sector are prevented from working in the other sector.

Schedule 6 also includes provision to ensure the Commission can share information in relation to aged care workers, governing persons and approved providers, including information about past compliance activity, so as to allow for effective enforcement across care sectors and jurisdictions. Sharing information regarding enforcement and compliance about aged care workers and governing persons with worker screening units and other bodies, in accordance with the Schedule and the proposed rules, ensures that relevant information is available about whether such persons pose a risk to aged care recipients.

The right to privacy under article 17 can be permissibly limited to achieve a legitimate objective and where the limitations are lawful and not arbitrary. The term 'unlawful' in article 17 of the ICCPR means that no interference can take place except as authorised under domestic law.

The information sharing provisions for sharing between Commonwealth departments and authorities are proportionate, with safeguards against arbitrary interference with privacy in the following ways:

- the information shared must be for the purpose of the performance of functions or exercise of powers of the receiving Commonwealth body;
- any additional receiving Commonwealth body prescribed by the rules must have regulatory, compliance or enforcement functions in relation to the provision of care, support, treatment or other related services or assistance;
- information shared with a receiving Commonwealth body would be subject to the protected information provisions in Part 6.2 of the Aged Care Act, the information sharing and confidentiality provisions in Part 7 of the Quality and Safety Commission Act, as well as the general protections under the *Privacy Act 1988*; and

- all secondary disclosure of information, including protected information, is limited to the purpose of the exercise of the functions or powers of the receiving Commonwealth body.

The information sharing provisions for sharing with worker screening units and other bodies are proportionate, with safeguards against arbitrary interference with privacy in the following ways:

- the Commissioner is not required to disclose protected information and may exercise discretion with respect to the information he or she elects to disclose;
- the Commissioner is only permitted to disclose protected information to the person or body performing functions or exercising powers under, or for the purposes of, an NDIS worker screening law; and
- the Commissioner is only permitted to disclose protected information if he or she believes, on reasonable grounds, that the information will assist in the performance of those functions or the exercise of those powers listed above.

Right to freedom of opinion and expression

Article 19 of the ICCPR provides that everyone shall have the right to hold opinions without interference and the right to freedom of expression, including the freedom to seek, receive and impart information and ideas of all kinds. This right extends to a right to seek, receive and impart information and the Human Rights Committee in its General Comment 34 has outlined that article 19(2) embraces a right of access to information held by public bodies, regardless of the form in which the information is stored, its source and the date of production.

Under article 19(3), to constitute a permissible limitation on article 19(2), this interference must be according to law and necessary (that is, reasonable, necessary and proportionate) for one of the purposes set out in article 19(3).

Article 19(3) of the ICCPR provides that this right may be subject to certain restrictions by law that are necessary for the respect of the rights and reputation of others the protection of national security, public order or of public health or morals. Any interference would be ‘lawful’ because it is provided for in legislation.

Schedule 6 allows for increased information sharing, including of personal information (as defined under the *Privacy Act 1998*). It also limits this right insofar as the information is subject to the existing secrecy provisions as protected information under the relevant legislation, including limitations on secondary disclosure. These limitations are reasonable, necessary and proportionate in order to promote the right to privacy of individuals.

As outlined above, protected information (which includes personal information) can only be shared if it will assist receiving Commonwealth bodies to carry out their regulatory, compliance or enforcement functions.

The objective of this limitation is to ensure that only protected information that will achieve the Bill’s intention will be shared in order to protect personal information. To the extent that Schedule 6 interferes with the right to freedom of expression, it is a legitimate objective that falls within the permissible purposes of protecting the rights and reputations of others.

In addition, Items 1,4 and 7 of Schedule 6 are reasonable, necessary and proportionate in the circumstances to provide for legitimate disclosure of information. These items permit the Secretary or Commissioner (as appropriate) to disclose protected information to a receiving Commonwealth body or body with functions relevant to complaints or NDIS worker screening, for the performance of functions or exercise of powers. As outlined above, the limitation to sharing information is relatively narrow. There are no general limitations to the disclosure of information related to the aged care sector. On these bases, Items 1,4 and 7 are sufficiently circumscribed to remain consistent with their objective.

Schedule 7 – Use of refundable deposits and accommodation bonds

This schedule to the Bill engages the following human rights:

- the right to privacy in article 17 of the ICCPR and article 22 of the CRPD;
- the right to the presumption of innocence in article 14(2) of the ICCPR; and
- the right to a fair trial and prohibition of retrospective application of criminal laws in article 14(2) of the ICCPR.

Right to privacy

The protection against arbitrary or unlawful interference with privacy, including in respect of persons with disability, is contained in article 17 of the ICCPR and article 22 of the CRPD. Schedule 7 to the Bill engages the right to privacy by authorising the collection, use and disclosure of protected information relating to the use of refundable accommodation deposits and bonds, which may include personal information.

The amendments aim to achieve the legitimate objective of ensuring that a refundable accommodation deposit or bond paid by residents and guaranteed by the Commonwealth are only used for purposes that are legally permitted. This objective is supported by the Secretary or the Commissioner being able to request information or documents from an approved provider or borrower of a loan made with a refundable accommodation deposit or bond. Such a request could potentially include personal information (for example, a loan agreement may include the name and signature of someone who executed the agreement). The amendments provide increased oversight for Government of the use of refundable funds to mitigate the risks of both funds being used for non-permitted purposes and providers becoming insolvent while owing residents' money.

The amendments contain protections to ensure personal information is collected in an appropriate manner to achieve the legitimate policy aim of the amendments. This includes limiting the collection of information to the Secretary or the Commissioner or their delegate. The secrecy provisions establish a framework for the collection, use and disclosure of protected information, and includes criminal penalties of up to 2 years' imprisonment.

Right to the presumption of innocence

Article 14(2) of the ICCPR recognises the right to the presumption of innocence, and provides that everyone charged with a criminal offence shall have the right to be presumed innocent until proven guilty according to law.

This right is engaged when legislation creates an offence of strict liability because the defendant may be found guilty, or an element of an offence may be proven against the defendant, without the prosecution being required to prove fault. Strict liability offences will not necessarily be inconsistent with the presumption of innocence where they are reasonable, necessary and proportionate in pursuit of a legitimate objective.

Schedule 7 creates an offence of strict liability where a borrower of a refundable accommodation deposit or bond fails to provide information or documents in accordance with a request made by the Commissioner. This offence of strict liability is reasonable, necessary and proportionate in pursuit of the regulatory regime governing the use refundable accommodation deposits and bonds. This is because the information being made available to the Commissioner will enable the Commissioner to ensure these funds are used in accordance with their permitted use. Applying strict liability to this offence will help to deter non-compliance with this requirement, and borrowers of refundable accommodation deposits and bonds will be on notice that this requirement must be complied with.

The offence has been considered in light of the *Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, and carries a maximum penalty of 30 penalty units without the possibility of imprisonment. Accordingly, the application of strict liability to these offences is not inconsistent with the presumption of innocence.

Right to a fair trial and prohibition of retrospective application of criminal laws

The right that ‘everyone charged with a criminal offence shall have the right to be presumed innocent until proved guilty according to law’ is contained in article 14(2) of the ICCPR.

Schedule 7 to the Bill engages this right in relation to subsection 9-3B(5B) of the Aged Care Act. Where a defendant is seeking to rely on the exception to the offence of failing to provide the Secretary with requested information, the defendant will bear the burden of adducing or pointing to evidence that suggests the exception is met.

This is in accordance with subsection 13.3(3) of the *Criminal Code Act 1995*, which provides that a defendant who wishes to rely on any exception, exemption or qualification provided by the law creating an offence bears an evidential burden in relation to that matter.

This is reasonable, necessary and proportionate in pursuit of the objective of ensuring care recipients refundable accommodation deposits and bonds are only used in line with a permitted use. It is designed to ensure the funds are not misused by providers.

Schedule 8 – Independent Health and Aged Care Pricing Authority

This schedule engages the following human rights:

- the right to privacy in article 17 of the ICCPR and article 22 of the CRPD;
- the right to freedom of opinion and expression in articles 19 and 20 of the ICCPR; and
- the right to a fair trial and prohibition of retrospective application of criminal laws in article 14(2) of the ICCPR

Right to privacy

The protection against arbitrary or unlawful interference with privacy, including in respect of persons with disability, is contained in article 17 of the ICCPR and article 22 of the CRPD. Article 17 of the ICCPR provides that no one shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour or reputation, and that everyone has the right to the protection of the law against such interference or attacks. Article 22 of the CRPD outlines a similar right.

Schedule 8 to the Bill engages the right to privacy under article 17(1) of the ICCPR by amending the exceptions to the secrecy offence contained in section 213 of the National Health Reform Act. Items 62 and 63 will enable the sharing of personal information if it is in compliance with a requirement under a Commonwealth law.

The right to privacy under article 17 can be permissibly limited to achieve a legitimate objective and where the limitations are lawful and not arbitrary. The term ‘unlawful’ in article 17 of the ICCPR means that no interference can take place except as authorised under domestic law. The objective of this provision is to protect personal information from being shared. This is a legitimate objective that falls within the permissible purposes of protecting the rights and reputations of people and protecting public health.

This provision is also reasonable, necessary and proportionate to achieving this objective since that sharing of the information is only permitted if in compliance with a Commonwealth law. While this is broad, it is consistent with existing section 213 of the National Health Reform Act where items 62 and 63 of Schedule 8 simply expand upon this in the context of aged care.

New sections 215A and 220A will engage the right to privacy under article 17 of the ICCPR by allowing an official to disclose aged care information to the following bodies:

- the Aged Care Advisory Committee;
- a committee established under the National Health Reform Act;
- the Australian Institute of Health and Welfare; or
- the Australian Statistician.

The objective of this amendment is to enable disclosure of aged care information if it would:

- assist committees to advise the Pricing Authority to determine efficient prices and costs for health care services provided by public hospitals and to publish this information to inform decision makers in relation to the funding of public hospitals under section 128 of the National Health Reform Act (new section 215A), and
- enable the Australian Institute of Health and Welfare or the Australian Statistician to carry out their functions, which can broadly be described as collecting statistics to inform government policy (section 6 of the *Australian Bureau of Statistics Act 1975* and section 5 of the *Australian Institute of Health and Welfare Act 1987*) (new section 220A).

The intention of new sections 215 and 220A is to assist the development of quality aged care, health care and public policy. This is a legitimate objective that falls within the permissible purposes of the protection of public health. Disclosure is limited to certain bodies and it will be an offence for certain officials to use or disclose such information to persons for reasons other than those permitted by the National Health Reform Act. For this reason, the proposed amendments are reasonable and proportionate because they provide a sufficient connection to the legitimate objective outlined above.

Schedule 8 to the Bill separately engages the right to privacy under article 17(1) of the ICCPR by amending the protected information provisions contained in Division 86 of Aged Care Act. Items 111, 112 and 113 will enable officials of the Pricing Authority (within the meaning of the National Health Reform Act) to disclose protected information (within the meaning of the Aged Care Act) to the Secretary (within the meaning of the Aged Care Act) and to the Aged Care Quality and Safety Commissioner (within the meaning of the Aged Care Quality and Safety Act) if the information was obtained in the course of the performance of an Aged Care Act function (within the meaning of the National Health Reform Act).

This power complements a provision in item 110 enabling the Secretary to share protected information (within the meaning of the Aged Care Act) to the Pricing Authority to assist in the performance of an Aged Care Act function, and another provision in Item 121 enabling the Commissioner (within the meaning of the Aged Care Quality and Safety Act) to share protected information (within the meaning of the Aged Care Quality and Safety Act) to the Pricing Authority to assist in the performance of an Aged Care Act function (within the meaning of the National Health Reform Act),

The exchange of protected information between the Pricing Authority and the Secretary and between the Pricing Authority and the Commissioner under these provisions is reasonable, necessary and proportionate for achieving the effective performance of all parties' respective legislated functions under the National Health Reform Act, the Aged Care Act and the Aged Care Quality and Safety Commission Act.

The type of information relating to performance of Aged Care Act functions that may be disclosed by the Pricing Authority may include (but is not limited to):

Extra service fees information

- the amount of any extra service fee approved by the Pricing Authority under Division 35 of the Aged Care Act;
- the residential care service in respect of which the extra service fee was approved;
- the accommodation, food and services that are to be provided to a care recipient for the approved extra service fee;
- the date on which the extra service fee was approved;
- any other information relating to approved extra service fees required by the Secretary to assist the Secretary to perform a function or duty, or exercise a power, under the Act or the Transitional Act.

Accommodation payment information

- the amount of any accommodation payment approved by the Aged Care Pricing Commissioner under section 52G- 4 of the Aged Care Act;
- the residential care service or flexible care service in respect of which the accommodation payment was approved;
- the date on which the accommodation payment was approved;
- any other information relating to approved accommodation payments required by the Secretary to assist the Secretary to perform a function or duty, or exercise a power, under the Act or the Transitional Act.

Right to freedom of opinion and expression

Article 19 of the ICCPR provides that everyone shall have the right to hold opinions without interference and the right to freedom of expression, including the freedom to seek, receive and impart information and ideas of all kinds. This right extends to a right to seek, receive and impart information and the Human Rights Committee in its General Comment 34 has outlined that article 19(2) embraces a right of access to information held by public bodies, regardless of the form in which the information is stored, its source and the date of production. Schedule 8 to the Bill engages with article 19(2) of the ICCPR, which provides that everyone shall have the right to freedom of expression.

New subsection 211C(5) of the National Health Reform Act limits the publication of any part of a report or document that contains protected Pricing Authority information that is aged care information, or protected information within the meaning of the Aged Care Act that is not aged care information. Similarly, new subsections 217(2), 218(2) and 220(5) will limit the disclosure of aged care information to state and territory health ministers, heads of the health department of a state or territory and prescribed agencies listed in section 220 of the National Health Reform Act.

Under article 19(3), to constitute a permissible limitation on article 19(2), this interference must be according to law and necessary (that is, reasonable, necessary and proportionate) for one of the purposes set out in article 19(3). Article 19(3) of the ICCPR provides that this right may be subject to certain restrictions by law that are necessary for the respect of the rights and reputation of others the protection of national security, public order or of public health or morals. Any interference would be 'lawful' because it is provided for in legislation.

The objective of these provisions is to protect personal information. This is a legitimate objective that falls within the permissible purposes of protecting the rights and reputations of others. Further, these measures are reasonable, necessary and proportionate to the achievement of that purpose, since the limitation on disclosure is restricted to aged care information and does not apply generally to information about aged care functions. This limitation is sufficiently narrow so as to achieve the objective of protecting the rights and reputations of others in a manner which balances those rights with the right to freedom of expression.

Section 215A will engage the right to freedom of expression because it will be an offence for certain officials to use or disclose such information to persons for reasons other than those permitted by the Act. Any interference would be 'lawful' because it is provided for in legislation. Further, the objective of limiting the sharing of aged

care information to instances where it would assist the prescribed bodies to develop quality aged care, health care and public policy is legitimate and falls within the permissible purposes of the protection of public health. New subsection 215(3) sets out a number of exceptions to the non-disclosure offence contained in new subsection 215(2), which provide a legitimate basis for sharing information in prescribed circumstances. This limits the extent of interference with the right to freedom of expression, while still achieving the objective of the provision.

Right to a fair trial and prohibition of retrospective application of criminal laws

The right that ‘everyone charged with a criminal offence shall have the right to be presumed innocent until proved guilty according to law’ is contained in article 14(2) of the ICCPR.

Schedule 8 engages the right under article 14(2) of the ICCPR to the presumption of innocence in relation to section 213 and new section 215A of the National Health Reform Act. Where a defendant is seeking to rely on an exception to the general prohibition against disclosure of protected pricing authority information that is aged care information or health care pricing and costing information under section 213, the defendant will bear the burden of adducing or pointing to evidence that suggests that one of the exceptions was met. The defendant will also bear the burden of adducing or pointing to evidence that suggests that one of the exceptions was met when they are seeking to rely on an exception under new section 215A in relation to a disclosure of protected pricing authority information that is aged care information.

This is in accordance with subsection 13.3(3) of the *Criminal Code Act 1995*, which provides that a defendant who wishes to rely on any exception, exemption or qualification provided by the law creating an offence bears an evidential burden in relation to that matter.

This is reasonable, necessary and proportionate in pursuit of the objective of maintaining confidentiality over aged care information or health care pricing and costing information, and is therefore compatible with the presumption of innocence.

The disclosure or use of sensitive health information or commercially sensitive information that constitutes aged care information could harm the relationship of trust between the government, care recipients and approved providers, which may in turn prevent or discourage potential care recipients from seeking care or approved providers from sharing commercially sensitive information with government. Similarly, the disclosure or use of sensitive health information or commercially sensitive information that could harm the relationship of trust between the government, care recipients and health providers, which may in turn prevent or discourage potential care recipients from seeking care or health providers from sharing commercially sensitive information with government. This could impact the ability of the pricing authority to perform its functions.

Schedule 9 – Restrictive practices

This schedule engages the following human rights:

- the right to health in article 12(1) of the ICESCR and articles 23(1)(c) and 25 of the CRPD;
- the right not to be subjected to cruel, inhuman or degrading treatment in

- article 7 of the ICCPR and article 15 of the CRPD; and
- the right to security of the person and freedom from arbitrary detention under article 9 of the ICCPR and article 14 of the CRPD.

Right to health

The right to health is contained under article 12 of the ICESCR and article 25 of the CRPD. These articles refer to the right of individuals, including persons with disability, to the highest attainable standard of physical and mental health.

Schedule 9 to the Bill promotes the right to health by ensuring there are mechanisms available to ensure greater protections to the physical and mental health of individuals receiving aged care by allowing for restrictive practices to be used in circumstances where consent is provided and the use will prevent harm to the care recipient and others. This may include, for example, circumstances where mechanical restraints, such as bed rails, are used to reduce the risk of a care recipient falling out of their bed overnight.

The amendments address limitations with current consent arrangements and provide alternative arrangements so that restrictive practices are able to be used in necessary circumstances, in accordance with the Quality of Care Principles. This promotes the right to health by allowing for interventions that reduce the risk of harm to care recipients and others in residential aged care.

Right not to be subjected to cruel, inhuman or degrading treatment

The right not to be subjected to torture or cruel, inhuman or degrading treatment is contained in article 15 of the CRPD and article 7 of the ICCPR. Schedule 9 to the Bill engages the right not to be subjected to cruel, inhuman or degrading treatment. As the amendments introduce arrangements that would provide for a person or body to consent to the use of restrictive practices in circumstances where State and Territory consent laws do not apply, it could be argued that these changes would permit increased use of restrictive practices compared with the current legislative arrangements. The use of restrictive practices on care recipients may be perceived as subjecting an individual to cruel, inhuman or degrading treatment.

However, the aim of the amendments is to address unexpected outcomes in relation to the interaction with State and Territory guardianship and consent laws. While practically the outcome of these amendments may increase the use of restrictive practices (if consent is given), the amendments only aim to provide for the policy's original intention, which is that if a care recipient is not able to consent to the use of restrictive practices, consent should be sought from a person who is authorised to provide that consent.

Any perceived limitation is proportionate to prevent harm to the care recipient and others (including other care recipients). It should also be noted that the existing requirements under the Quality of Care Principles afford care recipients extra protections to ensure that restrictive practices are only ever to be used as a last resort, only to the extent that is necessary, for the shortest time and in the least restrictive form, to prevent harm to the care recipient.

Further, the amendments also promote this right by addressing issues with the current

restrictive practices consent arrangements to ensure that in all circumstances there will be an appropriate person from whom the approved provider must obtain informed consent before restrictive practices are used. This is because, without clear arrangements on who is able to consent, there is a heightened risk that restrictive practices will be used without consent from a person who is authorised to provide that consent. The amendments will ensure there are clear arrangements for an appropriate person to be approached to provide consent to the use of a restrictive practice where the care recipient does not have the capacity to consent themselves.

Providing clarity on who the approved provider may seek informed consent from will also ensure that appropriate consideration is given to the personal rights and liberties of care recipients prior to determining whether restrictive practices should be used.

Right to security of the person and freedom from arbitrary detention

Article 9 of the ICCPR and article 14 of the CRPD provide for the right to personal liberty, which requires that an individual not be subjected to arrest and detention, except as provided for by law, and provided that the law itself and the manner of its execution are not arbitrary.

This right is engaged by Schedule 9 to the Bill because the amendments relate to the authority to provide consent to the use of restrictive practices which may, in some circumstances, amount to detention. However, this is not considered arbitrary as the existing arrangements provide that restrictive practices may only be used in certain circumstances, including as a last resort to protect the care recipient and others from harm. Schedule 9 also promotes this right by ensuring that there are adequate safeguards to ensure that restrictive practices are not used in an arbitrary manner.

The amendments strengthen and clarify the current arrangements to ensure that an appropriate person is authorised to consent on behalf of a care recipient to the use of restrictive practices where the care recipient lacks capacity to consent themselves. This will strengthen measures to ensure approved providers can seek informed consent from an appropriate person before using a restrictive practice, as is required under the legislation. The combination of the existing requirements and the amendments will ensure that restrictive practices are only used as a necessary and proportionate response in certain circumstances.

Conclusion

The Bill is consistent with human rights as it promotes the rights of older Australians to the right to social security and an adequate standard of living and health, and strengthens the protection of care recipients by implementing measures to ensure greater protections from exploitation, violence, abuse and cruel, inhuman or degrading treatment. The Bill also ensures the inclusion of civil penalties is consistent with human rights criminal process guarantees. While the Bill limits certain human rights, such as the right to privacy and the right to a presumption of innocence, these rights are limited in pursuit of the permissible legitimate objectives, and in a way that is reasonable, necessary and proportionate in the particular circumstances to achieving that objective.

**[Circulated by the authority of the Minister for Aged Care,
the Hon Anika Wells MP]**

AGED CARE AND OTHER LEGISLATION AMENDMENT (ROYAL COMMISSION RESPONSE) BILL 2022

NOTES ON CLAUSES

Clause 1 – Short Title

Clause 1 provides that the short title of this Act is the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (the Act).

Clause 2 – Commencement

Clause 2 provides a table setting out the commencement dates of various sections in, and Schedules to, the Act.

Clause 3 – Schedules

Clause 3 provides that each Act that is specified in a Schedule is amended or repealed as set out in that Schedule, and any other item in a Schedule to the Bill has effect according to its terms.

Schedule 1 – Residential aged care funding

Overview

Schedule 1 amends the *Aged Care Act 1997* (Aged Care Act) and the *Aged Care (Transitional Provisions) Act 1997* (Transitional Act) to enable the introduction of a new residential aged care basic subsidy calculation model, known as the Australian National Aged Care Classification (AN-ACC) funding model. The AN-ACC funding model will replace the Aged Care Funding Instrument from the *transition day, being 1 October 2022 or a later date either to be fixed by proclamation or on the day after the end of a period of 6 months beginning on the day the Act receives the Royal Assent. The new funding model will link calculation of a variable amount of residential aged care subsidy to each care recipient's AN-ACC classification level. It will also link calculation of a fixed amount of subsidy to the characteristics of residential aged care services. This fixed component will be the same for all residents at a residential care service and will be higher for services in remote locations and certain specialist services, in recognition of higher fixed operating costs.

The amendments in Schedule 1 to the Bill build on previous amendments made by the *Aged Care Amendment (Aged Care Recipient Classification) Act 2020*, which inserted Part 2.4A of the Aged Care Act to enable the Secretary of the Department of Health and Aged Care (Secretary) to start assessing each residential aged care recipient using a new AN-ACC assessment tool and to use data from those assessments in deciding an AN-ACC classification for the care recipient. Schedule 1 to the Bill will now enable AN-ACC classifications to affect calculation of basic subsidy.

Schedule 1 of the Bill responds to Recommendation 120 of the Royal Commission into Aged Care Quality and Safety (Royal Commission) *Final Report: Care, Dignity and Respect* (Final Report).

Part 1—Amendments

Aged Care Act 1997

For the Aged Care Act, a summary of the amendments is as follows.

Part 2.2 (Allocation of places) – provisions will have the effect that any existing *condition of allocation* made under Part 2.2 that would limit the number of residential respite days a provider can offer through an allocated place will cease to have effect on and from the *transition day, freeing providers to offer more residential respite days.

Part 2.4 (Classification of care recipients) – rename to Part 2.4—Classification of care recipients before the transition day, and limit the operation of the Part so that approved providers must not submit appraisals and reappraisals relating to classifications which would have a date of effect on or after the *transition day, and so that the Secretary is not required to classify a care recipient under Part 2.4 if the

classification would take effect, or be taken to have had effect, from or on a day that is on or after the *transition day.

Part 2.4A (Classification of care recipients on Secretary's initiative) – rename to Part 2.4A—Classification of care recipients on or after the transition day, and repeal rules which currently have the effect of preventing AN-ACC classifications under this Part from influencing calculation of residential aged care provider subsidy. Amendments also deal with where assessments under the Part may be performed.

Part 3.1 (Residential aged care subsidy):

- Amend to limit the effect of classifications made under Part 2.4 on the calculation of basic subsidy to the period pre-transition day.
- Amend to permit the calculation of basic subsidy on and from the transition day as a combination of a variable amount linked to the care recipient's Part 2.4A (AN-ACC) classification and a fixed amount linked to the characteristics (or 'kind') of the residential aged care service where the person receives care.
- Amend to permit the Minister to provide for or in relation to a matter relating to the basic subsidy amount (for example, a matter relating to a kind of residential aged care service) by conferring a power on the Secretary.
- Amend to provide for calculation of a 'default' variable amount as a component of the basic subsidy amount for the period before a care recipient is assessed and their Part 2.4A (AN-ACC) classification is decided.
- Amend to deal with calculation of basic subsidy when a person is on leave from a residential aged care service.
- Amend to repeal the concept of a *non-compliance deduction*, which relates to certain conditions of allocation of places made under Part 2.2, which is not required.
- Repeal the *adjusted subsidy reduction*, which reduces the amount of basic subsidy per care recipient paid at certain residential aged care services operated by state and territory governments, which is not required under the AN-ACC model.
- Amend provisions relating to the *care subsidy reduction*, so that it is calculated in part by reference to a new *adjusted basic subsidy amount*.

Part 4.3 (Accountability)

- Amend to clarify residential aged care provider responsibilities to assist the Secretary or delegates of the Secretary to perform AN-ACC assessments.
- Amend to create a new responsibility for approved providers of residential aged care to submit an exit notice when a residential care recipient permanently exits care.

Part 6.1 (Reconsideration and review of decisions):

- Amend to establish that the Secretary may charge an application fee for requests to reconsider certain decisions made under Part 2.4A: to classify a care recipient; not to reclassify a care recipient; and to change the classification of a care recipient.
- Amend to specify the procedures the Secretary must follow in reconsidering certain decisions made under Part 2.4A: to classify a care recipient; not to reclassify a care recipient; and to change the classification of a care recipient.

Chapter 7 (Miscellaneous)

- Amend to provide that the Secretary may delegate to a Senior Executive Service (SES) officer or acting SES officer of the Department a power conferred by the Minister to provide for or in relation to a matter relating to the basic subsidy amount (for example, a matter relating to a kind of service).

Schedule 1 (Dictionary)

- Insert a definition of *transition day
- Repeal redundant definitions.

Item 1 – Section 5-1 (paragraph beginning “the recipient of the care”) and Item 2 – Section 5-1 (paragraph beginning “the recipient of the care)

These items amend section 5-1 to provide that both Part 2.4 and Part 2.4A provide for classification of recipients of residential care and some kinds of flexible care.

Item 3 – Section 5-1

This item omits reference to limitations on the effect of classifications of care recipients of residential care and some kinds of flexible care, consequential to repeal of limitations on their effect through repeal of section 29F-1 (see item 26).

Item 4 – After Division 17

This item inserts a new section 17A-1 that revokes all conditions of allocation on residential aged care places that provide for either minimum or maximum numbers of days in a particular period that respite care must be provided through those places. The effect is that providers may provide respite care through allocated places on as many or as few days as they wish from the commencement of new section 17A-1.

This item also provides that sanctions for non-compliance with aged care responsibilities of approved providers under Part 7B of *the Aged Care Quality and Safety Commission Act 2018* (Quality and Safety Commission Act) may apply in relation to an approved provider who failed to comply with the revoked conditions before the commencement of the new section 17A-1.

Item 5 – Part 2.4 – Classification of care recipients before the transition day

This item repeals and substitutes the heading to provide that the heading is Part 2.4—Classification of care recipients before the transition day.

Item 6 – At the end of section 24-1

Section 24-1 describes what Part 2.4 is about. This item amends the description of Part 2.4 in section 24-1 to specify that classifications made under Part 2.4 may affect the amounts of residential care subsidy or flexible care subsidy payable to approved providers for providing care only on a day before the *transition day.

This is appropriate as on and from the transition day care recipient classifications under Part 2.4 will not have effect in relation to a day that is on or after the *transition day (see item 13).

Item 7 – After subsection 25-1(1)

Section 25-1 deals with classification of care recipients under Part 2.4. This item inserts a new subsection 25-1(1A) that provides that the Secretary is not required to classify a care recipient under Part 2.4 if the classification would take effect, or would be taken to have had effect, from or on a day that is on or after the *transition day.

This is appropriate as on and from the *transition day, care recipient classifications under Part 2.4 will not have effect in relation to a day that is on or after the *transition day (see item 13).

Item 8 – After subsection 25-3(1)

Section 25-3 deals with appraisal of care recipients under Part 2.4. This item inserts a new subsection 25-3(1A) that provides that, other provisions notwithstanding, an appraisal of a care recipient must not be made if the classification of the care recipient linked to the appraisal (through the operation of subsection 25-1(1)) would take effect, or would be taken to have had effect, from or on a day that is on or after the *transition day.

This is appropriate as on and from the *transition day care recipient classifications under Part 2.4 will not have effect in relation to a day that is on or after the *transition day (see item 13).

Item 9 – At the end of section 25-3

Section 25-3 deals with appraisal of care recipients under Part 2.4. Subsection 25-3(4) provides that if a care recipient is being, or is to be, provided with care as respite care, an assessment of the care recipient’s care needs made under section 22-4 is taken to be an appraisal of the level of care needed by the care recipient, and to have been received by the Secretary under subsection 25-1(1) as such an appraisal.

This item inserts a new subsection 25-3(5) to provide that the arrangement in subsection 25-3(4) does not apply if the classification of the care recipient that would be made under subsection 25-1(1) would take effect, or would be taken to have had effect, from or on a day that is on or after the *transition day.

This is appropriate as on and from the *transition day care recipient classifications under Part 2.4 will not have effect in relation to a day that is on or after the *transition day (see item 13).

Item 10 – Section 26-1

This item amends section 26-1, which is about when a classification based on an appraisal that is received within the appropriate period takes effect, to provide that it operates in relation to classification of a care recipient under Part 2.4. This amendment is to provide greater clarity about the operation of the section.

Item 11 – Subsection 26-2(1)

This item amends subsection 26-2(1), which is about when a classification based on an appraisal that is not received within the appropriate period takes effect, to provide that it operates in relation to classification of a care recipient under Part 2.4. This amendment is to provide greater clarity about the operation of the subsection.

Item 12 – Section 26-3

This item amends section 26-3, which is about when respite care classifications take effect, to provide that it operates in relation to classification of a care recipient under Part 2.4. This amendment is to provide greater clarity about the operation of the subsection.

Item 13 – At the end of section 27-1

Section 27-1 deals with when classifications under Part 2.4 cease to have effect. This item inserts a new subsection 27-1(3), which provides that despite other provisions in the section a classification under Part 2.4 has no effect in relation to a day that is on or after the *transition day.

Item 14 – After subsection 27-4(1)

Section 27-4 deals with the reappraisal of a care recipient at the initiative of an approved provider. This item inserts a new subsection 27-4(1A), which provides that, despite other provisions, an appraisal of a care recipient must not be made if the classification of the care recipient linked to the appraisal (through the operation of subsection 27-6(1)) would take effect, or would be taken to have had effect, from or on a day that is on or after the *transition day.

This is appropriate as on and from the *transition day care recipient classifications under Part 2.4 will not have effect in relation to a day that is on or after the *transition day (see item 13).

Item 15 – After section 27-5

This item inserts a new section 27-5A that provides that, despite anything in Division 27, a reappraisal otherwise triggered by an expiry date for a care recipient's classification according to the table in section 27-2 must not be made if the renewal of the classification (as made under the provisions of subsection 27-6(1)) would take effect, or would be taken to have had effect, from a day that is on or after the *transition day.

This is appropriate as on and from the *transition day care recipient classifications under Part 2.4 will not have effect in relation to a day that is on or after the *transition day (see item 13).

Item 16 – After subsection 27-6(1)

Section 27 deals with the expiry and renewal of classifications under Part 2.4 by the Secretary. This item inserts a new subsection 27-6(1A), which provides that, despite other provisions, the Secretary is not required to renew a classification of a care recipient if the classification of the care recipient would take effect, or would be taken to have had effect, from or on a day that is on or after the *transition day.

This is appropriate as on and from the *transition day care recipient classifications under Part 2.4 will not have effect in relation to a day that is on or after the *transition day (see item 13).

Item 17 – Subsection 29-1(1)

This item amends subsection 29-1(1), which is about how classifications are changed, to provide that it operates in relation to classification of a care recipient under

Part 2.4. This amendment is to provide greater clarity about the operation of the subsection.

Item 18 – Part 2.4A (heading)

This item amends the heading of Part 2.4A to Part 2.4A—Classification of care recipients on or after the transition day. This amendment is to reflect the amended operation of Part 2.4A from on or after the *transition day.

Item 19 – Section 29B-1

This item amends section 29B-1 to omit a reference to classification being “on the Secretary’s initiative”, to reflect the amended operation of Part 2.4A from on or after the *transition day.

Item 20 – Section 29B-1

This item amends section 29B-1, which describes the content of Part 2.4A. This amendment is consequential to the repeal of section 29F-1, which limited the effect of a classification under Part 2.4A (see Item 26).

The effect is that the amended section describes that classifications under Part 2.4A will affect the amount of residential care subsidy, or flexible care subsidy, payable to approved providers for providing that kind of care on or after the *transition day.

Item 21 – Subsection 29C-2(7) (note)

This item repeals a note to subsection 29C-2(7) which referred to section 29F-1, consequential to repeal of section 29F-1 (see Item 26).

Item 22 – Subsection 29C-3(1)

This item amends subsection 29C-3(1), which deals with the circumstances in which the Secretary may assess a care recipient as a step in deciding a classification under Part 2.4A. The effect is that the Secretary may assess the level of care needed by the care recipient, relative to the needs of other care recipients, either while or after a care recipient is provided with care. This amendment enables the Secretary to assess a care recipient who left care before an assessment could be performed while the care recipient was still being provided with care.

This is appropriate as, depending on the date of effect of the classification decided after the assessment, the care recipient’s classification may affect payment of subsidy to the care recipient’s approved provider for the period during which the care recipient received care, even if the care recipient has subsequently stopped receiving care from the approved provider.

Item 23 – At the end of subsection 29C-3(1)

This item adds a new paragraph 29C-3(1)(c), which provides that the Secretary may assess a care recipient for the purposes of reconsidering, either on their own initiative (section 85-4) or in response to a valid request to do so (section 85-5), a decision to classify a care recipient (subsection 29C-2(1)), not to reclassify a care recipient (subsection 29D-1(1)) or change a classification (subsection 29E-1(1)).

The effect of this amendment is to expand the purposes for which the Secretary may assess a care recipient, so that an assessment may occur for the purposes of

reconsidering, under sections 85-4 or 85-5, a decision made under subsections 29C-2(1), 29D-1(1) or 29E-1(1).

Item 24 – Subsection 29C-3(2)

This item repeals and substitutes subsection 29C-3(2) to provide that the Classification Principles may specify where the Secretary may or must make the assessment, and the procedures that the Secretary must follow in making the assessment. Taken with item 22, which allows the Secretary to assess a care recipient after the care recipient has ceased to receive care, the effect is that the Secretary, in the circumstances specified in the Classification Principles, may assess a care recipient at a place other than the place where the care recipient is or was receiving care.

Item 25 – Subsection 29D-1(1)

This item repeals and substitutes subsection 29D-1(1), and inserts new subsections (1A) and (1B), to provide for the preconditions that must be met before the Secretary may reclassify a care recipient under section 29C-2.

The effect is to provide that either the care recipient or the care recipient's approved provider may request that Secretary may reclassify the care recipient and the request must:

- if made by the approved provider, be made in writing;
- if made by the care recipient, be made orally or in writing; and
- be accompanied by any application fee (which must not be such as to amount to taxation) specified in or worked out in accordance with rules in the Classification Principles.

Item 26 – Division 29F

This item repeals Division 29F, which limited the effect of a classification made under Part 2.4A. The effect is that a classification made under Part 2.4A may, from the *transition day, affect other Parts of the Aged Care Act, including any amount of subsidy payable under Chapter 3 of the Aged Care Act or Chapter 3 of the Transitional Act and any amount that an approved provider may charge the care recipient for the provision of care and services. The repeal of this Division will also mean that certain decisions made under Part 2.4A will be subject to reconsideration or review under Division 85.

Item 27 – Paragraphs 43-1(3)(b) and (d)

This item repeals paragraphs 43-1(3)(b) and (d) and substitutes a new paragraph 43-1(3)(b) with the effect of repealing a reference to non-compliance deductions from a list of amounts that the Secretary may, in accordance with the Subsidy Principles, deduct from the amount of residential care subsidy otherwise payable in respect of a payment period. This item is consequential to the repeal of section 43-8, which established non-compliance deductions (see Item 28).

Item 28 – Section 43-8

This item repeals section 43-8, which established non-compliance deductions as a form of deduction of subsidy otherwise payable in respect of a residential care service if conditions specified in the Subsidy Principles relating to whether conditions of allocation on places in the service made under section 14-5 or 14-6 had not been met.

This is appropriate as subsidy payment arrangements from the *transition day do not require non-compliance deductions.

Item 29 – Subsection 44-3(2)

This item repeals and substitutes subsection 44-3(2) to provide that the basic subsidy amount for a care recipient for a day is either the amount determined by the Minister by legislative instrument, or worked out in accordance with a method determined by the Minister by legislative instrument. The effect is to enable the Minister to either determine the basic subsidy amount or determine a method by which the basic subsidy amount for a day is to be worked out.

Item 30 – Before paragraph 44-3(3)(a)

Subsection 44-3(3) provides that the Minister may determine different amounts of basic subsidy (including nil amounts) based on any one or more matters in the list of matters set out under that subsection. This item inserts two new paragraphs in subsection 44-4(3) to provide for two additional matters which the Minister may take into account when determining different amounts of basic subsidy for a care recipient:

- the kind of residential care service through which residential care is provided to the care recipient;
- whether a care recipient being provided with residential care has been classified under Part 2.4A.

The effect of new paragraph 44-3(3)(aa) is that the Minister may determine different amounts of basic subsidy based on the kind of residential care service through which residential care is provided to the care recipient, such as whether the service is of a kind that is located in a particular region or whether the service delivers particular specialised services.

The effect of new paragraph 44-4(3)(ab) is that the Minister may determine different amounts of basic subsidy contingent on the care recipient having not yet been classified under Part 2.4A.

Item 31 – Paragraph 44-3(3)(a)

Subsection 44-3(3) provides that the Minister may determine different amounts of basic subsidy for a care recipient for a day (including nil amounts) based on any one or more matters in the list of matters set out under that subsection. This item amends paragraph 44-3(3)(a) to provide that it operates in relation to care recipients who have been classified under Part 2.4A.

The effect is that the Minister may determine the different amounts (including nil amounts) based on classification levels for care recipients who have been classified under Part 2.4A.

A related effect is that classifications under Part 2.4 will cease to be a basis for the Minister to determine amounts of basic subsidy for the period on and after the *transition day. This is appropriate as on and from the *transition day care recipient classifications under Part 2.4 will not have effect in relation to a day that is on or after the *transition day (see item 13).

Item 32 – Paragraphs 44-3(3)(cb) and (cc)

Subsection 44-3(3) provides that the Minister may determine different amounts of basic subsidy for a care recipient for a day (including nil amounts) based on any one or more matters in the list of matters set out under that subsection. This item repeals paragraphs 44-3(3)(cb) and (cc), which provided in the listed matters:

- whether an appraisal of a care recipient's care needs is received after the end of the period mentioned in paragraph 26-1(a) or (b) in Part 2.4;
- whether a reappraisal of a care recipient's care needs is received after the end of the reappraisal period for the classification determined under section 27-2 in Part 2.4.

This is appropriate as determination of subsidy for payment periods on and after the *transition day does not rely on the operation of Part 2.4. Determination of subsidy for payment periods before the *transition day inclusive of reliance on Part 2.4 is saved by the transitional and savings provisions in Division 4 of the Bill.

Item 33 – Subsection 44-3(4)

This item repeals the previous subsection 44-3(4), with the effect of removing a rule that limited the Minister's ability to determine a different amount of basic subsidy for a day on which a care recipient is on extended hospital leave, and substitutes the ability for the Minister to make provision for, or in relation to, a matter under section 44-3 by conferring a power on the Secretary.

If exercised, this power may, for example, have the effect of permitting the Secretary to determine that a specific residential aged care service is a specific kind of service for the purposes of new paragraph 44-3(3)(aa) (see Item 30). This delegation of the Minister's powers is appropriate as the essentially administrative character of making decisions in relation to the matters that relate to the basic subsidy amount, taken with the frequency with which residential aged care services commence and cease to provide services, makes it impractical for the Minister to make such decisions on a day-to-day basis.

Item 34 – Subparagraph 44-5(1)(a)(iv)

This item repeals subparagraph 44-5(1)(a)(iv), which established the dementia and severe behaviours supplement as a primary supplement. The effect of this supplement will be covered by the new method of calculating basic subsidy. In relation to the dementia and severe behaviours supplement, payment of this supplement ceased in 2014 and this item will repeal the reference in subparagraph 44-5(1)(a)(iv).

Item 35 – Paragraph 44-17(a)

This item repeals paragraph 44-17(a), which referenced the adjusted subsidy reduction that was established under section 44-19. This item is consequential to the repeal of section 44-19 (see Item 36).

Item 36 – Section 44-19

This item repeals section 44-19, which established the adjusted subsidy reduction as a type of reduction in subsidy for the care recipient under step 3 of the residential care subsidy calculator in section 44-2. This is appropriate as subsidy calculation arrangements from the *transition day do not require this type of subsidy reduction.

Item 37 – Subsection 44-21(2) (Care subsidy reduction calculator, step 4, paragraphs (a) and (b)) and Item 38 – Subsection 44-21(2) (Care subsidy reduction calculator, step 5, paragraphs (a) and (b))

Section 44-21 deals with the care subsidy reduction, an amount used in the calculation of both residential care subsidy (see section 44-2) and the maximum daily amount of resident fees (see section 52C-3). Subsection 44-21(2) provides for the care subsidy reduction calculator.

Item 37 repeals in subsection 44-21(2), step 4, paragraphs (a) and (b) and substitutes new paragraphs (a) and (b) so that step 4 operates by reference to the sum of two amounts:

- the adjusted basic subsidy amount for the care recipient for the day (see item 40 new subsection (6A)); and
- any primary supplement amounts for the care recipient for the day (see subdivision 44-C).

Item 38 repeals in subsection 44-21(2), step 5, paragraphs (a) and (b) and substitutes new paragraphs (a) and (b) so that step 5 operates by reference to the sum of two amounts:

- the adjusted basic subsidy amount for the care recipient for the day (see item 40 subsection (6A)); and
- any primary supplement amounts for the care recipient for the day (see subdivision 44-C).

Item 39 – Subsection 44-21(3)

Subsection 44-21(3) deals with the amount of care subsidy reduction in the circumstance that the care recipient has not provided sufficient information about the care recipient's income and assets for the care recipient's means tested amount (see section 44-22) to be determined.

This item amends subsection 44-21(3) so that for the purposes of the subsection the care subsidy reduction is the sum of the adjusted basic subsidy amount (see item 40 new subsection (6A) and any primary supplement amounts (see subdivision 44-C) for the care recipient for that day, for consistency with amendments to subsection 44-21(2).

Item 40 – After subsection 44-21(6)

This item inserts a new subsection 44-21(6A), which provides that the adjusted basic subsidy amount for a care recipient for a day (as used in amended subsections 44-21(2) and 44-21(3)) is an amount:

- determined by the Minister by legislative instrument; or
- worked out in accordance with a method determined by the Minister by legislative instrument.

The adjusted basic subsidy amount is required to be used in relation to calculation of the amount of care subsidy reduction (see subsections 44-21(2) and (3) as amended), and indirectly also the maximum daily amount of resident fees (see section 52C-3), consequential to the effect of the amendments in Schedule 1 as a whole being to legislatively enable use of a new residential aged care funding model, the Australian National Aged Care Classification.

Item 41 – Subsection 44-21(7)

Section 44-21 deals with the care subsidy reduction. This item repeals subsection 44-21(7) which refers to the determination of the annual cap by the Minister by legislative instrument for the class of care recipients of which the care recipient is a member, and substitutes the rule that the annual cap is the amount determined by the Minister by legislative instrument. The effect is the annual cap will apply equally to all affected care recipients, which in practice already occurred at the time of amendment.

Item 42 – Paragraph 44-28(2)(a)

Section 44-28 deals with a non-primary supplement known as the accommodation supplement. This item repeals and substitutes paragraph 44-28(2)(a) to provide that a condition for a care recipient to be eligible for the accommodation supplement on a particular day is that on that day the residential care provided to the care recipient is not provided on an extra service basis. This is appropriate as care recipients who receive care on an extra service basis, which requires paying an extra service fee for a higher standard of accommodation, will not meet the overall accommodation supplement eligibility criteria. As such, this amendment will not reduce access to the supplement.

Item 43 – Section 52C-5

Section 52C-5 deals with the maximum daily amount of resident fees for reserving a place when a care recipient is absent from a residential care service on a particular day, the care recipient is not on leave from the residential care service on that day, and the care recipient would have been on a form of leave from the residential care service on that day specified in subsection 42-2(3), informally known as ‘social leave’, except that the care recipient had previously been on social leave, during the current financial year, for 52 days.

This item omits and substitutes text to provide the maximum fee in respect of a day that can be charged for reserving a place in the residential care service for that day is the amount determined by the Minister by legislative instrument or worked out in accordance with a method determined by the Minister by legislative instrument.

The effect of this item is to allow the maximum daily amount of resident fees for reserving a place to be aligned with the maximum daily amount of resident fees as calculated under subsection 52C-3 as amended by Items 37 and 38.

Item 44 – Paragraph 63-1(1)(ha)

This item amends paragraph 63-1(1)(ha) to specify that it is a responsibility of approved providers to allow those delegates of the Secretary under subsection 96-2(15) of the Act access to a residential care service, as required under the Accountability Principles, in order to assess, under section 29C-3, the care needs of care recipients provided with care through the service. The effect is to limit the delegates of the Secretary who must be permitted access in accordance with this responsibility.

Item 45 – After section 63-1B

This item inserts a new section 63-1BA that creates a new responsibility for approved providers of residential aged care to submit an exit notice, in a form approved by the Secretary and within the period specified in the Accountability Principles, when a residential care recipient permanently ceases to receive care at a residential care service. This item mirrors the responsibility under existing section 63-1B for approved providers to record and notify the Secretary of the entry of care recipients into a residential care service. This is appropriate as it will assist to maintain residential aged care payment integrity and ensure that approved providers are accurately subsidised.

Item 46 – After subsection 85-4(3)

Section 85-4 provides for the Secretary to reconsider certain reviewable decisions on their own initiative if satisfied that there is sufficient reason to reconsider the decision.

This item inserts a new subsection 85-4(3A) to provide that in reconsidering a decision made under subsection 29C-2(1) (which deals with a decision to classify a care recipient under Part 2.4A), 29D-1(1) (which deals with a decision not to reclassify a care recipient under Part 2.4A) or 29E-1(1) (which deals with a decision to change a classification under Part 2.4A) the Secretary must assess (under section 29C-3) the level of care needed by the relevant care recipient, relative to the needs of other care recipients, and must take that assessment into account before making the reconsideration decision under subsection 85-4(4).

This item also inserts a new subsection 85-4(3B) to provide that if the Secretary cannot assess the care recipient for the purposes of the reconsideration, the Secretary must not make a reconsideration decision under subsection 85-4(4). The practical effect in this instance is that the original decision stands.

Item 47– Subsection 85-4(4)

This item amends subsection 85-4(4), which deals with the decisions the Secretary can make when reconsidering certain reviewable decisions on their own initiative if satisfied that there is sufficient reason to reconsider the decision, to provide that the operation of the subsection is subject to the operation of new subsection 85-4(3B) (see Item 46).

Item 48 – Subsection 85-5(4A)

Section 85-5 provides for the Secretary to reconsider certain reviewable decisions at the request of a person whose interests are affected by the reviewable decision.

This item amends subsection 85-5(4A) to provide that the person's request must comply with section 85-6 (application fee) if the reviewable decision was made under subsection 29-1(1), 29C-2(1), 29D-1(1) or 29E-1(1) (which deal with decisions relating to the classification of a care recipient).

Item 49 – Subsection 85-5(5) and Item 50 – After subsection 85-5(5)

Section 85-5 provides for the Secretary to reconsider certain reviewable decisions at the request of a person whose interests are affected by the reviewable decision. This item amends subsection 85-5(5) and insert new subsections 85-5(5A) and 85-5(5B).

Subsection 85-5(5) as amended provides that, after receiving the request, the Secretary must reconsider the decision, subject to the operation of new paragraph 85-5(5B)(b).

Subsection 85-5(5A) provides that in reconsidering a decision made under subsection 29C-2(1), 29D-1(1) or 29E-1(1) (which deal with decisions relating to the classification of a care recipient), the Secretary must, under section 29C-3, assess the level of care needed by the relevant care recipient, relative to the needs of other care recipients, and must take that assessment into account before making the reconsideration decision.

Subsection 85-5(5B) provides that if the Secretary cannot assess the care recipient for the purposes of the reconsideration, the Secretary must not make a reconsideration decision under subsection 85-5(5). The practical effect in this instance is that the original decision stands.

Item 51 – Subsection 85-6(1)

Section 85-6 deals with the application fee for reconsideration of a decision about the classification of a care recipient under either Part 2.4 or Part 2.4A. This item amends subsection 85-6(1) to provide that a request made under subsection 85-5(1) for reconsideration of a reviewable decision made under subsection 29-1(1), 29C-2(1), 29D-1(1) or 29E-1(1) (which deal with decisions relating to the classification of a care recipient) must be accompanied by the application fee (if any) specified in, or worked out in accordance with, the Classification Principles.

Item 52 – Paragraph 85-6(3)(b)

Section 85-6 deals with the application fee for reconsideration of a decision about the classification of a care recipient under either Part 2.4 or Part 2.4A. This item amends paragraph 85-6(3)(b) with the effect that the Classification Principles may deal with other matters in relation to the fee, including the circumstances in which a person is exempt from paying the fee.

Item 53 – After subsection 96-2(15)

This item inserts new section 96-2(15A) which provides that the Secretary may, in writing, delegate a power conferred by the Minister under section 44-3 (as amended by Item 33) to an SES officer or acting SES officer in the Department. The note specifies that the expressions SES employee and acting SES employee are defined in section 2B of the *Acts Interpretation Act 1901*.

This item is appropriate as the essentially administrative character of making decisions in relation to matters that relate to the basic subsidy amount (see section 44-3 as amended), such as which residential care service is of what kind, when taken with the frequency with which residential aged care services commence and cease to provide services, makes it impractical for the Secretary to make such decisions on a day-to-day basis. Such tasks are suited to being delegated to an SES or acting SES officer who is dedicated to making a decision in relation to a matter under section 44-3.

Item 54 – Clause 1 of Schedule 1 (definition of adjusted subsidy place)

This item repeals the definition of adjusted subsidy place from Clause 1 of Schedule 1. This is consequential to repeal of arrangements relating to adjusted subsidy reduction (see Item 36).

Item 55 – Clause 1 of Schedule 1

This item inserts the definition of *transition day as the day Schedule 1 to the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* commences.

Aged Care (Transitional Provisions) Act 1997

The Transitional Act applies only to certain residential aged care recipients who entered care prior to 1 July 2014, known as *continuing care recipients*. For this Act, a summary of the amendments is as follows.

Part 3.1 (Residential aged care subsidy):

- Amend to limit the effect of classifications made under Part 2.4 on the calculation of basic subsidy to the period prior to the *transition day.
- Amend to permit the calculation of basic subsidy on and from the *transition day, being 1 October 2022 or, if later, a date to be fixed by Proclamation or six months after the day the Act receives Royal Assent as a combination of a variable amount linked to the care recipient's Part 2.4A (AN-ACC) classification and a fixed amount linked to the characteristics (or 'kind') of the residential aged care service where the person receives care.
- Amend to permit the Minister to provide for or in relation to a matter relating to the basic subsidy amount (for example, a matter relating to a kind of residential aged care service) by conferring a power on the Secretary.
- Amend to deal with calculation of basic subsidy when a continuing care recipient is on leave from a residential aged care service.
- Repeal the *charge exempt resident supplement*, the *transitional supplement*, and the *viability supplement* in respect of continuing care recipients, as these supplements are not required under the AN-ACC model. The effect of these supplements will be covered by the new method of calculating basic subsidy.
- Repeal the *adjusted subsidy reduction* in respect of continuing care recipients, which reduces the amount of subsidy per care recipient at certain residential aged care services operated by state and territory governments, which is not required under the AN-ACC model.
- Amend provisions relating to the *daily income tested reduction*, so that it is calculated in part by reference to a new *adjusted basic subsidy amount*.

Part 4.2 (User rights):

- Repeal references to the concepts of *high level of care* and *low level of care* (or equivalent) throughout, as these are not required under the AN-ACC model.
- Amend to preserve continuing care recipients' existing rights to pay on entry an *accommodation bond* or *accommodation charge* when moving between residential aged care services.

Part 6.1 (Reconsideration and review of decisions) – repeal a reference to the repealed *viability supplement*.

Chapter 7 (Miscellaneous)

- Amend to provide that the Secretary may delegate to an SES officer or acting SES officer of the Department a power conferred by the Minister to provide for or in relation to a matter relating to the basic subsidy amount (for example, a matter relating to a kind of service).

Schedule 1 (Dictionary) – Repeal redundant definitions.

Item 56 – Paragraph 42-1(2)(c)

Section 42-1 deals with eligibility for residential care subsidy. This item amends paragraph 42-1(2)(c), which deals with circumstances in which an approved provider is not eligible for basic subsidy in respect of residential care provided to the care recipient during a day, so that it ceases to refer to subsection 42-1(4), which is repealed (see Item 57).

Item 57 – Subsection 42-1(4)

Section 42-1 deals with eligibility for residential care subsidy. This item repeals subsection 42-1(4), which provided for certain limits on the operation of paragraph 42-1(2)(c), relating to whether residential care was provided as a low level of residential care or a high level of residential care, that are no longer relevant on or after the *transition day.

Item 58 – Paragraphs 43-1(3)(b) and (d)

This item repeals paragraphs 43-1(3)(b) and (d) and substitutes a new paragraph 43-1(3)(b) with the effect of repealing a reference to non-compliance deductions from a list of amounts that the Secretary may, in accordance with the Subsidy Principles, deduct from the amount of residential care subsidy otherwise payable in respect of a payment period. This item is consequential to the repeal of section 43-8, which established non-compliance deductions (see Item 59).

Item 59 – Section 43-8

This item repeals section 43-8, which established non-compliance deductions as a form of deduction of subsidy otherwise payable in respect of a residential care service if conditions specified in the Subsidy Principles relating to whether conditions of allocation on places in the service made under section 14-5 or 14-6 of the Aged Care Act had not been met. This is appropriate as subsidy payment arrangements from the *transition day do not require non-compliance deductions.

Item 60 – Subsection 44-3(2)

This item repeals and substitutes subsection 44-3(2) to provide that the basic subsidy amount for a care recipient for a day is either the amount determined by the Minister by legislative instrument or worked out in accordance with a method determined by the Minister by legislative instrument. The effect is to enable the Minister to either determine the basic subsidy amount or determine a method by which the basic subsidy amount for a day is to be worked out.

Item 61 – Paragraphs 44-3(3)(a) and (aa)

Subsection 44-3(3) provides that the Minister may determine different amounts of basic subsidy (including nil amounts) based on any one or more matters in the list of matters under that subsection.

This item repeals paragraphs 44-3(3)(a) and (aa) and substitutes new paragraphs 44-3(3)(a), (aa) and (ab) in subsection 44-3(3) to provide that among the matters which the Minister may take into account when determining different amounts of basic subsidy for a care recipient includes:

- the kind of residential care service through which residential care is provided to the care recipient;

- whether a care recipient being provided with residential care has been classified under Part 2.4A of the Aged Care Act;
- the classification levels for care recipients who have been classified under Part 2.4A of the Aged Care Act.

The effect of repealing paragraph 44-4(3)(a) is that classifications under Part 2.4 of the Aged Care Act will cease to be a basis for the Minister to determine amounts of basic subsidy for the period on and after the *transition day. This is appropriate as on and from the *transition day care recipient classifications under Part 2.4 of the Aged Care Act will not have effect in relation to a day that is on or after the *transition day (see item 13).

The effect of repealing paragraph 44-3(3)(aa) is that the concept of whether care is delivered at a low level of care ceases to be a relevant matter for determining basic subsidy on and after the *transition day. This is appropriate as the new funding model does not rely on the concept of a level of care.

The effect of new paragraph 44-3(3)(a) is that the Minister may determine different amounts of subsidy based on the kind of residential care service through which residential care is provided to the care recipient, such as whether the service is of a kind that is located in a particular region or whether the service delivers particular specialised services.

The effect of substituted paragraphs 44-3(3)(aa) and (ab) is that the Minister may determine amounts of basic subsidy (including nil amounts) contingent on the care recipient having not yet been classified under Part 2.4A of the Aged Care Act, or on the care recipient's classification level under Part 2.4A of the Aged Care Act if the care recipient has been classified.

Item 62 – Paragraphs 44-3(3)(cb), (cc) and (d)

This item repeals paragraphs 44-3(3)(cb) and (cc), which provided in the listed matters:

- whether an appraisal of a care recipient's care needs is received after the end of the period mentioned in paragraph 26-1(a) or (b) in Part 2.4 of the Aged Care Act;
- whether a reappraisal of a care recipient's care needs is received after the end of the reappraisal period for the classification determined under section 27-2 in Part 2.4 of the Aged Care Act.

This is appropriate as determination of subsidy for payment periods on and after the *transition day does not rely on the operation of Part 2.4 of the Aged Care Act. Determination of subsidy for payment periods before the *transition day inclusive of reliance on Part 2.4 of the Aged Care Act is saved by Division 4 of Schedule 1 of the Bill - transitional and savings provisions.

This item also repeals paragraph 44-3(3)(d), which referenced the State or Territory in which a residential care service is located. The State or Territory in which a residential care service is located is not a relevant matter for determining basic subsidy on and after the *transition day.

Item 63 – Subsection 44-3(4)

This item repeals the previous subsection 44-3(4), with the effect of removing a rule that limited the Minister's ability to determine a different amount of basic subsidy for a day on which a care recipient is on extended hospital leave, and substitutes the ability for the Minister to make provision for, or in relation to, a matter under section 44-3 by conferring a power on the Secretary.

If exercised, this new power may, for example, have the effect of permitting the Secretary to determine that a specific residential aged care service is a specific kind of service for the purposes of amended paragraph 44-3(3)(a) (see Item 61). This delegation of the Minister's powers is appropriate as the essentially administrative character of making decisions in relation to the matters that relate to the basic subsidy amount, taken with the frequency with which residential aged care services commence and cease to provide services, makes it impractical for the Minister to make such decisions on a day-to-day basis.

Item 64 – Paragraphs 44-5(aa)

This item repeals paragraph 44-5(aa) which established as a primary supplement the charge exempt supplement. This is appropriate as primary supplement arrangements from the *transition day does not require this supplement. The effect of this supplement will be covered by the new method of calculating basic subsidy.

Item 65 – Paragraph 44-5A(2)(a)

Section 44-5A deals with a non-primary supplement known as the accommodation supplement. This item repeals paragraph 44-5A(2)(a) with the effect that the conditions for a care recipient to be eligible for the accommodation supplement on a particular day are that on that day the care recipient is both a supported resident and that the residential care provided to the care recipient is not provided on an extra service basis for the purposes of Division 36 of the Aged Care Act.

This is appropriate as care recipients who receive care on an extra service basis, which requires paying an extra service fee for a higher standard of accommodation, will not meet the overall accommodation supplement eligibility criteria. As such, this amendment will not reduce access to the supplement.

Item 66 – Paragraph 44-6(2)(a), Item 67 – After subsection 44-6(2), Item 68 – Subsection 44-6(5) and Item 69 – Subsection 44-6(6)

Section 44-6 deals with a non-primary supplement known as the concessional resident supplement.

Item 66 repeals paragraph 44-6(2)(a) which removes the reference to a care recipient's eligibility for the concessional resident supplement on a particular day being partly based on the care recipient's classification not being the lowest applicable classification level. The effect of this item is that subsection 44-6(2) will provide that a condition for a care recipient to be eligible for concessional resident supplement on a particular day is that on that day the care recipient is either a concessional resident or an assisted resident and the residential care provided to the care recipient is not provided on an extra service basis for purposes of Division 36 of the Aged Care Act.

Item 67 inserts a new subsection 44-6(3) which provides that another condition for a care recipient to be eligible for concessional resident supplement on a particular day is that on the day before the *transition day the care recipient was eligible for the repealed charge exempt resident supplement (see item 64) or for a transitional supplement under repealed section 33 (eligibility for transitional supplement) of the *Aged Care (Transitional Provisions) Principles 2014* (Transitional Principles).

Item 68 amends subsection 44-6(5) to remove a reference to subsection 44-6(6), which is repealed by Item 69. Both changes are consequential to the amendments in Item 66 and Item 67.

The effect of Items 66, 67, 68 and 69 taken together is to repeal a rule requiring different rates of the concessional resident supplement to be paid to concessional residents and assisted residents, being two classes of residents who entered care pre-1 July 2014, as this is not required under the AN-ACC model.

Item 70 – Sections 44-8A and 44-8B

This item repeals section 44-8A, which deals with the charge exempt resident supplement, and section 44-8B, which deals with the meaning of charge exempt resident. This item is consequential to repeal of the charge exempt resident supplement from the list of primary supplements (see Item 64).

Item 71 – Paragraph 44-17(b)

This item repeals paragraph 44-17(b), which referenced the adjusted subsidy reduction that was established under section 44-19. This item is consequential to the repeal of section 44-19 (see Item 72).

Item 72 – Section 44-19

This item repeals section 44-19, which established the adjusted subsidy reduction as a type of reduction in subsidy. This is appropriate as subsidy calculation arrangements from the *transition day do not require this type of subsidy reduction.

Item 73 – Subsection 44-21(3) (Income tested reduction calculator, step 4, paragraph (c))

Section 44-21 deals with the income tested reduction, an amount used in the calculation of both residential care subsidy (see section 44-2) and the maximum daily amount of resident fees (see section 58-2). Subsection 44-21(3) provides for the income tested reduction calculator.

This item repeals in subsection 44-21(3), step 4, paragraph (c) and substitutes a new paragraph (c), so that this element of step 4 operates by reference to the subsidy related amount for a care recipient for a day (see new subsection 44-21(4)).

Item 74 – At the end of section 44-21

This item inserts new subsections 44-21(4) and (5) at the end of section 44-21.

Subsection 44-21(4) provides that the subsidy related amount for a care recipient for a day (used in the income tested reduction calculator in subsection 44-21(3)), is the sum of:

- the adjusted basic subsidy amount for the care recipient for the day (see subsection (5)); and
- the amounts of any primary supplements worked out using Subdivision 44-C for the care recipient for the day;
less
- any reductions in subsidy worked out using Subdivision 44-D for the care recipient for the day.

Subsection 44-21(5) provides that the adjusted basic subsidy amount for a care recipient for a day (as used in subsection 44-21(4)) is an amount:

- determined by the Minister by legislative instrument; or
- worked out in accordance with a method determined by the Minister by legislative instrument.

The subsidy related amount and the adjusted basic subsidy amount are required to be used in relation to calculation of the amount of income tested reduction (see section 44-21 and 44-23 as amended), and indirectly also the maximum daily amount of resident fees (see section 58-2), consequential to the effect of the amendments in Schedule 1 as a whole being to legislatively enable use of a new residential aged care funding model, the AN-ACC.

Item 75 – Paragraph 44-23(4)(b)

Section 44-23 deals with the amount of income tested reduction in the circumstance that the care recipient has not provided sufficient information about the care recipient’s total assessable income (see section 44-24) to be determined.

This item amends paragraph 44-23(4)(b) so that for the purposes of the paragraph the income tested reduction is the subsidy related amount worked out under subsection 44-21(4) for the care recipient for that day, for consistency with amendments to subsection 44-21(3).

Item 76 – Paragraph 44-27(1)(b)

This item repeals paragraph 44-27(1)(b), which established the viability supplement as a supplement under subsection 44-27(1). This is appropriate as primary supplement arrangements from the *transition day do not require this supplement.

Item 77 – Section 44-29

This item repeals paragraph 44-29, which established the viability supplement. This item is consequential to the repeal of paragraph 44-27(1)(b) (see Item 76).

Item 78 – Paragraphs 57-2(1)(aa) and (ab)

Section 57-2 deals with basic rules about accommodation bonds. This item repeals paragraphs 57-2(1)(aa) and (ab), which specify certain rules relating to charging an accommodation bond for the entry of a person to a residential care service, or flexible care service, and substitutes new paragraphs 57-2(1)(a) and (aa).

New paragraph 57-2(1)(a) specifies that, subject to other rules in subsection 57-2(1), accommodation bond must be charged for an entry if:

- the care recipient enters the service within 28 days after the day on which the care recipient ceased (other than because the care recipient is on leave) being provided with care through another such service (the prior service); and
- an accommodation bond was paid by the care recipient for entry to the prior service.

The effect is that if a care recipient who paid an accommodation bond for entry to the residential care service they were receiving care in immediately before the *transition day moves to another such service on or after the *transition day then they must be charged an accommodation bond. This is the case for however many such services the care recipient enters on or after the *transition day..

This item is related to Item 80, which deals with the maximum amount of accommodation bond that can be charged if a care recipient moves between aged care services.

Item 79 – Paragraph 57-2(1)(g)

This item amends paragraph 57-2(1)(g) to omit a reference to repealed section 57-23 in subdivision 57-H (see Item 81).

Item 80 – Section 57-13

This item repeals and substitutes section 57-13, which deals with the maximum amount of accommodation bond if care recipient moves between aged care services.

Subsection 57-13(1) provides that if paragraph 57-2(1)(a) (as amended – see item 78) applies in relation to the charging of an accommodation bond for entry by a care recipient to an aged care service, the maximum amount of the accommodation bond for the entry of the care recipient to the service is the amount set out in subsection 57-13(2).

Subsection 57-13(2) provides that the amount is the accommodation bond balance that was refunded or is repayable to the care recipient under Division 52P of the Aged Care Act in respect of the accommodation bond referred to in subparagraph 57-2(1)(a)(ii) (as amended – see Item 78).

The effect is that if an accommodation bond is charged for entry by a care recipient to an aged care service, the maximum amount of the accommodation bond is the amount of the accommodation bond balance that was refunded or repayable to the care recipient by the prior service.

Item 81 – Subdivision 57-H

This item repeals subdivision 57-H, which dealt with charging an accommodation bond instead of an accommodation charge, consequential to changes to rules about charging an accommodation charge (see Item 82).

Item 82 – Paragraphs 57A-2(1)(a) and (b)

Section 57A-2 deals with basic rules about accommodation charges. This item repeals paragraphs 57A-2(1)(a) and (b), which specify certain rules relating to charging an accommodation charge for the entry of a person to a residential care service, or flexible care service, and substituting new paragraphs 57A-2(1)(a) and (b).

New paragraph 57A-2(1)(a) specifies that, subject to other rules in subsection 57A-2(1), an accommodation charge must be charged for an entry if:

- the care recipient enters the service within 28 days after the day on which the care recipient ceased (other than because the care recipient is on leave) being provided with care through another such service (the prior service); and
- an accommodation charge was payable by the care recipient for entry to the prior service.

The effect is that if a care recipient for whom an accommodation charge was payable for entry to the residential care service they were receiving care in immediately before the *transition day moves to another such service on or after the *transition day then they must be charged an accommodation charge. This is the case for however many such services the care recipient enters on or after the *transition day .

This item is related to item 83, which deals with the maximum amount of accommodation charge that can be charged if a care recipient moves between aged care services.

Item 83 – Section 57A-8A

This item repeals and substitutes section 57A-8A, which deals with the maximum amount of accommodation charge if a care recipient moves between aged care services.

Subsection 57A-8A(1) provides that if paragraph 57A-2(1)(a) (as amended – see Item 82) applies in relation to the charging of an accommodation charge for entry by a care recipient to an aged care service, the maximum daily amount at which the accommodation charge accrues for the entry of the care recipient to the service is the amount set out in subsection 57A-8A(2).

Subsection 57A-8A(2) provides that this amount is the maximum daily amount of accommodation charge that accrued under section 57A-6 for entry of the care recipient to the prior service referred to in subparagraph 57A-2(1)(a)(i) (as amended – see Item 82).

The effect is that if an accommodation charge is charged for entry by a care recipient to an aged care service, the maximum daily amount at which the accommodation charge accrues is the amount that accrued at the prior service.

Item 84 – Section 58-6

Section 58-6 deals with the maximum daily amount of resident fees for reserving a place when a care recipient is absent from a residential care service on a particular day, the care recipient is not on leave from the residential care service on that day, and the care recipient would have been on a form of leave from the residential care service on that day specified in subsection 42-2(3), informally known as ‘social leave’, except that the care recipient had previously been on social leave, during the current financial year, for 52 days.

This item omits and substitutes text to provide the maximum fee in respect of a day that can be charged for reserving a place in the residential care service for that day is

the amount determined by the Minister by legislative instrument or worked out in accordance with a method determined by the Minister by legislative instrument.

The effect of this item is to allow the maximum daily amount of resident fees for reserving a place to be aligned with the maximum daily amount of resident fees as calculated under section 58-2 using section 44-21 as amended by Item 73.

Item 85 – Section 85-1 (table item 47)

This item repeals table item 47 in section 85-1, which references the viability supplement. This item is consequential to the repeal of section 44-29 (see Item 77).

Item 86 – After subsection 96-2(11)

This item inserts new subsection 96-2(11A) which provides that the Secretary may, in writing, delegate a power conferred by the Minister under section 44-3 (as amended by Item 63) to an SES officer or acting SES officer in the Department. The note specifies that the expressions SES employee and acting SES employee are defined in section 2B of the *Acts Interpretation Act 1901*.

This item is appropriate as the essentially administrative character of making decisions in relation to matters that relate to the basic subsidy amount (see section 44-3 as amended), such as which residential care service is of what kind, when taken with the frequency with which residential aged care services commence and cease to provide services, makes it impractical for the Secretary to make such decisions on a day-to-day basis. Such tasks are suited to being delegated to an SES or acting SES officer who is dedicated to making a decision in relation to a matter under section 44-3.

Item 87 – Clause 1 of Schedule 1

This item in Clause 1 of Schedule 1 repeals the definitions of adjusted subsidy place, charge exempt resident, high level of residential care, lowest applicable classification level and low level of residential care. This item is consequential to the repeal of arrangements relating to these definitions.

Part 2—Application, transitional and saving provisions

Division 1—Introduction

Item 88 – Definitions

This item inserts defined terms for Part 2 of this Schedule:

Aged Care Act means the *Aged Care Act 1997*.

amending Part means Part 1 of this Schedule.

payment period has the meaning given by:

- when used in relation to a provision of the Aged Care Act—section 43-2 of that Act; or
- when used in relation to a provision of the Transitional Act—section 43-2 of that Act.

Transitional Act means the *Aged Care (Transitional Provisions) Act 1997*.

transition day means the day this item commences.

viability supplement decision means a decision made under subsection 44 29(2) of the Transitional Act to refuse to make a determination in respect of a residential care service.

Division 2—Classifications of care recipients

Item 89 – Application—classification, and renewal of classification, of care recipients by the Secretary

Subsection 25-1(1A) of the Aged Care Act, as inserted by the amending Part, provides in relation to an appraisal received by the Secretary that the Secretary is not required to classify the care recipient if the classification would take effect, or be taken to have had effect, from or on a day that is on or after the *transition day.

Subsection 27- 6(1A) of the Aged Care Act, as inserted by the amending Part, provides in relation to a reappraisal received by the Secretary that the Secretary is not required to renew the classification of the care recipient if the renewal would take effect, or be taken to have had effect, from a day that is on or after the *transition day.

This item provides that these subsections apply to an appraisal or a reappraisal received, or that is taken to have been received, by the Secretary before, on or after the *transition day.

Item 90 – Saving—Classification Principles made in relation to assessments

Section 29C-3 of the Aged Care Act provides that the Secretary may assess care recipients. Subsection 29C-3(2) as substituted by the amending Part provides that Classification Principles may specify where the Secretary may or must make the assessment, and the procedures that the Secretary must follow in making the assessment.

This item applies to the Classification Principles to provide that rules in the version of the Classification Principles that are in force immediately before the *transition day that were originally made with respect to the repealed subsection 29C-3(2) continue in force (and may be dealt with), on and after the *transition day, as if they had been made with respect to the new, substituted subsection 29C-3(2).

Item 91 – Application—application for reclassification of a care recipient

Section 29D-1 of the Aged Care Act, as amended by the amending Part, provides for matters relating to reclassification of a care recipient.

This item provides that this section (as amended) applies to an application by an approved provider that is made on or after the *transition day.

Division 3—Residential care subsidy on or after the transition day

Item 92 – Application—eligibility for residential care subsidy under the Transitional Act

Section 42-1 of the Transitional Act, as amended by the amending Part, provides for eligibility for residential care subsidy.

This item provides that this section (as amended) applies in relation to a day that is on or after the *transition day.

Item 93 – Application—basic subsidy amount under the Aged Care Act and Transitional Act

Section 44-3 of the Aged Care Act and section 44-3 of the Transitional Act provide for the basic subsidy amount.

Subsection 44-3(2) of the Aged Care Act and subsection 44-3(2) of the Transitional Act, as amended by the amending Part, provide that the basic subsidy amount for a day is the amount determined by the Minister by legislative instrument or worked out in accordance with a method determined by the Minister by legislative instrument.

This item provides Subsection 44-3(2) of the Aged Care Act, and subsection 44-3(2) of the Transitional Act, as amended by the amending Part, apply in relation to a day that is on or after the *transition day.

Subsection 44-3(3) of the Aged Care Act and subsection 44-3(3) of the Transitional Act, as amended by the amending Part, provides that the Minister may determine different amounts of basic subsidy for a care recipient for a day (including nil amounts) based on any one or more of a list of matters under those subsections.

This item also provides that subsection 44-3(3) of the Aged Care Act, and subsection 44-3(3) of the Transitional Act, as amended by the amending Part 1 of this Schedule, applies, apply in relation to a determination made on or after the *transition day.

Subsection 44-3(4) of the Aged Care Act and subsection 44-3(4) of the Transitional Act, as amended by the amending part, provides that the Minister to make provision for, or in relation to, a matter within the meaning of section 44-3 by conferring a power on the Secretary.

This item also provides that subsection 44-3(4) of the Aged Care Act, and subsection 44-3(4) of the Transitional Act, as amended by the amending Part 1 of this Schedule, applies, apply in relation to a determination made on or after the *transition day

Item 94 – Application—other amendments relating to residential care subsidy under the Aged Care Act and Transitional Act

This item provides that certain provisions of the Aged Care Act, as amended by the amending Part, that affect payments of subsidy and supplements to approved providers apply in relation to a payment period that starts on or after the *transition day:

- subsection 43-1(3), which provides for deductions from the amount of residential care subsidy otherwise payable in respect of a payment period;

- subsection 44-5(1), which provides for the primary supplements in relation to the care recipient in respect of a payment period;
- section 44-17, which provides for reductions in subsidy in respect of a payment period; and
- section 44-21, which provides for the care subsidy reduction;
- subsection 44-28 (2), which provides for payment of a supplement called the accommodation supplement in respect of a payment period.

This item also provides that the repeal of the following sections of the Aged Care Act by the amending Part applies in relation to a payment period that starts on or after the *transition day:

- section 43-8, which provided for non-compliance deductions; and
- section 44-19, which provided for the adjusted subsidy reduction.

This item provides that certain provisions of the Transitional Act, as amended by the amending Part, that affect payments of subsidy and supplements to approved providers apply in relation to a payment period that starts on or after the *transition day:

- subsection 43-1(3), which provides for deductions from the amount of residential care subsidy otherwise payable in respect of a payment period;
- section 44-5, which provides for the primary supplements in relation to the care recipient in respect of a payment period;
- subsection 44-5A (2), which provides for payment of a primary supplement called the accommodation supplement in respect of a payment period;
- section 44-6, which provides for the concessional resident supplement in respect of a payment period;
- section 44-17, which provides for reductions in subsidy in respect of a payment period;
- section 44-21, which provides for the income tested reduction calculator;
- paragraph 44-23(4)(b), which provides for the income tested reduction amount if the care recipient fails to give information required for determining total assessable income; and
- subsection 44-27(1), which provides for other supplements in respect of a payment period.

This item also provides that the repeal of the following sections of the Transitional Act by the amending Part applies in relation to a payment period that starts on or after the *transition day:

- section 43-8, which provided for non-compliance deductions;
- section 44-8A, which provided for the charge exempt resident supplement;
- section 44-8B, which provided for the definition of a charge exempt resident;
- section 44-19, which provided for the adjusted subsidy reduction; and
- section 44-29, which provided for the viability supplement.

Division 4—Residential care subsidy for a day that is before the *transition day

Item 95 – Saving—eligibility for residential care subsidy under the Transitional Act

Section 42-1 of the Transitional Act provides for eligibility for residential care subsidy. This item provides that conditions on eligibility for residential care subsidy that were in force under section 42-1 as it was immediately before the *transition day continue to apply, on and after that day, in relation to a day that is before the *transition day. The effect is that eligibility for residential care subsidy in respect of a pre-*transition day operates under the terms of section 42-1 as it was immediately before the *transition day.

This item also provides that certain repealed definitions in clause 1 of Schedule 1 that relate to section 42-1 as it was immediately before the *transition day continue to apply, on and after that day, in relation to a day that is before *transition day, being:

- the definition of high level of residential care; and
- the definition of low level of residential care.

Item 96 – Saving—non-compliance deductions under the Aged Care Act and Transitional Act

Subsection 43-1(3) of the Aged Care Act, subsection 43-1(3) of the Transitional Act, section 43-8 of the Aged Care Act and section 43-8 of the Transitional Act, without the operation of the amending Part, deal with non-compliance deductions.

This item provides that those provisions as they are in force immediately before the *transition day continue to apply, on and after that day, in relation to a day that is before the *transition day. The effect is that non-compliance deductions in respect of a day that is before the *transition day operate under the terms of those provisions as they were immediately before the *transition day.

This item also provides that any subsidiary provisions in the Subsidy Principles or the Transitional Principles in force immediately before the *transition day that were made for the purposes of a non-compliance deduction continue to apply, on and after that day, in relation to a day that is before the *transition day.

Item 97 – Saving—basic subsidy amount under the Aged Care Act and Transitional Act

Section 44-3 of the Aged Care Act and section 44-3 of the Transitional Act provide for the basic subsidy amount. This item provides that conditions on the basic subsidy amount that were in force under section 44-3 of either Act as they were immediately before the *transition day continue to apply, on and after that day, in relation to a day that is before the *transition day. It also provides that any determination of the basic subsidy made under section 44-3 of either Act continues in force as if the amendments had not been made. The effect is that the basic subsidy amount for a day that is before the *transition day operates under the terms of section 44-3 of either Act as they were immediately before the *transition day.

This item also provides that certain repealed definitions in clause 1 of Schedule 1 that relate to section 44-3 of the Transitional Act as it was immediately before the *transition day continue to apply, on and after that day, in relation to a day that is before the *transition day, being the definition of low level of residential care.

Item 98 – Saving—charge exempt resident supplement and viability supplement under the Transitional Act

This item provides that provisions relating to the charge exempt resident supplement and viability supplement, which are repealed from the Transitional Act under the amending Part, as they are in force immediately before the *transition day, continue to apply, on and after that day, in relation to a payment period that starts before the *transition day.

This item also provides that any determination in relation to the charge exempt resident supplement and the viability supplement in force immediately before the *transition day continues in force and is to be taken to apply in relation to a day that is before the *transition day.

This item also provides that any subsidiary provisions in the Transitional Principles in force immediately before the *transition day that are made for the purposes of the charge exempt resident supplement and the viability supplement continue to apply, on and after that day, in relation to a pre-*transition day.

This item also provides that certain repealed definitions in clause 1 of Schedule 1 that relate to the Transitional Act as it was immediately before the commencement day continue to apply, on and after that day, in relation to a day that is before the *transition day, being:

- the definition of charge exempt resident.

Item 99 – Saving—eligibility for concessional resident supplement under the Transitional Act

Section 44-6 of the Transitional Act provides for eligibility for the concessional resident supplement. This item provides that conditions on eligibility for residential care subsidy that were in force under section 44-6 as it was immediately before the *transition day continue to apply, on and after that day, in relation to a pre-*transition day. The effect is that eligibility for residential subsidy care in respect of a pre-*transition day operates under the terms of subsection 44-6(2) as it was immediately before the *transition day.

This item also provides that certain repealed definitions in clause 1 of Schedule 1 that relate to section 44-6 as it was immediately before the *transition day continue to apply, on and after that day, in relation to a pre-*transition day, being:

- the definition of lowest applicable classification level.

Item 100 – Saving—adjusted subsidy amount under the Aged Care Act and Transitional Act

This item provides that provisions relating to the adjusted subsidy amount, repealed from the Aged Care Act and from the Transitional Act by the amending Part, as they are in force immediately before the *transition day, continue to apply, on and after that day, in relation to a payment period that starts before the *transition day.

This item also provides that any determination in relation to the adjusted subsidy amount in force immediately before the *transition day continues in force and is to be taken to apply in relation to a day that is before the *transition day.

Item 101 – Saving—care subsidy reduction under the Aged Care Act

This item provides that provisions relating to amendment of the care subsidy reduction under the Aged Care Act (see section 44-21 of that Act, as amended) as in force immediately before the *transition day, continue to apply, on and after that day, in relation to a payment period that starts before that day.

Item 102 – Saving—daily income tested reduction under the Transitional Act

This item provides that provisions relating to amendment of the daily income tested reduction under the Transitional Act (see section 44-21 and paragraph 44-23(4)(b) of that Act, as amended) as in force immediately before the *transition day, continue to apply, on and after that day, in relation to a payment period that starts before that day.

Item 103 – Saving—accommodation supplement under the Aged Care Act and Transitional Act

This item provides that provisions relating to the accommodation supplement, amended in the Transitional Act under the amending Part, as they are in force immediately before the *transition day, continue to apply, on and after that day, in relation to a payment period that starts before the *transition day.

This item also provides that certain repealed definitions in clause 1 of Schedule 1 that relate to provisions relating to the accommodation supplement in the Transitional Act, as it was immediately before the *transition day continue to apply, on and after that day, in relation to a pre-*transition day, being:

- the definition of lowest applicable classification level.

Division 5—Resident fees

Item 104 – Application—maximum daily amount of resident fees on or after the transition day under the Aged Care Act and Transitional Act

Section 52C-5 of the Aged Care Act and section 58-6 of the Transition Act provides for the maximum amount of resident fees to reserve a place, and is amended by the amending Part. This item provides that section 52C-5 of the Aged Care Act and section 58-6 of the Transitional Act, as amended by the amending Part, applies in relation to a day that is on or after the *transition day.

Item 105 – Saving—maximum daily amount of resident fees for a day that is before the transition day under the Aged Care Act and Transitional Act

Section 52C-5 of the Aged Care Act and section 58-6 of the Transitional Act provides for the maximum amount of resident fees to reserve a place, and is amended by the amending Part. This item provides that section 52C-5 of the Aged Care Act and section 58-6 of the Transitional Act, as in force immediately before the *transition day, applies in relation to a day that is before the transition day.

Division 6—Accommodation bonds and charges

Item 106 – Application—accommodation bonds and charges under the Transitional Act

Sections 57-2, 57-13, 57A-2 and 57A-8A of the Transitional Act, as amended by the amending Part, provide for rules about accommodation bonds and charges for the entry of a person to a residential care service, or flexible care service.

This item provides that these provisions apply in relation to the entry of a person to a residential care service, or flexible care service, on a day that is on or after the *transition day.

Division 7—Viability supplement decisions under the Transitional Act

Item 107 – Application—reconsideration of viability supplement decisions at Secretary’s own initiative

Section 85-4 of the Transitional Act provides that the Secretary may reconsider reviewable decisions at the Secretary’s own initiative.

This item provides that the Secretary may continue to reconsider a viability supplement decision made on a pre-transition day on and after the *transition day, despite item 47 of the table in section 85-1 of the Transitional Act, which provided for review of a viability supplement decision, being repealed by the amending Part.

This item also provides that the Administrative Appeals Tribunal review of reviewable decisions applies to a viability supplement decision made on and after the transition day, despite item 47 of the table in section 85-1 of the Transitional Act, which provided for review of a viability supplement decision, being repealed by the amending Part.

Item 108 – Application—reconsideration of viability supplement decisions where reconsideration period has not ended

Section 85-5 of the Transitional Act provides that the Secretary must reconsider a reviewable decision when a person whose interests are affected by a reviewable decision requests in the correct manner that the Secretary reconsider the decision. Subsection 85-5(3) provides that the person’s request must be made by written notice given to the Secretary within a period defined in that subsection after the day on which the person first received notice of the decision.

This item provides that the Secretary must continue to reconsider a viability supplement decision made before the *transition day if a person whose interests are affected by a reviewable decision provides a written notice within the relevant period defined in paragraph 85-5(3)(a) after the *transition day, even if the day the request is received by the Secretary is on or after the *transition day. This is despite the repeal by the amending Part of item 47 of the table in section 85-1 of the Transitional Act, which provided for review of a viability supplement decision.

This item also provides that the Administrative Appeals Tribunal review of reviewable decisions applies to a viability supplement decision made on and after the *transition day, despite item 47 of the table in section 85-1 of the Transitional Act, which provided for review of a viability supplement decision, being repealed by the amending Part.

Item 109 – Application—pending request for reconsideration of viability supplement decisions

Section 85-4 of the Transitional Act provides that the Secretary may reconsider reviewable decisions at the Secretary’s own initiative. Section 85-5 of the Transitional Act provides that the Secretary must reconsider a reviewable decision when a person

whose interests are affected by a reviewable decision requests in the correct manner that the Secretary reconsider the decision.

This item applies to a request made under subsection 85-5(1) of the Transitional Act for the reconsideration of a viability supplement decision if the request was made on a day before the *transition day, and immediately before the *transition day the Secretary has not made a decision in relation to the request.

This item provides that the Secretary must continue to reconsider that viability supplement decision, despite the repeal by the amending Part of Item 47 of the table in section 85-1 of the Transitional Act (which provided for review of a viability supplement decision).

This item also provides that the Administrative Appeals Tribunal review of reviewable decisions applies to a viability supplement decision made on and after the *transition day, despite item 47 of the table in section 85-1 of the Transitional Act, which provided for review of a viability supplement decision, being repealed by the amending Part.

Item 110 – Application—review by the Administrative Appeals Tribunal of pre-transition viability supplement decisions

Section 85-4 of the Transitional Act provides that the Secretary may reconsider reviewable decisions at the Secretary’s own initiative. Section 85-5 of the Transitional Act provides that the Secretary must reconsider a reviewable decision when a person whose interests are affected by a reviewable decision requests in the correct manner that the Secretary reconsider the decision.

This item provides that if the Secretary made a reconsideration decision on a viability supplement decision before the *transition day and, before the *transition day:

- an application for review of the decision by the Administrative Appeals Tribunal has not been made, and
- the time for a person to make such an application has not ended (including any extensions of that time under section 29 of the *Administrative Appeals Tribunal Act 1975*),

then the person can continue to apply for review of the decision, despite the repeal by the amending Part of item 47 of the table in section 85-1 of the Transitional Act (which provided for review of a viability supplement decision).

Division 8—Other matters

Item 111 – Transitional rules

This item provides that the Minister may, by legislative instrument, make rules prescribing matters of a transitional nature (including prescribing any saving or application provisions) relating to the amendments or repeals made by the amending Part. However, the rules may not do the following:

- create an offence or civil penalty;
- provide powers of arrest or detention or entry, search or seizure;
- impose a tax;
- set an amount to be appropriated from the Consolidated Revenue Fund under an appropriation in this Act; or

- directly amend the text of this Act.

This item does not otherwise limit the transitional rules that may be made.

Schedule 2 – Star ratings

Overview

Schedule 2 amends the Aged Care Act to introduce a requirement for the Secretary to publish information about the new Star Ratings system. The amendments require the Secretary to publish information about the quality of aged care provided through an aged care service, and the performance of the approved provider in relation to responsibilities and standards under the Aged Care Act.

Schedule 2 also provides that the Secretary may publish the information in the form of one or more star ratings for the service.

These amendments will allow star ratings to be published for all residential aged care services on My Aged Care by the end of 2022. On 1 March 2021, the Royal Commission Final Report was publicly released. The Royal Commission highlighted the need for aged care quality to be measured, monitored and for this information to be made available to people seeking and receiving aged care, with Recommendation 24 being the development of a star rating system.

The Royal Commission recommended that the Government should develop and publish a system of star ratings based on measurable indicators of quality and available data that allow older Australians and their families to make meaningful comparisons of the quality and safety of residential care services and approved providers of those services and that the star ratings and accompanying performance information should be published on My Aged Care.

In line with Recommendation 24 of the Royal Commission, the Star Ratings will be published as an overall rating, as well as against the four sub-categories (or data elements of those categories) on My Aged Care:

- the five existing quality indicators - pressure injuries, physical restraint, unplanned weight loss, falls and major injury, and medication management.
- service compliance ratings relevant to the regulatory activities undertaken by the Aged Care Quality and Safety Commission.
- consumer experience information to be collected from face-to-face interviews, with approximately 20% of older Australians across all residential aged care services.
- staff minutes of care.

The amendments also clarify that the Secretary may use protected information (within the meaning of the Aged Care Act) for the purposes of publishing the information or calculating a star rating for the residential care service. The amendments further provide that information that is published must not include personal information.

In addition, the amendments provide that the Secretary is not liable to civil proceedings for loss, damage or injury suffered by an approved provider of a residential care service or any other person as a result of the publication of the star rating.

Part 1—Amendments

Aged Care Act 1997

Item 1 – In the appropriate position in Division 86

Item 1 inserts new section 86-11 in Division 86 of the Aged Care Act. New section 86-11 introduces new requirements that facilitate the publication of star ratings for a residential aged care service.

New subsection 86-11(1) provides that Secretary must publish information about:

- the quality of aged care provided through a residential aged care service, and
- the performance approved providers of such services in relation to responsibilities and standards under the Aged Care Act.

This will allow for the Secretary to publish information about quality and performance, including information relevant to quality indicators, service compliance ratings, consumer experience information and staff care minutes. This provision aims to assist current and prospective care recipients to make informed decisions about their care, and to help ensure their health, safety and well-being by encouraging approved providers of residential care services to maintain a high star rating.

New subsection 86-11(2) provides that the Secretary may publish the information under new subsection (1) in the form of one or more star ratings for the residential aged service. Under the star rating, the Secretary has developed methodology to use measurable data, including quality indicators, service compliance ratings, consumer experience information and staff minute of care to develop a rating that can be used by older Australians and their families to make a clear comparison between the quality and safety of residential care services.

New subsection 86-11(3) provides that the Secretary may use protected information (as defined in section 86-1 of the Aged Care Act) for the purposes of creating information for publication under subsection 86-11(1) or calculating a star rating for a residential care service. This amendment authorises the use of protected information by the Secretary for the purposes of the Star Ratings system.

New subsection 86-11(4) provides that the information published by the Secretary in relation to new subsection 86-11(1) must not include personal information (within the meaning of the *Privacy Act 1988*) about an individual.

New subsection 86-11(5) also provides that the Secretary is not liable to civil proceedings for loss, damage or injury of any kind suffered by the approved provider of a residential care service or another person as a result of the publication of the information under new subsection 86-11(1). This provides additional support to the Secretary in publishing information under new subsection 86-11(1), including in the form of one or more star ratings. This immunity aims to ensure current and prospective care recipients are able to access important information about approved providers of residential care services.

Item 2 – Application—publishing of star ratings for residential care services

Item 2 provides application arrangements with respect to new section 86-11 of the Aged Care Act as inserted by Item 1. Item 2 provides that new section 86-11 of the Aged Care Act applies in relation to information whether the information was acquired or created before, on or after the commencement of this Schedule. This means the Secretary can publish any information under subsection 86-11(1) regardless of when the information was acquired or created. This is because under the new Star Ratings system, the Secretary will derive the star rating of a residential care service using measurable data provided to the Secretary in accordance with existing requirements, which necessarily includes information that was acquired or created before the commencement of the provision.

Schedule 3—Code of conduct and banning orders

Overview

Schedule 3 amends the Aged Care Act and the Quality and Safety Commission Act to introduce a Code of Conduct (Code) that will apply to approved providers and their aged care workers and governing persons.

The Schedule expands the powers and functions of the Commission to take action in relation to compliance with the Code by an approved provider or their aged care workers or governing persons. The Code will be set out in the rules made under the Quality and Safety Commission Act (Commission Rules). A consultation process has been undertaken with sector stakeholders on both the content and the operation of the Code. The Code will be based on the existing National Disability Insurance Scheme (NDIS) Code of Conduct as provided for in the *National Disability Insurance Scheme (Code of Conduct) Rules 2018* with modifications to ensure relevance to the aged care sector. The intention is to align obligations between the care and support sectors to increase harmonisation.

The Commission will be responsible for regulatory oversight of the Code in respect of approved providers and their aged care workers and governing persons, and the Commissioner will have the ability to take action in relation to compliance with the Code in accordance with the Commission Rules, or by taking action through the Commission's regulatory, complaints, and other functions as appropriate. To promote consistency across the aged care and disability support sectors, the intention is that these arrangements will seek to mirror the NDIS arrangements.

As part of its enforcement of the Code, the Commissioner's monitoring and investigation powers under the *Regulatory Powers (Standard Provisions) Act 2014* will be extended to include provisions relating to the Code. This will allow the Commissioner to effectively enforce compliance with the Code.

Schedule 3 also introduces new powers for the Commissioner to impose banning orders on current and former aged care workers and governing persons of approved providers. This will have the effect of prohibiting or restricting them from being involved in the provision of any type, or specified types, of aged care, or from engaging in specified activities as an aged care worker or governing person of an approved provider. Civil penalties may apply to approved providers, aged care workers or governing persons, including former aged care workers and governing persons, for breaching a banning order.

Individuals who have a banning order in place against them, will have the power to seek to have the order varied or revoked. The Commissioner will also have the power to vary or revoke a banning order on their own initiative. The amendments contained in Schedule 3 make clear that certain decisions made by the Commissioner in relation to a banning order against an individual are reviewable decisions.

The Commissioner must also establish and maintain a register containing certain information about individuals against whom a banning order has been made at any time.

Schedule 3 to the Bill responds to Royal Commission Recommendation 77 by implementing the Code, including in relation to aged care workers. This is a key element of the proposed national registration scheme for the personal care workforce. It also responds to Recommendation 103 relating to introducing banning orders as one of a wider range of enforcement powers.

Aged Care Act 1997

Item 1 - After paragraph 54-1(1)(f)

Item 1 inserts new paragraphs 54-1(1)(g) and (ga), which provide for two new responsibilities of an approved provider. The new responsibilities are to comply with the provisions of the Code that apply to the approved providers (see Item 35 below), and to take reasonable steps to ensure that the aged care workers and governing persons of the approved provider comply with the provisions of the Code that apply to them.

Item 2 - Clause 1 of Schedule 1

Item 2 inserts new definitions of ‘aged care worker’, ‘Code of Conduct’ and ‘governing person’ into Clause 1 of Schedule 1 (the Dictionary). These definitions have the same meaning as in the Quality and Safety Commission Act (see Item 5).

Aged Care Quality and Safety Commission Act 2018

Item 3 - Section 6 (after paragraph (d))

Item 3 inserts new subsection 6(da) to the simplified outline of the Quality and Safety Commission Act, which states that one of the functions conferred on the Commissioner is the code functions. The code functions are also addressed in Item 7, Item 8 and are set out in further detail in Item 9.

Item 4 – Section 6 (paragraph beginning “This Act also”)

Item 4 amends the simplified outline to make clear that the Quality and Safety Commission Act also deals with the Code.

Item 5 - Section 7

Item 5 inserts new definitions of ‘ABN’, ‘aged care worker’, ‘banning order’, ‘code functions’, ‘Code of Conduct’ and ‘governing person’ into the Quality and Safety Commission Act. These terms are used in other provisions in the Schedule.

‘ABN’ has the same meaning as under the *A New Tax System (Australian Business Number) Act 1999*.

‘Aged care worker’ of an approved provider means an individual employed or otherwise engaged (including on a voluntary basis) by the provider; or an individual who is employed or otherwise engaged (including on a voluntary basis) by a contractor or subcontractor of the provider, and who provides care or other services to care recipients through an aged care service of the provider. This definition ensures that the Code will apply to a broad range of workers, including volunteers and employees of contractors of approved providers where they provide care or other services to care recipients. This aligns with the application of the NDIS Code of

Conduct and is designed to cover similar types of workers. The note accompanying this definition makes clear that an aged care worker includes an independent contract. Including independent contractors and subcontractors of approved providers also reinforces the responsibilities of approved providers in relation to care provided by another person on their behalf under a contract or arrangement, as set out in section 96-4 of the Aged Care Act.

The term ‘banning order’ is defined as an order made under subsection 74GB(1) or (3), code functions are defined in section 18A and ‘Code of Conduct’ means the Code made through rules under subsection 74AE(1) of the Quality and Safety Commission Act (see Items 9, 11 and 26).

‘Governing person’ of an approved provider means an individual who is one of the key personnel of the provider under paragraph 8B(1)(a) or (b) of the Quality and Safety Commission Act. This means a governing person is either a member of the group of persons who is responsible for the executive decisions of the approved provider at that time, or any other person who has authority or responsibility for, or significant influence over, planning, directing or controlling the activities of the approved provider at that time, where the approved provider is not a State or Territory. This will include a member of the group of persons referred to in subsection 8B(2). The definition of governing persons excludes persons responsible for nursing services or day-to-day operations of the aged care service, who would otherwise be key personnel. This is because these persons will be included under the definition of aged care worker.

Item 6 - After paragraph 8C(1)(a)

Item 6 inserts new paragraph 8C(1)(aa), which requires an approved provider to take into account whether a banning order against an individual is, or has at any time been, in force, when considering whether that individual is suitable to be a key personnel (as defined in section 8B) of the approved provider.

Item 7 - Section 14 (after paragraph (d))

Item 7 adds paragraph (da) to the simplified outline of Part 3 and provides that the functions of the Commissioner include the code functions. The code functions are a function of the Commissioner under new paragraph 16(1)(da) (see Item 8 below) and are set out in further detail in new section 18A (see Item 9 below).

Item 8 - After paragraph 16(1)(d)

Item 8 adds new paragraph (da), which provides that the Commissioner’s functions include Code functions. The Code functions are set out in new section 18A (see Item 9 below).

Item 9 - After section 18

Item 9 inserts new section 18A, which sets out the Code functions of the Commissioner.

Subsection 18A(1) provides a new function for the Commissioner to take action in relation to compliance with the Code by approved providers, and their aged care workers and governing persons, and to do anything else relating to that matter as specified in the rules. The rules will set out the process and procedures to take action in relation to compliance with the Code (see Item 10 below). Rules made under

paragraphs 18A(1)(a) and (b) are disallowable legislative instruments for the purposes of the *Legislation Act 2003* (Legislation Act).

Subsection 18A(2) stipulates that any rules made for the purposes of the Commissioner’s code functions do not limit, or otherwise affect, the operation of any other provision of the Quality and Safety Commission Act in relation to the Code.

Subsection 18A is not intended to restrict the Commission from taking action in relation to compliance with the Code through its ordinary regulatory, complaints or other functions where appropriate.

Item 10 - After subsection 21(3)

Item 10 inserts new subsection 21(3A) and (3B).

New subsection 21(3A) allows for the rules to make provision for the taking of action in relation to compliance by an approved provider, aged care worker of an approved provider or governing person with the provisions of the Code that apply to them. The Rules may make provision for a range of things relating to compliance with the Code, including, for example, how information about compliance with the Code may be given to the Commissioner; the actions that may be taken by the Commissioner in relation to compliance with the Code (which may include requiring a person to do something); and the review or reconsideration of decisions made in relation to compliance with the Code.

New subsection 21(3B) provides that, without limiting new subsection (3A), the rules may make provision for or in relation to a number of matters relating to action taken in relation to compliance with the Code, including how information about compliance with the Code may be given the Commissioner; the actions that may be taken by the Commission, which may include requiring a person to do something; and the review or reconsideration of decisions.

New subsections 21(3A) and 21(3B) are not intended to restrict the Commission from taking action in relation to compliance with the Code through its regulatory, complaints or other functions where appropriate.

It is appropriate that the details of these processes are in subordinate legislation as they are primarily of an administrative nature.

Item 11 - After Part 8

Item 11 inserts a new Part 8AA—Code of Conduct.

Part 8AA—Code of Conduct

Division 1—Introduction

New section 74AA provides a simplified outline of Part 8AA. It makes clear that approved providers and their aged care workers and governing persons must comply with the provisions of the Code that apply to them. A failure to comply with this obligation by an approved provider may result in sanctions and/or a civil penalty. A failure to comply with this obligation by an aged care worker or governing person may also result in a civil penalty.

Division 2—Code of Conduct

New section 74AB provides that if approved providers that are corporations contravene the Code that is applicable to them, a civil penalty of up to 250 penalty units can be imposed. In accordance with subsection 82(5) of the Regulatory Powers Act, the amount of the civil penalty in relation to a body corporate cannot exceed 5 times the penalty specified in the civil penalty provision. A note to the section explains that approved providers have a responsibility under paragraph 54-1(1)(g) of the Aged Care Act to comply with the Code and that a failure to comply with that responsibility may result in a sanction under section 63N of the Quality and Safety Commission Act.

This new subsection only allows for the imposition of a civil penalty in respect of an approved provider that is a corporation. This is because there are existing conduct requirements and enforcement arrangements that apply to state and territory approved providers under state and territory legislation. This provision aims to reduce duplicative compliance measures and enable the States and Territories to exercise their own statutory powers with respect to state and territory approved providers.

New subsection 74AC(1) requires that aged care workers of an approved provider must comply with the provisions of the Code that apply to them.

New subsection 74AC(2) provides that if aged care workers of approved providers that are corporations fail to comply with the provisions of the Code that apply to them, a civil penalty of up to 250 penalty units may be imposed. This new subsection only allows for the imposition of a civil penalty in respect of a contravention by an aged care worker of an approved provider that is a corporation. As above, this is because there are existing conduct requirements and disciplinary arrangements in place under state and territory legislation that apply to aged care workers of state and territory approved providers. This provision aims to reduce duplicative compliance measures and enable the States and Territories to exercise their own statutory powers with respect to aged care workers of state and territory approved providers.

New subsection 74AD(1) states that a governing person of an approved provider must comply with the provisions of the Code that apply to them.

New subsection 74AD(2) provides that a civil penalty may be imposed if a governing person of an approved provider contravenes the provisions of the Code that applies to them. The contravention is punishable by a maximum of 250 penalty units. Due to the definition of ‘governing person’ (see Item 7 above) a civil penalty can only be imposed in relation to governing persons of approved providers that are corporations. This does not include State, Territory and local government providers.

New subsection 74AE(1) provides that the rules may make provision for, or in relation to, a Code that applies to approved providers, and their aged care workers and governing persons.

New subsection 74AE(2) provides that without limiting subsection (1), the rules may specify provisions of the Code to apply to either approved providers, aged care workers of approved providers or governing persons, or specified kinds of approved

providers, aged care workers of approved providers or governing persons. This will allow the flexibility to appropriately tailor the Code, if necessary.

Item 12 - Part 8A (heading)

Item 12 repeals the current heading to Part 8A and substitutes ‘Part 8A—Enforcement and compliance’.

Part 8A—Enforcement and compliance

Item 13 - Section 74A (paragraph beginning “An authorised officer may enter”)

Item 13 inserts new paragraph (aa) in to the simplified outline of Part 8A to make clear that an authorised officer may enter premises under a warrant or with consent of the occupier to exercise monitoring powers under Part 2 of the Regulatory Powers Act for the purpose of determining whether an aged care worker, or governing person, of an approved provider has complied, or is complying, with the provisions of the Code that apply to them. This reflects amendments to the Quality and Safety Commission Act introduced by Item 16 below.

Item 14 – Section 74A

Item 14 amends the simplified outline of this Part and expands the application of enforceable undertakings and injunctions under Parts 6 and 7 of the Regulatory Powers Act to include compliance with the provisions of the Code that apply to an aged care worker, or governing person, of an approved provider in addition to an approved providers’ responsibilities under Chapter 4 of the Aged Care Act. This reflects amendments to the Quality and Safety Commission Act introduced by Items 20 and 21 below.

Item 15 – At the end of section 74A

Item 15 inserts into the simplified outline of this Part that the Commissioner may, in certain circumstances, making a banning order against an individual who is or was an aged care worker, or governing person, of an approved provider. This reflects amendments to the Quality and Safety Commission Act introduced by Item 25 below.

Item 16 - Subsection 74B(1)

Item 16 repeals subsection 74B(1) and substitutes new subsection 74B(1), which provides that provisions of Chapter 4 of the Aged Care Act (responsibilities of approved providers) and new subsections 74AC(1) and 74AD(1) (obligations of aged care workers and governing persons of approved providers to comply with the Code) are subject to monitoring under Part 2 of the Regulatory Powers Act.

A note to the new subsection 74B(1) explains that Part 2 of the Regulatory Powers Act creates a framework for monitoring whether a provision has been complied with, and that it includes powers of entry and inspection.

The application of the monitoring powers under Part 2 of the Regulatory Powers Act is reasonable and proportionate in relation to breaches of the Code to ensure compliance with banning orders and to allow for the Commissioner to take steps where appropriate to ensure that approved providers and their aged care workers and governing persons are complying with the Code. This will promote the safety, health and wellbeing of care recipients by ensuring the persons and organisations responsible for their care are acting in accordance with their obligations.

Item 17 - Subsection 74B(3)

Item 17 is a consequential amendment of the change to subsection 74B(1) made in Item 16. It amends subsection 74B(3) to omit the existing reference to subsection 74B(1) and substitute ‘paragraph (1)(b)’. The effect of this change is to apply subsection 74B(3) to new subsections 74AC(1) and 74AD(1) to make clear that for the purposes of Part 2 of the Regulatory Powers Act, new subsections 74AC(1) and 74AD(1) are related to a provision mentioned in subsection (1).

Item 18 - Subsections 74B(4) to (7)

Item 18 is a consequential amendment of the change to subsection 74B(1) made in Item 16. It amends subsections 74B(4) to (7) to omit references to ‘the provision’ mentioned in subsection 74B(1) and substitute ‘a provision’. The effect of this change is to apply subsections 74B(4) to (7) to new subsections 74AC(1) and 74AD(1).

This includes the power of an authorised officer to use such force against things as is necessary and reasonable in the circumstances in the process of executing a warrant issued under Part 2 of the Regulatory Powers Act (see subsection 74B(6)). It is reasonable and proportionate that this power be extended to subsections 74AC(1) and 74AD(1) to enable the Commissioner to effectively monitor compliance with the Code. It is anticipated that the ability to use force to enter premises under a warrant to exercise monitoring powers will be necessary where entry has been demanded but refused, or where there is evidence of non-compliance being concealed. In these circumstances, it may be reasonably necessary for an authorised person executing a warrant to open locked doors, cabinets, drawers and other similar objects for the purposes of determining whether a person is complying with the Code.

Item 19 - Paragraph 74C(1)(a)

Item 19 is a consequential amendment to the change to subsection 74B(1) made in Item 16. It amends paragraph 74C(1)(a) to omit the reference to ‘the provision’ and substitute ‘a provision’. The effect of this amendment is to apply the modifications of Part 2 of the Regulatory Powers Act to new subsections 74AC(1) and 74AD(1).

As above, it is appropriate to extend these modifications to 74AC(1) and 74ACA(1) to allow the Commissioner to effectively investigate suspected breaches of the Code and therefore form a view as to the appropriate enforcement action to take, if any. This will also bring these provisions in line with the treatment of the other provisions referred to in section 74B.

Item 20 - Subsection 74EC(1)

Item 20 repeals paragraph 74EC(1) and substitutes new paragraph 74EC(1), which makes new subsections 74AC(1) and 74AD(1) in addition to a provision of Chapter 4 of the Aged Care Act enforceable under Part 6 of the Regulatory Powers Act, which deals with enforceable undertakings. The amendment reproduces the note in the existing provision, which explains that Part 6 of the Regulatory Powers Act creates a framework for accepting and enforcing undertakings relating to compliance with provisions.

Item 21 - Subsection 74ED(1)

Item 21 repeals paragraph 74ED(1) and substitutes new paragraph 74ED(1), which makes new subsections 74AC(1) and 74AD(1) in addition to a provision of Chapter 4 of the Aged Care Act enforceable under Part 7 of the Regulatory Powers Act, which

deals with injunctions. The amendment reproduces the note in the existing provision, which explains that Part 7 of the Regulatory Powers Act creates a framework for using injunctions to enforce provisions.

Item 22 - After subsection 74EE(1A)

Item 22 inserts new subheading 'Code of Conduct' and new subsection 74EE(1AA), which provides that the Commissioner may give to an approved provider a written notice if the Commissioner is satisfied that an approved provider is not complying with their responsibility under paragraph 54-1(1)(g) or (ga) of the Aged Care Act (see Item 1), or is aware of information that suggests that an approved provider may not be complying with that responsibility. Failure to comply with a compliance notice can result in the imposition of a civil penalty of up to 60 penalty units (see subsection 74EE(3)). In accordance with subsection 82(5) of the Regulatory Powers Act, the amount of the civil penalty in relation to a body corporate cannot exceed 5 times the penalty specified in the civil penalty provision.

Item 23 - After section 74F

Item 23 inserts new section 74FA. New subsections 74FA(1) and (2) enable the Commissioner to issue notices to a person to attend and answer questions before, or to give information or documents (of copies of documents) specified in the notice to an authorised officer where the Commissioner believes on reasonable grounds that the person has information or documents or both relating to:

- (a) whether aged care worker or former aged care worker of an approved provider that is a corporation is complying or has complied with a provision of the Code that applies to that worker; or
- (b) whether a governing person or former governing person of an approved provider is complying or has complied with a provision of the Code that applies to that person.

In accordance with new subsections 74FA(3) and (4), the notice must specify the authorised officer before whom the person is required to attend and the day on which, and the time and place at which the person must attend, being at least 14 days after the notice is given.

New subsection 74FA(5) makes it an offence to fail to comply with a requirement in the notice given under subsection (2) punishable by 30 penalty units.

New subsection 74(F A)(6) entitles a person to be paid by the Commonwealth reasonable compensation for complying with a requirement to give copies of documents under the notice issued under subsection (1).

These provisions are similar to those currently applying under section 74F of the Quality and Safety Commission Act. To the extent that this provision impacts on a person's privilege against self-incrimination (see also Item 25), it is reasonable and proportionate to ensure the integrity of aged care workers and governing persons and their compliance with the Code. The purpose of this provision is to ensure the Commissioner has all the relevant information and documents available to them in order to make an informed decision about any enforcement action it may take against an individual in relation to a breach of the Code.

Item 24 - Paragraph 74G(1)(a)

Item 24 is a consequential amendment arising from Item 23. Section 74G deals with attendance before an authorised officer pursuant to a notice. The item amends paragraph 74G(1)(a) by adding a reference to a notice given under new subsection 74FA(2).

Item 25 – At the end of Division 3 of Part 8A

Item 25 inserts new section 74GAA, which makes clear that nothing in this Division affects the right of a person to refuse to answer a question, give information or a document on the grounds that doing so might tend to incriminate the person.

New subsection 74GAA(2) makes clear that this section is not intended to imply a contrary intention regarding the privilege against self-incrimination in any other Act, nor depart from the settled position that the privilege against self-incrimination is not abrogated unless the relevant legislation expressly provides for this.

Item 26 - At the end of Part 8A

Item 26 inserts new Division 4—Banning orders, at the end of Part 8A.

Division 4—Banning orders

Section 74GB

New subsection 74GB(1) provides that, subject to subsection (2), the Commissioner may make an order (the banning order) prohibiting or restricting an individual who is or was an aged care worker, or a governing person, of an approved provider from being involved the provision of any type, or specified types, of aged care, or from engaging in specified activities as an aged care worker, or governing person, of the approved provider. This provision is designed to allow for a banning order to be made in respect of a person who is a former or current aged care worker or governing person.

A note at the end of subsection 74GB(1) references new section 74GE about when the Commissioner must give notice of an intention to make a banning order.

New subsection 74GB(2) provides that the Commissioner must not make a banning order under subsection (1) unless the Commissioner reasonably believes that one of a number of listed circumstances exist. These include that the individual did not comply, is not complying or is not likely to comply with a provision of the applicable Code, that the individual is not suitable to provide any or specified types of aged care or engage in particular activities, the Commissioner reasonably believes that there is an immediate or severe risk to the safety, health or wellbeing of one or more care recipients, the person has at any time been convicted of an indictable offence involving fraud or dishonesty, or the individual is an insolvent under administration.

New subsection 74GB(3) provides that subject to subsection (4), the Commissioner may make a banning order prohibiting or restricting an individual who has not previously been an aged care worker, or a governing person, of an approved provider from being involved in the provision of any type, or specified types, of aged care, or from engaging in specified activities as an aged care worker, or governing person, of the approved provider.

A note at the end of subsection (3) refers to new section 74GC for when the Commissioner must give notice of an intention to make a banning order.

New subsection 74GB(4) provides that the Commissioner must not make a banning order against an individual under subsection (3) unless the Commissioner reasonably believes the individual is not suitable to be involved in the provision of any type, or specified types, of aged care or to engage in specified activities as an aged care worker, or governing person, of the approved provider.

New subsection 74GB(5) provides that in considering whether an individual is suitable to be involved in the provision of any type, or specified types, of aged care, the Commissioner must consider the 'suitability matters' in relation to the individual. A reference to the 'suitability matters' is a reference to the suitability matters set out in section 8C, introduced under Schedule 5 to this Bill.

New subsection 74GB(6) makes clear that subsection 74GB(5) does not restrict the Commissioner from considering other matters in determining a person's suitability in relation to paragraphs 74GB(2)(b) and 74GB(4).

New subsection 74GB(7) provides that a banning order is not a legislative instrument. This provision is declaratory only. It is included to assist readers to make clear that a banning order is not a legislative instrument within the meaning of subsection 8(1) of the Legislation Act.

Given the restrictions imposed by a banning order, the intention is for banning orders to be issued in only the most egregious circumstances. The Commission will be able to take other regulatory or enforcement action in relation to other breaches of the Code that are less serious in accordance with its Code functions, including as set out in the rules (see Items 9 and 10 above).

Section 74GC

New section 74GC introduces requirements for the application of a banning order against an individual who is or was an aged care worker or governing person of an approved provider. Under these amendments, banning orders will only be able to be applied to individuals and not approved providers. This is because appropriate regulatory and enforcement powers already exist under Part 8A of the Quality and Safety Commission Act, including the issuing of sanctions. Approved providers may also be revoked under Division 4 of Part 7A of the Quality and Safety Commission Act. These powers are available to the Commissioner for breaches of the Code by approved providers.

New subsection 74GC(1) provides that this section applies when making a banning order against an individual who is or was an aged care worker, or governing person, of an approved provider. The inclusion of former aged care workers and governing persons aligns with the arrangements for banning workers from the NDIS under the *National Disability Insurance Scheme Act 2013* (NDIS Act). The intention of this provision is to ensure the continued safety of care recipients, including by preventing a former aged care worker or governing person from being able to work in the Commonwealth aged care sector.

Subsection 74GC(2) provides that a banning order may apply generally or be of limited application; be permanent or for a specified period; and be made subject to specified conditions.

This provision is inserted to align with the NDIS and the reference to specified conditions is based on paragraph 73ZN(3)(c) of the NDIS Act. It does not limit nor specify in the legislation the kinds of conditions that may be included in a banning order.

Without limiting the kinds of conditions that may be imposed, it is anticipated that the types of conditions the Commissioner may impose on a banning order may include, for example, that an individual that is the subject of a banning order must provide a copy of that banning order to prospective employers where the banning order restricts them from engaging in some but not all activities related to aged care service provision. This will assist prospective employers to ensure the worker is not involved in those activities. Another type of condition that may also be imposed is one that requires the subject of the banning order to undertake and successfully complete specified training or skills development and provide evidence of this to the Commissioner.

New subsection 74GC(3) provides that if the banning order is made against an individual who is an aged care worker, or governing person, of an approved provider, the order continues to have effect even if that individual ceases to be such a worker or person. This provision aligns with the approach taken under the NDIS Act and is intended to ensure the ongoing safety of care recipients in the aged care sector by preventing individuals who have had a banning order made against them from avoiding the effect of the order by ceasing to be an aged care worker or governing person for a period of time and then resuming a similar role in the aged care sector.

New subsection 74GC(4) provides that as soon as practicable after deciding to make a banning order, the Commissioner must give the individual a written notice setting out the decision, the reasons for the decision, and other listed details, including any conditions of the order and how to apply for reconsideration of the decision. This notice allows affected individuals to understand the basis for the decision and how they can have the decision reconsidered if they wish to do so.

New subsection 74GC(5) requires that where the Commissioner gives a notice under subsection (4) to an aged care worker or governing person, of an approved provider, the Commissioner must, as soon as is practicable, give that approved provider a copy of the notice. This promotes transparency and provides notice to the approved provider that it must take reasonable steps to ensure the banning order is complied with.

Section 74GD

New section 74GD deals with contraventions of a banning order.

New subsection 74GD(1) provides that if an individual engages in conduct that breaches a banning order, or condition of a banning order, that is in force against that individual, a civil penalty of 1,000 penalty units may be imposed.

New subsection 74GD(2) provides that it is a contravention of the subsection if a

corporation that is an approved provider fails to take reasonable steps to ensure that an individual the subject of a banning order who is an aged care worker, or governing person, of the approved provider, does not engage in conduct that breaches the banning order, or a condition of the banning order, that is in force against the individual. A contravention of this subsection is punishable by a civil penalty of 1,000 penalty units. In accordance with subsection 82(5) of the Regulatory Powers Act, the amount of the civil penalty in relation to a body corporate cannot exceed 5 times the penalty specified in the civil penalty provision.

The high civil penalty for contravening these subsections reflects the importance of complying with a banning order by both individuals and approved providers to ensure the safety, health and wellbeing of care recipients. This is appropriate given the nature of a banning order and its application in only the most egregious forms of misconduct.

Section 74GE

New section 74GE deals with notices of intention to make a banning order.

Subsections 74GE(1) and (2) require that before the Commissioner makes a banning order, they must first notify the relevant individual in writing that an order is being considered, unless the Commissioner reasonably believes that there is an immediate and severe risk to the health, safety or wellbeing of one or more care recipients.

Subsection 74GE(3) sets out the requirements of what must be included in the notice. This includes the reasons why the Commissioner is considering making a banning order against the individual, inviting the individual to make written submissions in relation to the matter within 14 days after receiving the notice, and informing the individual that, following consideration of the written submissions, the Commissioner may issue a banning order against the individual.

Subsection 74GE(4) states that the Commissioner must consider an individual's written submissions in accordance with the notice issued under subsection (1) before making a decision to issue a banning order. This new section affords appropriate procedural fairness to individuals who may be subject to a banning order.

Section 74GF

New subsections 74GF(1) and (2) allow the Commissioner to vary or revoke a banning order on the Commissioner's own initiative, if satisfied it is appropriate to do so. This includes the power to vary, or revoke, a condition of the order, or specify one or more new conditions in accordance with new subsection 74GD(2).

New subsection 74GF(3) requires that if the Commissioner decides to vary or revoke a banning order, the Commissioner must, as soon as is practicable, give the individual to whom the banning order relates a written notice setting out the decision, the reasons for the decision, and other specified details, including how the individual may apply for reconsideration of the decision.

New subsection 74GF(4) provides that where the individual is an aged care worker, or governing person, of an approved provider, the Commissioner must also give a copy of the variation or revocation notice to that approved provider.

These provisions ensure that the individual is informed of the decision, the reasons for the decision and how they may apply for reconsideration, and gives reasonable notice to the approved provider of the Commissioner's decision.

Subsection 74GF(5) provides that a variation or revocation of a banning order is not a legislative instrument. This provision is declaratory only: it is included to assist readers, because a banning order is not a legislative instrument within the meaning of subsection 8(1) of the Legislation Act.

Section 74GG

New section 74GG allows the Commissioner to vary or revoke a banning order on application by an individual who is the subject of the banning order.

New subsection 74GG(1) allows an individual to whom a banning order applies to apply to the Commissioner to have the banning order varied or revoked. The application must be in writing, in the form approved by the Commissioner and accompanied by any relevant documents or information specified by the Commissioner in accordance with new subsection 74GG(2).

New subsection 74GG(3) allows the Commissioner to vary or revoke a banning order against an individual if the Commissioner is satisfied it is appropriate to do so.

New subsection 74GG(4) provides that if the Commissioner proposes not to vary or revoke the banning order, the Commissioner must give the individual a written notice setting out the reasons why the Commissioner is proposing not to vary or revoke the order, and inviting the individual to make submissions in writing within 14 days after receiving the notice, or a shorter period as specified in the notice. The notice must also advise that the Commissioner may, after considering any submissions made by the individual, decide not to vary or revoke the order.

New subsection 74GG(5) requires the Commissioner to consider any written submissions made by the individual in accordance with the notice issued under subsection (4).

Under new subsections 74GG(6) and (7), if the Commissioner decides either to vary or revoke the banning order, or not to do so, the Commissioner must, as soon as is practicable, give the individual a written notice setting out their decision, the reasons for their decision, the day on which the variation or revocation takes effect (if applicable), and how the individual may apply for reconsideration of the decision. This enables an individual who is the subject of the decision to be aware of the reasons for the decision and the process for applying for reconsideration of the decision.

Subsection 74GG(8) provides that a variation or revocation of a banning order is not a legislative instrument. This provision is declaratory only: it is included to assist readers, because a banning order is not a legislative instrument within the meaning of subsection 8(1) of the Legislation Act.

Section 74GH

New section 74GH allows the Commissioner to vary or revoke a condition of a banning order on application by an individual.

The application, notice and other requirements are the same as outlined in new section 74GG above in relation to an application by an individual to vary or revoke a banning order. This section includes appropriate processes designed to afford the individual appropriate procedural fairness.

Subsection 74GH(8) provides that a variation or revocation of a banning order is not a legislative instrument. This provision is declaratory only: it is included to assist readers, because a banning order is not a legislative instrument within the meaning of subsection 8(1) of the Legislation Act.

Section 74GI

New section 74GI requires the Commissioner to establish and maintain a register of banning orders, including banning orders that are no longer in force.

New subsection 74GI(1) requires that the register include certain information in relation to each individual against whom a banning order has been made at any time, including for example, the name of the individual, their ABN (if any), the details of the banning order (including any conditions to which the order is subject). Additional information is also required to be captured by the register, including, if applicable, a statement where the Commissioner is considering whether or not to revoke a banning order, or a request for reconsideration of a banning order decision has been made but not yet determined, and any other information specified in the rules.

New subsection 74GI(3) make clear that while subsection (2) states that 74GI(1) applies to banning orders which are no longer in force - subsection (1) does not apply in relation to banning orders which have been revoked or which have been set aside on reconsideration of the decision, or on review. This amendment also inserts new subsection 74GI(2B) to ensure the register is kept up-to-date.

New subsection 74GI(4) states that the Commissioner must ensure the register is kept up-to-date.

New subsection 74GI(5) states that the register may be kept in any form that the Commissioner considers appropriate.

New subsection 74GI(6) allows for the rules to make provision for, or in relation to, the correction of information that is included in the register, including how an individual may access information about the individual that is included in the register and seek the correction of such information. This requirement is consistent with an individual's ability under Australian Privacy Principle 13 to request correction of their personal information.

New subsection 74GI(7) allows for the rules to make provision for making the register publicly available in whole or in part, otherwise making specified information in the register publicly available, and any other matter relating to the administration or operation of the register.

It is not anticipated that the matters which may be included in the register prescribed by the rules will extend to any highly sensitive or highly personal information about the person subject to the banning order. However, in some instances, such as where an individual or business has a common name, it may be necessary to include further information, to publish an amount of information that is sufficient to ensure the person can be identified. This would not extend, for example, to the nature of the incident/s that prompted the making of the banning order.

The purpose of this provision is to make information about banned individuals accessible to the public, including future employers of such individuals in the aged care sector. This aims to ensure the safety of care recipients by putting employers on notice of individuals who were found unsuitable to provide aged care or specified types of aged care services. This provision aligns with the approach taken under the NDIS (see section 73ZS of the NDIS Act) Publication of this information is considered reasonable, necessary and proportionate in order to protect the safety of vulnerable older Australians.

Item 27 - Section 74J (after table item 6)

Item 27 inserts additional items to the table in section 74J, which sets out the decisions by the Commissioner that are reviewable decisions and the persons or bodies that may request reconsideration of those decisions. The effect of this amendment is to make the Commissioner's new decisions to make a banning order under new section 74GB, to vary a banning order under new section 74GF, not to vary or revoke a banning order under new section 74GG, not to vary or revoke a condition of banning order under new section 74GH, and not to specify one or more new conditions under new section 74GH.

This means that the individual who is subject to one of those decisions may apply for review of the decision, including to the Administrative Appeals Tribunal in accordance with section 74N.

Schedule 4 — Extension of incident management and reporting etc.

Overview

Schedule 4 to the Bill amends the Aged Care Act to extend the Serious Incident Response Scheme (SIRS) beyond residential care to home care and flexible care delivered in a home or community setting from 1 December 2022. This Schedule introduces new responsibilities for approved providers of home care, and flexible care delivered in a home or community setting to manage incidents, including through implementing and maintaining an incident management system that complies with requirements set out in the Quality of Care Principles.

The definition of reportable incident will also be extended to home and community care settings, so that home care and flexible care providers operating in these settings will be required to notify the Commissioner of these incidents. Protections against retribution or vilification for individuals reporting such incidents will also extend to reportable incidents in these settings.

Schedule 4 to the Bill will also amend the Quality and Safety Commission Act to expand the Commissioner’s powers to deal with incidents that are reported by Commonwealth grant funded aged care service providers, and authorise these providers to collect, use and disclose information relevant to their obligations in relation to the SIRS for the purposes of the *Privacy Act 1988*.

Schedule 4 to the Bill responds to Royal Commission Recommendation 100.

Part 1—Main amendments

Aged Care Act 1997

Item 1 - Paragraph 54-1(1)(e)

Item 1 omits the phrase “if the type of aged care is residential care or flexible care provided in a residential setting—” from paragraph 54-1(1)(e). Subsection 54-1(1) lists the responsibilities of an approved provider in relation to the quality of the aged care that the approved provider provides. Currently paragraph 54-1(1)(e) provides that an approved provider of residential aged care or flexible care delivered in a residential setting has a responsibility to manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system that complies with the Quality of Care Principles; and complying with any other requirements for managing or preventing incidents specified in the Quality of Care Principles. The amendments made by Item 1 will mean that this responsibility will also apply to approved providers of home care and flexible care provided in a home or community setting.

The Quality of Care Principles will specify requirements relating to the management, assessment and response to incidents, including improvements to incident management systems and the prevention of incidents, for approved providers of home care and flexible care provided in a home or community setting. It is appropriate to

include these matters in delegated legislation as the arrangements will go into the operational detail of processes and procedures to manage and prevent incidents. This approach is also consistent with existing arrangements for the SIRS for residential aged care, including flexible care delivered in a residential setting, and also with the NDIS incident management and disclosure protection scheme. While the SIRS is in its initial stages, it is also appropriate to include these matters in delegated legislation to ensure there is the ability to promptly respond to unforeseen implementation issues and sector feedback and ensure there are timely response to matters affecting the safety, health and wellbeing of care recipients.

Item 2 - Subsection 54-3(2)

Item 2 omits the phrase “residential care, or flexible care provided in a residential setting, to a *residential” from subsection 54-3(2) and substitutes the phrase “*aged care to a” in its place. Subsection 54-3(2) defines the term reportable incident. The amendments made by Item 2 remove references to residential care and flexible care provided in a residential setting, so that the definition also applies to home care and flexible care provided in a home or community setting.

Item 3 - Paragraphs 54-3(2)(a) to (h)

Item 3 omits the phrase “residential care recipient” from paragraphs 54-3(2)(a) to (h) and substitutes the phrase “care recipient” in its place. Paragraphs 54-3(2)(a) to (h) list the kinds of incidents that are reportable incidents for the purposes of the SIRS. The amendments made by Item 3 change references to “residential care recipients” to “care recipients” so that the definition of reportable incident can also apply to care recipients who receive home care and flexible care provided in a home or community setting.

Item 4 - Subsection 54-3(3)

Item 4 repeals subsection 54-3(3), which defines the term *residential care recipient*. This term is no longer required as the SIRS will not be limited to residential care or flexible care delivered in a residential setting.

Item 5 - Paragraph 54-3(5)(a) and Item 6 - Paragraph 54-3(5)(b)

Item 5 omits the word “*residential” from paragraph 54-3(5)(a) and Item 6 omits the word “residential” from paragraph 54-3(5)(b). Paragraphs 54-3(5)(a) and (b) currently provide that, despite the definition of reportable incident at subsection 54-3(2), the Quality of Care Principles may provide that a specified act, omission or event involving a residential care recipient is, or is not, a reportable incident. The amendments made by Items 5 and 6 allow for the Quality of Care Principles to provide that a specified act, omission or event involving a care recipient (now also including recipients of home care or flexible care delivered in a home or community setting) is a reportable incident.

This will allow for the Quality of Care Principles to provide clarity about reportable incidents and to specify certain events that do not fall within the definition of a reportable incident. For example, this may include incidents that have resulted from a care recipient refusing care or services provided by the approved provider, which may otherwise be considered neglect, but which ensure that the rights of the care recipient, including their autonomy and choice, are maintained. This may also include providing that a specified act, omission or event involving a care recipient is or is not a

reportable incident for different kinds of approved providers, to reflect the significant difference in care settings.

It is appropriate that the ability to specify what act, omission or event does or does not constitute a reportable incident is included in delegated legislation. This will ensure flexibility to facilitate prompt modifications, should the amendments have any unintended consequences that may affect the health, safety and wellbeing of care recipients. Inclusion of these arrangements in delegated legislation will also ensure ease of interpretation and implementation by having the operational arrangements for the SIRS in one place. Further, this approach is also consistent with existing arrangements under the SIRS for residential aged care, including flexible care delivered in a residential setting, and the legislative arrangements for the NDIS incident management and disclosure protection scheme.

Item 7 - Paragraphs 54-3(7)(a) and 54-4(1)(d)

Item 7 omits the word “*residential” from paragraphs 54-3(7)(a) and 54-4(1)(d).

Paragraph 54-3(7)(a) provides that action taken in response to an investigation into the reportable incident may include requiring an approved provider to provide a residential care recipient of the provider with information regarding the use of an advocate (including an independent advocate) in relation to an investigation into the reportable incident. The amendments made by Item 7 extends the current arrangements to include all care recipients, including those who receive home care or flexible care delivered in a home or community setting.

Subsection 54-4(1) identifies categories of persons who qualify for protection if they disclose information in accordance with subsection 54-4(2). Paragraph 54-4(1)(d) currently lists a person who is or was a residential care recipient of an approved provider, or a family member, carer, representative, advocate (including independent advocate) of the recipient, or another person who is significant to the recipient. Item 7 extends the current arrangements to include a person who is or was a care recipient, including care recipients who receive or received home care or flexible care delivered in a home or community setting. The amendments also mean that a person who is or was a family member, carer, representative, advocate (including independent advocate) of a care recipient of home care or flexible care provided in a home or community setting, or another person who is significant to a care recipient is covered by the protections.

It should be noted that protections will be included in the relevant funding agreements of service providers of Commonwealth grant funded aged care services to cover disclosures made by individuals in relation to reportable incidents in that context.

Item 8 - Clause 1 of Schedule 1 (definition of *residential care recipient*)

Item 8 repeals the definition of residential care recipient from Clause 1 of Schedule 1 (the Dictionary). The amendments made by Item 8 are consequential to the amendments made by Item 4.

Item 9 – Application provision

Item 9 provides that the amendments of the Aged Care Act made by Part 1 of Schedule 4 apply in relation to an incident that occurs, is alleged to have occurred or is suspected of having occurred on or after 1 July 2022.

Part 2—Other amendments

Aged Care Quality and Safety Commission Act 2018

Item 10 - Section 7 (definition of *reportable incident*)

Item 10 repeals the definition of *reportable incident* from section 7 and substitutes a new definition. The current definition provides that the term has the meaning given by subsections 54-3(2) and (5) of the Aged Care Act. The new definition provides different meanings of the term depending on whether the incident occurs in relation to services provided by an approved provider or a service provider of a “Commonwealth-funded aged care service”. Consistent with the current definition, paragraph (a) provides that for an approved provider a reportable incident has the same meaning as in the Aged Care Act. Paragraph (b) provides that for a service provider of a “Commonwealth-funded aged care service”, a reportable incident is the same as a reportable incident under the grant agreement that relates to the service.

Section 8 of the Quality and Safety Commission Act defines “Commonwealth-funded aged care services” as a service provided under a program of a kind specified in the Rules. Section 8 of the Rules provides that for the purposes of subsection 8(1) of the Quality and Safety Commission Act, the programs known as CHSP and NATSIFACP are “Commonwealth-funded aged care services”.

Equivalent SIRS requirements will be introduced for service providers of the CHSP and the NATSIFACP delivered in a home or community setting from 1 July 2022. This will be achieved by including the requirements in the CHSP Program Manual and NATSIFACP Program Manual, which service providers are required to comply with under the relevant grant agreements. ‘Reportable incident’ will be defined under the relevant program manuals in the same way as is done for approved providers under subsection 54-3(2) of the Aged Care Act.

Item 11 - Subsection 21(7)

Item 11 omits the phrase “reportable incidents” from subsection 21(7) and substitutes the phrase “a reportable incident for an approved provider”. Section 21 provides for the Rules to make provision for, or in relation to, how the Commissioner performs their functions. Subsection 21(7) currently provides that the Rules may make provision for, or in relation to, how the Commissioner deals with reportable incidents. The amendment made by Item 11 limits subsection 21(7) to reportable incidents for an approved provider, meaning subsection 21(7) does not apply to reportable incidents for a service provider of a Commonwealth grant funded aged care service (CHSP or NATSIFACP). The amendments made by Item 11 are consequential to the amendments made by Item 10 and are complemented by the amendments made by Items 12 and 13.

Item 12 - Paragraph 21(7)(a)

Item 12 omits the phrase “a reportable incident, which may include requiring an” from paragraph 21(7)(a), and substitutes the phrase “such a reportable incident, which may include requiring the”. Paragraph 21(7)(a) provides that the Rules may make provision for action that may be taken by the Commissioner in dealing with a

reportable incident, which may include requiring an approved provider to do something.

The amendments made by Item 12 are consequential to the amendments made by Item 11 and ensure that the relevant subsections referring to a reportable incident apply only to approved providers.

Item 13 - Paragraphs 21(7)(b) and (c)

Item 13 inserts the word “such” before the phrase “a reportable” in paragraphs 21(7)(b) and (c). Paragraphs 21(7)(b) and (c) provide that the Rules may make provision for the circumstances in which the Commissioner may authorise or carry out an inquiry in relation to a reportable incident on the Commissioner’s own initiative and how the information given to the Commissioner about a reportable incident may be dealt with. The amendments made by Item 13 are consequential to the amendments made by Item 11 and ensure that the relevant subsections referring to a reportable incident apply only to approved providers.

Item 14 - At the end of section 21

Item 14 inserts new subsection (8) into section 21. Section 21 provides for the Rules to make provision for, or in relation to, how the Commissioner performs their functions. New subsection 21(8) provides that the Rules may make provision for, or in relation to, how the Commissioner deals with a reportable incident for a service provider of a “Commonwealth-funded aged care service” (providers of NATSIFACP and CHSP). This includes:

- action that may be taken by the Commissioner in dealing with such a reportable incident, which may include requiring the service provider to do something;
- the circumstances in which the Commissioner may authorise or carry out an inquiry in relation to such a reportable incident on the Commissioner’s own initiative; or
- how information given to the Commissioner about such a reportable incident may be dealt with.

This mirrors the provisions in relation to approved providers under new subsection 21(7).

Item 14 will allow the Rules to specify how the Commissioner deals with a reportable incident for a service provider of “Commonwealth-funded aged care services” (NATSIFACP and CHSP). It is proposed on receipt of a notification of a reportable incident by a provider of a Commonwealth grant funded aged care services, the Rules would specify matters such as allowing the Commissioner to require additional information in relation to the notification or a final report on the incident, or to refer the incident to police or another body with responsibility in relation to the incident.

It is considered reasonable that these matters be dealt with in delegated legislation as they relate to operational matters such as process and procedures. Including these arrangements in delegated legislation will allow flexibility to respond to unforeseen issues and respond to community and sector concerns in a timely manner. As these matters relate to actions taken in response to reportable incidents it is appropriate that there is flexibility for the Commissioner to take appropriate and prompt action in response to any unforeseen matters. It is anticipated that the community would expect such action to be taken. It is intended that the Government’s ability to undertake such

actions in a prompt and flexible manner will prevent abuse and neglect of older Australians and to ensure it is appropriately addressed when it occurs.

It should be noted that while the Commissioner will receive notifications of reportable incidents by service providers of Commonwealth grant funded aged care services, any compliance action in relation to the requirements under the SIRS will be undertaken through the terms of the relevant funding agreement.

Item 15 - At the end of Part 7

Item 15 inserts new Division 5 regarding other matters at the end of Part 7 of the Quality and Safety Commission Act. Part 7 includes provisions about information sharing and confidentiality etc.

Division 5—Other matters

New section 63AA – Authorisations for the purposes of the *Privacy Act 1988*

New section 63AA provides an authorisation for “Commonwealth-funded aged care service” providers (providers of NATSIFACP and CHSP) to collect, use or disclose information about a person, for the purposes of the *Privacy Act 1988* (Privacy Act), if the collection, use or disclosure is to meet responsibilities or obligations under the relevant funding agreement to manage and report incidents, or to take reasonable steps to prevent incidents, and the collection, use or disclosure is for the purpose of complying with those responsibilities.

Subsection 63AA(1) provides that if sensitive information is collected by a service provider of a “Commonwealth-funded aged care service” (providers of NATSIFACP and CHSP), and the provider has a responsibility under the funding agreement that relates to that service to manage incidents, and take reasonable steps to prevent incidents in accordance with that agreement, and the information is collected for the purposes of complying with that responsibility, then the collection of sensitive information is taken to be authorised by the Quality and Safety Commission Act for the purposes of paragraph 3.4(a) of Australian Privacy Principle 3. Paragraph 3.4(a) of Australian Privacy Principle 3 provides that an APP entity may collect sensitive information if the collection is required or authorised by or under an Australian law or a court or tribunal order.

‘Sensitive information’ is a sub-set of personal information and is given a higher level of protection under the Australian Privacy Principles. Sensitive information is defined in the Privacy Act to mean information or an opinion about an individual’s racial or ethnic origin; political opinions; membership of a political association; religious beliefs or affiliations; philosophical beliefs; membership of a professional or trade association; membership of a trade union; sexual preferences or practices; or criminal record. Sensitive information also includes health information and genetic information about an individual that is not otherwise health information. In respect of the SIRS, the types of sensitive information that may be relevant include health information, such as whether injury may have been sustained and treatment to that injury, or the level of cognition of the care recipients directly involved in the incident.

Subsection 63AA(2) also provides that if the use or disclosure of personal information by a service provider of a “Commonwealth-funded aged care service” (providers of

NATSIFACP and CHSP), and the provider has a responsibility under the funding agreement that relates to that service to manage and report incidents, and take reasonable steps to prevent incidents, in accordance with that agreement, and the use or disclosure is for the purposes of complying with that responsibility, then the use or disclosure of personal information (within the meaning of the *Privacy Act 1988*) is taken to be authorised by the Quality and Safety Commission Act for the purposes of paragraph 6.2(b) of Australian Privacy Principle 6. Paragraph 6.2(b) of the Australian Privacy Principle 6 provides that an APP entity may use or disclose personal information if it is required or authorised by or under an Australian law or a court or tribunal order.

These authorisations will ensure that service providers of NATSIFACP and CHSP are able to comply with the SIRS requirements imposed through their funding agreements and their obligations under the Privacy Act.

Item 16– Application provisions

Sub-item 16(1) provides that new subsection 21(8) of the Quality and Safety Commission Act, as inserted by Item 14 of Part 2 of Schedule 4, applies in relation to a reportable incident notified after the commencement of this item (the day after Royal Assent).

Sub-item 16(2) provides that new section 63AA of the Quality and Safety Commission Act, as inserted by Item 15 of Part 2 of Schedule 4, applies in relation to a collection, use or disclosure of information that occurs after the commencement of this item (the day after Royal Assent).

This earlier commencement date will ensure that this authorisation is in place for service providers of NATSIFACP who deliver care in a residential setting, as soon as possible following the requirement to make Priority 2 notifications to the Commissioner from 1 October 2021. The notification of such incidents, that have low or no impact on the care recipient, are less likely to be captured by existing general authorisations provided for under privacy law.

Schedule 5 — Governance of approved providers etc.

Overview

Schedule 5 of the Bill amends the Aged Care Act and the Quality and Safety Commission Act and aims to improve the governance of approved providers of aged care. From 1 December 2022, the amendments will introduce new governance responsibilities for approved providers in relation to the membership of their governing bodies, and the establishment of new advisory bodies, as well as measures to improve leadership and culture. These measures are aimed at improving transparency and accountability and ensuring the focus of approved providers, from the top down, is in the best interests of care recipients.

Schedule 5 also introduces new responsibilities for approved providers to give information to the Secretary about their operations on an annual basis. Under the Aged Care Legislation Amendment (Implementing Care Reform) Bill 2022 (Implementing Care Reform Bill), the Secretary will be required to publish specified information about aged care services. It is intended that the information given to the Secretary about a provider's operations will be made publicly available under the Implementing Care Reform Bill. This is intended to help care recipients and their families to understand key details of approved providers and increase transparency of information about approved provider's operations more generally.

The amendments will also require approved providers to notify the Commission of changes to key personnel and will replace the current disqualified individual arrangements with a suitability test for key personnel, consistent with the arrangements under the NDIS. The amendments enable the Commissioner to make a determination regarding the suitability of an approved provider's key personnel, and imposes civil penalties for approved providers that are corporations if requirements relating to key personnel are not complied with.

Schedule 5 of the Bill aligns with Recommendations 88 to 90 of the Royal Commission, which noted the importance of good provider governance arrangements to the provision of high quality care for care recipients.

Part 1—Amendments

Aged Care Act 1997

Item 1 - Section 6-1

Item 1 amends section 6-1, which provides a summary of Part 2.1 of the Aged Care Act. Item 1 omits the phrase “sets out offences relating to disqualified individuals and” and substitutes the phrase “deals with the *key personnel of approved providers and sets out”. This amendment is consequential to other amendments made to Part 2.1 by this Schedule.

Item 2 - Section 9-1 (heading)

Item 2 repeals the heading of section 9-1, and substitutes with “9-1 Obligation to notify of a change of circumstances that materially affect the suitability of an

approved provider”. This amendment is consequential to the amendments made by Item 6.

Item 3 - Subsection 9-1(1)

Item 3 omits the reference to “28 days” in subsection 9-1(1) and substitutes it with “14 days”. Subsection 9-1(1) provides that an approved provider must notify the Commissioner of a change in circumstances that materially affects the approved provider’s suitability to be a provider of aged care. Currently the notification must occur within 28 days after the change. The amendments made by Item 3 will reduce this timeframe, so that the notification must instead occur within 14 days after the change occurs. The revision to the timeframe will align with the timeframes for the new notification arrangements inserted by Item 6.

Item 4 - Subsection 9-1(3A)

Item 4 repeals subsection 9-1(3A), which deals with notification requirements in relation to key personnel or are or about to become a disqualified individual. This item is consequential to Items 24, 26, 27 and 29 below as the disqualified individual arrangements are replaced with suitability requirements.

Item 5 - Subsection 9-1(4)

Item 5 omits the reference to “28 days” in subsection 9-1(4) and substitutes it with “14 days”. Subsection 9-1(4) provides that an approved provider that is a corporation commits an offence if the approved provider fails to notify the Commissioner of a change. The amendments made by Item 5 will reduce this timeframe, so that the notification must instead occur within 14 days after the change occurs. The revision to the timeframe will align with the timeframes for the new notification arrangements inserted by Item 6.

Item 6 - After section 9-1

Item 6 inserts new section 9-2A into Division 9.

New section 9-2A – Obligation to notify of the occurrence of certain events relating to key personnel of an approved provider

New section 9-2A sets out a new obligation for approved providers to notify the Commissioner of changes to key personnel, or changes to the suitability of key personnel.

New subsection 9-2A(1) provides that an approved provider must notify the Commissioner if an individual becomes, or ceases to be, one of the key personnel of the approved provider. An approved provider must also notify the Commissioner if they become aware of a change of circumstances that relates to a suitability matter in relation to an individual who is one of the key personnel of the approved provider. The meaning of suitability matters is inserted by Item 26.

The existing definition of key personnel in section 8B of the Quality and Safety Commission Act, is broad in scope. For entities that are not a State or Territory, this includes:

- persons who are responsible for the executive decisions of the provider, and
- any person who has authority or responsibility for, or significant influence over, planning, directing or controlling the activities of the provider.

For all providers conducting an aged care service, it includes:

- any person who is responsible for the day-to-day operations of the aged care service provided by the provider (whether or not they are employed by the entity); and
- any person who is responsible for the nursing services provided by the service and who holds a recognised qualification in nursing.

These new arrangements were recommended by the Royal Commission which stated that in the absence of express obligations, the regulator is less likely to know who is controlling or directing the activities of approved providers.

The note following new subsection 9-2A(1) clarifies that approved providers have a responsibility under Part 4.3 of the Aged Care Act to comply with this new obligation. Specifically, paragraph 63-1(1)(e) of the Aged Care Act provides that an approved provider's responsibilities in relation to accountability include compliance with Division 9 of the Aged Care Act in relation to notifying and providing information. The note also clarifies that failure to comply with a responsibility can result in a sanction being imposed under Part 7B of the Quality and Safety Commission Act.

New subsection 9-2(2) provides that the approved provider's notification to the Commissioner regarding their key personnel must be given within 14 days after the event occurs and be in the form approved by the Commissioner. The timeframe is also consistent with the Royal Commission's recommendations.

If the notification relates to an individual becoming one of the key personnel of the approved provider, the approved provider must state in their notification to the Commissioner whether they have considered the suitability matters in relation to the individual, and if yes, after considering those matters, whether they are reasonably satisfied that the individual is suitable to be involved in the provision of aged care.

If the notification relates to an individual ceasing to be one of the key personnel of the approved provider, the approved provider must set out in their notification the reasons the individual ceased to be one of their key personnel.

If the notification relates to an event where the approved provider becomes aware of a change of circumstances that relate to a suitability matter in relation to an individual who is one of the key personnel of the approved provider, the approved provider must set out in their notification to the Commissioner:

- the details of the change of circumstances that relates to a suitability matter in relation to an individual; and
- whether the approved provider has considered the suitability matters in relation to the individual; and
- whether, after considering those matters, the approved provider is satisfied that the individual continues to be suitable to be involved in the provision of aged care; and
- what, if any, action the provider has taken, or proposes to take, in relation to the individual.

Subsection 9-2(3) provides that a corporation commits an offence of strict liability if the approved provider is a corporation and fails to comply with subsection 9-2(1) (the

requirement to notify the Commissioner of events relating to key personnel of an approved provider).

Contraventions of the new offence carry a maximum penalty of 30 penalty units. This penalty is consistent with the existing penalties attached to the obligation to notify of a change in circumstances that materially affects the approved provider's suitability to be a provider of aged care under section 9-1 of the Aged Care Act. Application of strict liability to these offences, and the amount of the maximum penalties, is based on *A Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, which sets guidelines about the circumstances in which strict liability is appropriate, and the appropriate maximum penalty. The use of strict liability for these offences is necessary to ensure the integrity of the regulatory regime given the Commission's reliance on information being provided in carrying out its function to protect and enhance the safety, health, wellbeing, and quality of life of care recipients. Applying strict liability to this offence will also help to deter against non-compliance with this requirement. There are legitimate grounds for penalising persons lacking fault because they will be placed on notice about the strict liability to guard against contravention. The offences are also minor, punishable by a fine of up to 30 penalty units for a body corporate, and not by imprisonment, and contraventions will be easily determined by reference to clear and objective criteria.

Item 7 - Section 9-2 (heading)

Item 7 amends the heading of section 9-2 to insert the abbreviation "etc." after the term "status". This amendment is consequential to amendments made to section 9-2 by Items 8 to 10.

Item 8 - After subsection 9-2(1)

Item 8 inserts new subsection (1A) after subsection 9-2(1). Section 9-2 provides that the Commissioner may request that an approved provider give information relevant to the provider's continuing status as an approved provider and includes an offence for an approved provider that fails to comply with this request.

New subsection (1A) provides that the Commissioner may also request that an approved provider give information relevant to the suitability of an individual who is one of the key personnel of the approved provider to be involved in the provision of aged care, as is specified in the request. This request must be made by the Commissioner in writing. The amendments made by Item 8 will ensure that the Commissioner will be able to request information about the suitability of a key personnel of an approved provider at any time.

Item 9 - Subsections 9-2(2) and (3)

Item 9 omits the phrase "with the request" from subsections 9-2(2) and (3) and substitutes it with the phrase "with a request made under subsection (1) or (1A)". The amendment made by Item 9 are consequential to the amendments made by Item 8.

The amendments to subsection 9-2(2) ensure that, consistent with existing arrangements for subsection 9-2(1), if the Commissioner makes a request for information under new subsection (1A) the approved provider must comply with the request within 28 days after the request was made, or within such a shorter period as is specified in the notice.

Also consistent with existing arrangements for information requested under subsection 9-2(1), the amendments to subsection 9-2(3) provide that, if an approved provider that is a corporation fails to comply with a request under new subsection 9-2(1A), the corporation commits a strict liability offence. Contraventions of the existing offence carries a maximum penalty of 30 penalty units.

Item 10 - Subsection 9-2(4)

Item 10 omits the phrase “The request” from subsection 9-2(4) and substitutes it with the phrase “A request made under subsection (1) or (1A)”. The amendments made by Item 10 are consequential to the amendments made by Item 8 and ensure that a request made by the Commissioner under new subsection 9-2(1A) contains a statement setting out the effect of subsections 9-2(2) and (3) (the timeframe and the strict liability offence for non-compliance).

Item 11 - Division 10A (heading)

Item 11 repeals the heading of Division 10A and replaces it with the new heading “key personnel of approved providers”. The amendments made by Item 11 are consequential to the amendments made by Items 12 and 13.

Item 12 - Section 10A-2

Item 12 repeals section 10A-2 and inserts new sections 10A-1, 10A-2, 10A-2A and 10A-2B, which implements new requirements relating to the suitability of key personnel. As recommended by the Royal Commission, these new suitability requirements replace the current disqualified individual arrangements.

New section 10A-1 – Key personnel of an approved provider must notify of change of circumstances relating to suitability

New section 10A-1 introduces a new requirement for key personnel of an approved provider that is a corporation to notify the approved provider if the individual becomes aware of a change in their circumstances relating to a suitability matter. This requirement will ensure that approved providers that are corporations have relevant information available to them to ensure that all their key personnel continue to be suitable to be involved in the provision of aged care.

New subsection 10A-1(2) provides that the notification must be given in writing within 14 days after the individual becomes aware of the change of circumstances and must set out the details of the change of circumstances that relates to suitability matters in respect of the individual.

New subsection 10A-1(3) provides that an individual who is one of the key personnel of an approved provider that is a corporation commits an offence of strict liability if the individual fails to comply with the notification requirements under new subsection 10A-1(1).

Contravention of the new offence by an individual who is a key personnel carries a maximum penalty of 30 penalty units. Application of strict liability to these offences, and the amount of the maximum penalties, is based on *A Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, which sets guidelines about the circumstances in which strict liability is appropriate, and the appropriate maximum penalty. The use of strict liability for these offences is necessary to ensure the integrity of the regulatory regime. This is because the

information being made available to approved providers by their key personnel will enable the provider to reconsider suitability, and if necessary, manage the situation including notifying the Commissioner. If notified, this will also ensure the Commissioner is supported in carrying out its functions to protect and enhance the safety, health, wellbeing, and quality of life of aged care recipients.

Applying strict liability to this offence will also help to deter against non-compliance with this requirement. There are legitimate grounds for penalising persons lacking fault because they will be placed on notice about the strict liability to guard against contravention. The offences are also minor, punishable by a fine of up to 30 penalty units, and not by imprisonment, and contraventions will be easily determined by reference to clear and objective criteria.

New section 10A-2 – Determination relating to suitability of key personnel of an approved provider

New section 10A-2 introduces arrangements for the Commissioner to determine that an individual who one of the key personnel of an approved provider that is a corporation is not suitable to be involved in the provision of aged care. As recommended by the Royal Commission, in the first instance it is the responsibility of the approved provider to regularly consider the suitability matters and be reasonably satisfied that an individual who is one of their key personnel is suitable to be involved in the provision of aged care. It is intended that the Commissioner will only focus on the application of the suitability matters in those cases that warrant their attention and potential intervention.

Determination relating to suitability of key personnel

New subsection 10A-2(1) provides that the Commissioner may, at any time, determine that an individual who is one of the key personnel of an approved provider that is a corporation is not suitable to be involved in the provision of aged care.

New subsection 10A-2(2) provides that when deciding whether to make this determination, the Commissioner must consider the suitability matters in relation to the individual. However, new subsection 10A-2(3) clarifies that the Commissioner is not limited to considering only the suitability matters when deciding whether to make the determination.

Notice of intention to make determination

New subsections 10A-2(4) to (6) ensure that the individual who is one of the key personnel of an approved provider, and the approved provider, are afforded procedural fairness prior to the determination being made.

New subsection 10A-2(4) provides that before the Commissioner makes a determination that an individual who is one of the key personnel of an approved provider that is a corporation is not suitable to be involved in the provision of aged care, the Commissioner must, by written notice, notify the individual and the approved provider that the Commissioner is considering making such a determination.

New subsection 10A-2(5) provides that the notice must:

- set out the reasons why the Commissioner is considering making the determination; and

- invite the individual and the provider to make submissions to the Commissioner in writing (within 14 days after receiving the notice or a shorter timeframe specified in the notice); and
- inform the individual and the provider that the Commissioner may decide to make the determination, after considering any submissions made by the individual and the provider.

New subsection 10A-2(6) provides that the Commissioner must consider any submissions made by the individual and the approved provider in accordance with the notice.

Notice of determination

New subsection 10A-2(7) provides that if the Commissioner decides to make a determination that an individual who is one of the key personnel of an approved provider that is a corporation is not suitable to be involved in the provision of aged care, the Commissioner must, within 14 days after making the decision, give the individual and the provider a written notice. The written notice must:

- set out the decision and reasons for the decision; and
- state that the provider must, within a specified period, take specified action to ensure that the individual ceases to be one of the key personnel of the provider; and
- sets out the effect of new sections 10A-2A and 10A-3 (explained below).

The note following new subsection 10A-2(7) provides that the approved provider may request that the Commissioner reconsider the decision under Part 8B of the Quality and Safety Commission Act. Part 8B deals with the reconsideration and review of certain decision, including internal review and merits review through the Administrative Appeals Tribunal.

New section 10A-2A – Offence relating to failure to take action as required by determination

New section 10A-2A provides that a corporation that is an approved provider commits an offence if the Commissioner makes a determination under new subsection 10A-2(1) in relation to a key personnel of the approved provider, and the approved provider fails to take action specified in the notice of the determination within the period specified in the notice. Contravention of the new offence carries a maximum penalty of 300 penalty units. The penalty amount is consistent with the comparable existing penalty under current section 10A-2 that is attached to the disqualified individual arrangements (repealed by this Item).

The note following paragraph 10A-2A clarifies that section 4K of the *Crimes Act 1914*, which deals with continuing and multiple offences, applies to the offence under new section 10A-2A. The effect of section 4K is that the obligation to comply with a determination continues notwithstanding that the period within which to comply has expired, and that a person may be guilty of an offence in respect of each day during which the person fails to comply.

New section 10A-2B – Offence relating to failure to comply with responsibility to consider suitability matters relating to key personnel

New section 10A-2B provides that a corporation that is an approved provider commits an offence if the corporation fails to comply with the responsibility under new subparagraph 63-1A(a)(i). New subparagraph 63-1A(a)(i) (inserted by Item 15) introduces a responsibility for an approved provider to consider the suitability matters in relation to an individual who is one of the key personnel of the provider at least once every 12 months.

Contravention of the new offence carries a maximum penalty of 300 penalty units. The penalty amount is consistent with the comparable existing penalty under current section 10A-2 that is attached to the disqualified individual arrangements (repealed by this Item).

Item 13 - Paragraphs 10A-3(1)(a) to (c)

Item 13 repeals paragraphs 10A-3(1)(a) to (c) and substitutes new paragraphs 10A-3(1)(a) and (b). This amendment redefines what amounts to an “unacceptable key personnel situation” to provide that an “unacceptable key personnel situation” exists where:

- the Commissioner makes a determination under subsection 10A-2(1) (that an individual who is one of the key personnel of an approved provider (that is a corporation) is not suitable to be involved in the provision of aged care); and
- the provider fails to take the action specified in the notice of determination within the period specified in the notice.

The intention of this amendment is to enable quick and effective action to be taken if an unacceptable key personnel situation exists, particularly so that the risk of such a situation to vulnerable older Australians is removed or otherwise addressed. The inclusion of this arrangement was recommended by the Royal Commission, which stated that the Commission should be able to apply to the Federal Court for a remedial order if it considers an unacceptable key personnel situation exists because a member of an approved provider’s key personnel is not suitable to be involved in the provision of aged care.

Item 14 - Section 53-1

Item 14 omits the term “basic” from section 53-1. Section 53-1 provides a summary of Chapter 4 of the Aged Care Act. Chapter 4 of the Aged Care Act includes the responsibilities of approved providers. Currently the summary in section 53-1 states the responsibilities relate to accountability for the care that is provided, and the basic suitability of their key personnel. The omission of the term “basic” is consequential to the amendments made by Item 15, which introduces a responsibility regarding the suitability of an approved provider’s key personnel.

Item 15 - Section 63-1A

Item 15 repeals section 63-1A and inserts new section 63-1A. Section 63-1A is currently a responsibility relating to the basic suitability of key personnel. This section is replaced with a strengthened responsibility.

New section 63-1A – Responsibilities relating to the suitability of key personnel of an approved provider

New section 63-1A introduces a new responsibility for approved providers relating to the suitability of their key personnel. Key personnel hold critical roles within approved providers in relation to the delivery of safe and high-quality care. The Royal Commission recommended that aged care legislation require an approved provider to exercise due diligence in gathering information about the existence or otherwise of suitability matters for each of its key personnel.

Consistent with this recommendation, new section 63-1A provides that an approved provider has a responsibility to, at least once every 12 months, consider the suitability matters in relation to an individual who is one of the key personnel of the approved provider and be reasonably satisfied that the individual is suitable to be involved in the provision of aged care.

As the new section 63-1A commences on 1 December 2022, to comply with its responsibilities, the approved provider must have considered the suitability matters in relation to all its key personnel and be reasonably satisfied that its key personnel are suitable to be involved in the provision of aged care by 1 December 2023.

Paragraph 63-1A(b) provides that an approved provider must keep a record of the suitability matters that complies with requirements specified in the Accountability Principles. This will ensure there is evidence that a provider is complying with this requirement.

Paragraph 63-1A(c) provides that an approved provider also has a responsibility to comply with other responsibilities as are specified in the Accountability Principles.

The note following paragraph 63-1A(c) clarifies that if an approved provider fails to comply with the responsibility to consider, at least once every 12 months, the suitability matters in relation to the individual in accordance with any requirements specified in the Accountability Principles, the provider may commit an offence (see new section 10A-2B at Item 12 above).

Item 16 - After section 63-1C

Item 16 inserts new sections 63-1D, 63-1E, 63-1F, 63-1G and 63-1H after section 63-1C, which introduce new responsibilities for approved providers in relation to their governing bodies, constitution and a requirement to give information to the Secretary.

New section 63-1D – Responsibilities of certain approved providers relating to their governing bodies etc.

New section 63-1D introduces several new responsibilities for certain approved providers that relate to their governing bodies. Subsection 63-1D(1) provides that the responsibilities under section 63-1D apply to approved providers other than a State or Territory, a State or Territory authority, and a local government authority.

Membership of governing body

New subsection 63-1D(2) provides that an approved provider must ensure that a majority of the members of its governing body are independent non-executive members; and at least one member of its governing body has experience in the provision of clinical care (governance responsibilities). These governance responsibilities are based on the recommendations of the Royal Commission. The

board or governing body of an aged care organisation has ultimate responsibility for the governance of that organisation and should have the right mix of skills, experience, and expertise to fulfil its duties, including the right mix of executive and non-executive, independent members. Governing bodies should comprise individuals who are able to ensure that there is the right culture and effective organisation-wide governance systems relating to care and services, including clinical governance.

Non-executive members bring independence and objectivity to a board. They can play a valuable role in providing specialist expertise and advice, challenging, monitoring, and holding management to account.

Similarly, governing bodies should have the appropriate mix of skills, experience, and knowledge, reflective of the needs of their organisation, and what they can contribute to the collective capability and effective functioning of the governing body. Clinical skills and expertise are critical, given a provider's core business is providing services to older Australians who have been assessed as requiring additional care and or support to ensure their safety, health, wellbeing, and quality of life. The amendments do not specify the clinical experience required to qualify as a member of approved provider's governing body - each approved provider should consider the clinical experience and qualifications that will best support their decision making in view of the types of care and services that are provided.

New subsection 63-1D(3) provides that the responsibilities under new subsection 63-1D(2) do not apply in relation to an approved provider at a particular time if at that time both of the following apply:

- the governing body of the provider has fewer than five members; and
- the provider provides aged care through one or more aged care services to fewer than 40 care recipients.

In addition, new subsection 63-1D(4) provides that the responsibilities under new subsection 63-1D(2) do not apply in relation to an approved provider at a particular time if the provider is a kind of body known as an Aboriginal Community Controlled Organisation. This provision addresses concerns raised by the Indigenous community that the measure is not consistent with the Priority Reforms in the National Agreement on Closing the Gap.

These arrangements are based on the recommendations of the Royal Commission, which highlighted the importance of approved providers having good governance arrangements in place for the delivery of high quality care.

These amendments recognise that some approved providers have smaller governing bodies, for example, where the approved provider is of a certain size and it would therefore be difficult to meet this responsibility. However, approved providers that deliver care to 40 or more care recipients, should ensure there is independence and objectivity in executive decision making, and that its governing body has the relevant experience and expertise to be easily able to interpret reports about the delivery of care and see signs of potential problems with care delivery.

While the responsibility to ensure that a majority of the members of the governing body of the approved provider are independent non-executive members does not

apply to approved providers where the circumstances specified in subsections 63(2) or (3) exist, it is intended that these providers will strongly be encouraged to implement other measures to ensure objective executive decision making as best corporate practice. This may be achieved through implementing strategies to support more objective decision making, including processes to break decisions into smaller parts, or applying a weighted decision matrix. Governing bodies may also seek external advice or seek feedback through the quality care advisory body or care recipients (for example through the consumer advisory body/bodies if established).

Similarly, while the responsibility to ensure at least one member of the governing body of the provider has experience in the provision of clinical care does not apply where the circumstances specified in subsections 63(2) or (3) exist, these providers could support their governing body's effective function through other means. For example, by seeking external advice or opinions on particular matters from a person with experience in the provision of clinical care when executive decision-making impacts or interacts with the delivery of care.

New subsection 63-1D(5) provides that paragraphs 63-1D(2)(a) or (b) do not apply in relation to an approved provider at a particular time, if a determination is under made under new section 63-1E (explained below) that one or both responsibilities set out in paragraphs 63-1D(2)(a) and (b) do not apply in relation to the provider is in force at that time.

Advisory bodies

New subsection 63-1D(6) provides that the approved provider must establish, and continue in existence, a quality care advisory body. The Royal Commission noted that the governing bodies of approved providers do not always pay sufficient attention to the quality of care being delivered to older people. As such, it recommended that every governing body have an advisory body with appropriate experience in providing care. The Royal Commission recommended that the quality of care advisory body should have responsibility for ensuring that processes are established and maintained to record, monitor and report relevant information to the governing body in a systematic way, and should also ensure that effective mechanisms are in place so that the governing body can take action where issues are identified.

New paragraph 63-1D(6)(a) provides that the quality care advisory body established by the approved provider must:

- comply with the requirements about membership specified in the Accountability Principles; and
- at least once every 6 months, give the governing body a written report about the quality of the aged care provided through an aged care service; and
- be able, at any time, to give feedback to the governing body of the provider about the quality of the aged care provided through an aged care service.

New paragraph 63-1D(6)(b) provides that approved provider must also require that their governing body:

- consider reports from the quality care advisory body, or any such feedback, when making decisions in relation to the quality of the aged care provided through the aged care service; and

- advise, in writing, the quality care advisory body how the governing body considered such a report or any such feedback.

New subsection 63-1D(7) provides that a report given to the governing body by the quality care advisory body about the quality of the aged care that the provider provides through an aged care service must comply with any requirements specified in the Accountability Principles.

New subsection 63-1D(8) provides that the approved provider must give the quality care advisory body information about the quality of the aged care delivered by the service, if requested to do so by the quality advisory body. For example, the quality advisory body may request that the governing body provide it with details of feedback and complaints by care recipients, their representatives, staff and others about the quality of aged care delivered at the service, or any regulatory action taken by the Commission.

New subsection 63-1D(9) provides that the approved provider must also offer, at least once every 12 months, care recipients and their representatives the opportunity to establish one or more consumer advisory bodies. If established, the consumer advisory body may give the governing body of the provider feedback about the quality of the aged care that the provider provides to the care recipients through an aged care service. This provision allows the approved provider to establish more than one consumer advisory body, to allow care recipients at each service to provide feedback. For example, a large residential aged care provider may wish to establish a consumer advisory body for each aged care service. However, for a small, community-based provider with a single service, it would be more practicable to establish one consumer advisory body for the whole organisation.

New subsection 63-1D(9) also provides that if one or more consumer advisory bodies are established, the approved provider must require their governing body to consider any feedback provided to it by the consumer advisory bodies when making decisions in relation to the quality of the aged care provided through the aged care service. The governing body must also provide written advice to the consumer advisory body or bodies, about how the governing body considered any such feedback.

New subsection 63-1D(10) provides that an offer to establish the consumer advisory body (or bodies) must be made in writing. The process of offering should involve the approved provider actively advising care recipients and their representatives of the purpose and functions of the consumer advisory body and asking if they would like to form the body. This may be through communications such as an annual letter directly to the care recipients and their representatives with instructions on how an interested person is able to be involved.

Staff members

New subsection 63-1D(11) provides that an approved provider must require their governing body to ensure that the staff members of the approved provider:

- have appropriate qualifications, skills, or experience to provide the care or other services that the approved provider provides to care recipients through an aged care service; and

- are given opportunities to develop their capability to provide that care or those other services.

This amendment seeks to implement the recommendations of the Royal Commission. The Royal Commission stated that a consumer-focused culture in an organisation needs to come from the top down, and that good leadership is vital to develop proactive and caring workplace culture that is necessary for the delivery of safe and high-quality care. The Royal Commission found that where directors and managers saw their business as simply doing the basic job of providing care, staff members tended to provide care in an unfeeling, mechanistic way, which does not provide good outcomes for older people.

Those who hold managerial and leadership positions in providers of aged care are able to exert a profound influence over the culture of the care environment and the people who operate within it. Introducing this responsibility for an approved provider to require that their governing body ensures that the staff members of the provider have appropriate qualifications, skills, or experience to provide the care or other services aims to ensure staff have the necessary attributes to fulfil their roles. This will include ensuring that managers and leaders within the organisation have the professional experience and qualifications to fulfil their roles, including managing complex aged care businesses well and supporting the broader reforms recommended by the Royal Commission.

The new responsibility to ensure staff are given opportunities to develop their capability to provide that care or those other services intends to support and drive renewed emphasis on leadership development, staff training, professional development and continuing learning, and staff engagement. The Royal Commission noted that investments in workforce development will be rewarded with higher staff performance, commitment, and retention.

New section 63-1E – Determination that certain responsibilities relating to the governing body of an approved provider do not apply

New section 63-1E provides that an approved provider may apply to the Commissioner for a determination that one or both responsibilities under new subsection 63-1D(2) do not apply to the approved provider.

Application for determination

New subsection 63-1E(1) provides that an approved provider may apply to the Commissioner for a determination that either or both of the responsibilities under paragraphs 63-1D(2)(a) and (b) (governance responsibilities) do not apply in relation to the provider.

New subsection 63-1E(2) provides that the application must be made in writing, in a form approved by the Commissioner, and be accompanied by any document, or information, or fee specified by the Commissioner.

Making of determination

New subsection 63-1E(3) provides that if an approved provider makes an application under subsection 63-1E(1), the Commissioner may determine that either or both

governance responsibilities do not apply in relation to the provider if the Commissioner is satisfied that it is reasonable to do so.

Consistent with the recommendations of the Royal Commission, new subsection 63-1E(4) provides that when the Commissioner is deciding whether to make the determination, they may consider the following matters:

- the number of aged care services through which the provider provides aged care;
- the number of care recipients who are provided with aged care through those services;
- the location of those services;
- the annual turnover in the provider's key personnel;
- the membership of the governing body of the provider;
- any arrangements that the provider has made, or proposes to make, to assist:
 - the members of the governing body to act objectively and independently in the best interests of the provider; or
 - the governing body to seek, when it considers it necessary to do so, advice from a person with experience in the provision of clinical care
- any other matters specified in the Accountability Principles.

As an example, the Commissioner may decide not to grant an exemption from the governance responsibilities if the approved provider delivers care to a large number of care recipients through several services and has not advised the Commissioner how they have implemented arrangements to ensure the members of the governing body can act objectively in executive decision making.

As a further example, the Commissioner may decide to make a determination that the requirement that at least one member of the governing body of the provider has experience in the provision of clinical care does not apply to an approved provider in a remote location. In making this determination, the Commissioner may seek information of the provider's inability to recruit a suitable board member due to the location of the service and information to demonstrate that the provider has made arrangements for the governing body to seek advice when necessary from a person with expertise in providing clinical care. The determination will apply for a stated period.

Notice of determination etc.

New subsection 63-1E(5) provides that if the Commissioner decides to make a determination in relation to the approved provider under subsection 63-1D(3), the Commissioner must give the provider written notice of the making of the determination, the governance responsibility to which the determination relates and the period which the determination is in force.

The note following new subsection 63-1E(5) clarifies that a determination may remain in force for a period specified by the Commissioner, or until it is revoked under section 63-1F.

New subsection 63-1E(6) provides that if the Commissioner decides not to make a determination in relation to the approved provider, the Commissioner must give the

provider written notice of the decision, the reasons for the decision, and how the approved provider may apply for reconsideration of the decision.

The inclusion of these determination provisions responds to the Royal Commission's recommendation that there be sufficient flexibility to allow approved providers to operate with a governing body that is the right fit for its circumstances. This is of particular importance for smaller providers, especially those in rural or remote areas, where there may be limitations on who may be available to join their governing body. For example, those most appropriately qualified and willing to be on the board may not be independent or may have similar underlying qualifications or skills to existing members.

Nevertheless, all approved providers, including those seeking a determination from the Commissioner, should consider how to improve the effective functioning of their governing body. This may be achieved by implementing strategies to support more objective decision making. For example, it is recommended that an approved provider that is not required to comply with the governing body membership requirements seek advice from a clinical care expert.

As noted by the Royal Commission, while independence and clinical experience in executive decision making will promote the delivery of quality care, enforcing inflexible requirements is not workable. The inclusion of subsection 63-1E(4) strikes the right balance, taking into consideration the individual circumstances of approved providers. The Royal Commission considered that if the responsibilities were merely recommended or the subject of general guidance they may be ignored by approved providers, while including the provision for a determination by the Commissioner will allow flexibility where there are circumstances that prevent a provider from meeting the new responsibilities.

The note following new subsection 63-1E(6) clarifies that reconsideration of a decision not to make the determination is managed through Part 8B of the Quality and Safety Commission Act.

New section 63-1F - Variation or revocation of determination on the Commissioner's own initiative

New section 63-1F provides that the Commissioner may, on the Commissioner's own initiative, vary or revoke the determination made under subsection 63-1E(3) (that either or both governance responsibilities do not apply in relation to the approved provider) if the Commissioner is satisfied that it is appropriate to do so.

If the Commissioner decides to vary or revoke a determination they must, as soon as reasonably practicable, give the approved provider a written notice that sets out the decision, the reasons for the decision, the day on which the variation or revocation takes effect, and how the person may apply for reconsideration of the decision.

It may be appropriate for a Commissioner to vary or revoke a determination in certain circumstances, for example, where the Commissioner has become aware of information that means that the circumstances upon which the Commissioner originally made the determination no longer exist.

The note following new section 63-1F clarifies that reconsideration of a decision not to make the determination is managed through Part 8B of the Quality and Safety Commission Act.

New section 63-1G – Responsibility relating to the giving of information relating to reporting periods

New section 63-1G introduces a new responsibility for approved providers to give the Secretary certain information, which relates to a reporting period for the approved provider that is information of a kind specified in the Accountability Principles. This provision, in conjunction with Schedule 3 of the Implementing Care Reform Bill, responds to the Royal Commission’s recommendation that aged care legislation be amended to require every approved provider to report annually on their operations to enable proper scrutiny. These provisions together will provide current and potential care recipients, and their families with clear, timely and meaningful information about the quality of services and performance of approved providers.

Under subsection 63-1G(2), approved providers must give the information outlined in new subsection (1) to the Secretary within 4 months after the end of the reporting period.

New subsection 63-1G(3) defines a ‘reporting period’ for an approved provider to be:

- the period of 12 months starting on 1 July of a year, or
- another 12 month period that is determined for the provider by the Secretary.

If the Secretary determines an alternative 12-month period for the approved provider, it must still start on the first day of a month and be in accordance with the Accountability Principles.

New subsection 63-1G(4) provides that without limiting paragraph 63-1G(3)(b), if the Secretary determines an alternative 12 month period for the provider, it may commence on a day before the commencement of this section (see Item 38). That is, the reporting period may commence before 1 December 2022.

The Accountability Principles will specify the information which must be given by the provider. The Royal Commission proposed this include details of key personnel, information on staffing, financial information and complaints. While some of this information may already be available to the public (for example, through an approved provider’s annual report) the totality of this information is not readily available, in one place, at no cost, about all approved providers. An Information Technology solution is being developed to enable use of the information when it is already submitted by the provider for other purposes to be used where practicable to prevent duplication of reporting by approved providers.

New section 63-1H – Responsibility relating to constitution of approved providers that are wholly-owned subsidiary corporations

New section 63-1H implements part of Recommendation 88 of the Royal Commission by setting out responsibilities for approved providers that are wholly-owned subsidiary corporations in regard to their constitution.

Section 187 of the *Corporations Act 2001* and section 265-35 of the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* permit a director, in certain circumstances, to discharge the duty to act in the best interests of a wholly-owned subsidiary by acting in the best interests of the holding company where this is expressly authorised in the subsidiary's constitution. The Royal Commission did not consider that directors of a wholly-owned subsidiary that is an approved provider should be permitted by law to give priority to the interests of the holding company that does not have any responsibilities under aged care law.

Corporations under the Corporations Act 2001

New subsection 63-1H(1) applies to approved providers that:

- are a body corporate incorporated, or taken to be incorporated, under the *Corporations Act 2001*,
- have a constitution; and
- are a wholly-owned subsidiary of another body corporate (and the holding company is not an approved provider).

If these circumstances exist, then it is a responsibility of that approved provider to ensure that its constitution does not authorise its directors to act in good faith in the best interests of the holding company.

However, this provision is not intended to preclude a director from making a decision in the best interests of the approved provider, even if the decision is also in the best interests of the holding company.

Aboriginal and Torres Strait Islander corporations

New subsection 63-1H(2) provides a new responsibility in circumstances where an approved provider is a body corporate incorporated, or taken to be incorporated, under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006*, is a wholly-owned subsidiary of another body corporate (and the holding company is not an approved provider). If these circumstances exist, and the approved provider has a constitution, then it is a responsibility of that approved provider to ensure that the constitution does not authorise its directors to act in good faith in the best interests of the holding company.

However, this provision is not intended to preclude a director from making a decision in the best interests of the approved provider, even if the decision is also in the best interests of the holding company.

Item 17 - Clause 1 of Schedule 1 (definition of *disqualified individual*)

Item 17 repeals the definition of “disqualified individual” from Clause 1 of Schedule 1 to the Aged Care Act. This is a consequential amendment to Items 12 and 15 above and implements the Royal Commission recommendation to replace the disqualified individual arrangements with a suitability test for the key personnel of an approved provider.

Item 18 - Clause 1 of Schedule 1

Item 18 amends Clause 1 of Schedule 1 to the Aged Care Act to include new definitions for “governing body” of an approved provider, “local government authority”, “reporting period”, “State or Territory authority” and “suitability matter”.

Aged Care Quality and Safety Commission Act 2018

Item 19 - Section 7

Item 19 inserts a new definition for “civil penalty order” in section 7 of the Quality and Safety Commission Act, which adopts the same meaning as in the Regulatory Powers Act.

Item 20 - Section 7 (definition of *compliance notice*)

Item 20 omits the phrase “subsection 74EE(1) or (1A)” from the definition of “compliance notice” in section 7 and substitutes the phrase “section 74EE”. This amendment is consequential to the amendments made by Schedule 3 of this Bill.

Item 21 - Section 7 (definition of *disqualified individual*)

Item 21 repeals the definition of “disqualified individual” from section 7. This is a consequential amendment to Items 12, 15 and 17 above.

Item 22 - Section 7 (paragraph (a) of the definition of *eligible adviser*)

Item 22 repeals paragraph (a) of the definition of “eligible adviser” in section 7. This amendment is consequential to the amendment made by Items 12, 15, 17 and 21 above.

Item 23 - Section 7

Item 23 amends section 7 to insert new defined terms. The term “NDIS banning order” is defined as a banning order made under section 73ZN of the NDIS Act. This term is relevant to the amendments made by Item 25. The term “suitability matter” is defined to have the meaning given by new section 8C, which is inserted by Item 25.

Item 24 - Section 8A

Item 24 repeals section 8A. This is a consequential amendment to Items 12 and 15 above.

Item 25 - After section 8B

Item 25 inserts new section 8C, after section 8B.

New section 8C – Meaning of *suitability matters* in relation to an individual

New section 8C outlines what matters constitute a “suitability matter” in relation to an individual, and includes:

- the individual’s experience in providing, at any time, aged care or other relevant forms of care;
- whether a NDIS banning order against the individual is, or has at any time been, in force;
- whether the individual has at any time been convicted of an indictable offence;
- whether the individual:
 - is, or has at any time been, the subject of any findings or judgment in relation to fraud, misrepresentation or dishonesty in any administrative, civil or criminal proceedings; or
 - is currently party to any proceedings that may result in the individual being the subject of such findings or judgment;
- whether the individual is, or has at any time been, disqualified from managing corporations under Part 2D.6 of the *Corporations Act 2001*;
- any other matter specified in the Rules.

When a person is considering whether an individual who is, or is proposed to be, one of the key personnel of an approved provider is suitable to be involved in the provision of aged care, the person should have regard to these matters.

New subsection 8C(2) provides that this section does not affect the operation of Part VIIC of the *Crimes Act 1914* (which includes provisions that, in certain circumstances, relieve persons from the requirement to disclose spent convictions and require persons aware of such convictions to disregard them).

Item 26- Paragraph 63D(2)(c)

Item 26 repeals paragraph 63D(2)(c) and substitutes it with new paragraph 63D(2)(c), which provides that the Commissioner must not approve a person as a provider of aged care unless the Commissioner is satisfied that each individual who is one of the key personnel of the person applying is suitable to be involved in the provision of aged care.

Consistent with the recommendations of the Royal Commission, the intention of this provision is to enable the Commissioner to rely on information in an application for approval as a provider of aged care. This application will contain information regarding whether the applicant is satisfied its key personnel are suitable to be involved in the provision of aged care. However, if necessary, this provision confers on the Commissioner the power to satisfy themselves of the suitability of the key personnel, when deciding whether to approve a person as a provider of aged care.

Item 27 - After paragraph 63D(3)(e)

Item 27 inserts new paragraphs 63D(3)(ea) and (eb), which insert two additional matters that the Commissioner must consider when deciding whether a person is suitable to provide aged care. These matters include:

- whether the person has at any time been convicted of an indictable offence; and
- whether a civil penalty order against the person has been made at any time.

As the Bill introduces a number of new offences and civil penalty provisions it is important that these matters also be considered when determining whether an approved provider is suitable to provide aged care.

Item 28 - At the end of section 63D

Item 28 inserts new subsections 63D(7) and (8), which provide that in deciding whether an individual who is one of the key personnel of the applicant is suitable to be involved in the provision of aged care, the Commissioner must consider the suitability matters in relation to the individual.

New subsection 63D(8) clarifies that this does not limit the matters the Commissioner may consider in deciding whether an individual who is one of the key personnel of the applicant is suitable to be involved in the provision of aged care.

Item 29 - After paragraph 63J(3)(e)

Item 29 inserts new paragraphs 63J(ea) and (eb), which insert two additional matters that the Commissioner must consider as part of deciding whether the person is suitable to provide aged care. These matters include:

- whether the person has at any time been convicted of an indictable offence; and
- whether a civil penalty order against the person has been made at any time.

As the Bill introduces several new offences and civil penalty provisions it is important that these matters also be considered when determining whether an approved provider is suitable to provide aged care.

Item 30 - Section 74A (paragraph beginning “The Commissioner may give”)

Item 30 omits the phrase “the provider’s responsibilities under paragraph 54-1(1)(e) or (f) of the Aged Care Act” from section 74A and substitutes it with the phrase “certain aged care responsibilities”. Section 74A provides a simplified outline of Part 8A of the Quality and Safety Commission Act, which is regarding the enforcement of responsibilities of approved providers. The amendment made by Item 30 is consequential to the amendments made by Schedule 3 of this Bill.

Item 31 - After subsection 74EE(1A)

Item 31 inserts a new subsection 74EE(1B) and provides for a new subheading, “Information relating to a reporting period”, prior to setting out new subsection 74EE(1B).

New subsection 74EE(1B) provides that the Commissioner may give a written notice to the approved provider if the Commissioner is satisfied that the approved provider is not complying with the provider’s responsibilities under new section 63-1H of the Aged Care Act. This is the responsibility for approved providers to give information to the Secretary relating to a reporting period (see Item 16 above).

Alternatively, the Commissioner may give a written notice to an approved provider if the Commissioner is aware of information that suggests that an approved provider may not be complying with that responsibility for approved providers to provide information as required by section 63-1G.

The Item mirrors existing provisions in subsections 74EE(1) and 74EE(1A) relating to compliance notices for incident management and the use of restrictive practices. The effect of new subsection 74EE(1B) is to establish a basis for the Commissioner to issue compliance notices regarding the reporting of specified information under section 63-1H.

Item 32 - Section 74J (table item 6, column 1)

Item 32 omits the phrase “subsection 74EE(1) or (1A)” from table item 6 of column 1 in section 74J and substitutes it with the phrase “section 74EE”. This amendment has the effect of including a decision to issue a compliance notice under new subsection 74EE(1B), as well as existing subsections 74EE(1) and (1A), as a reviewable decision for a person whose interests are affected by those decisions. This is a consequential amendment to Item 31.

Item 33 - Section 74J (at the end of the table)

Item 33 inserts new items to the table at section 74J to specify the following decisions of the Commissioner as reviewable decisions:

- a decision to make a determination under new subsection 10A-2(1) of the Aged Care Act in relation to an individual who is one of the key personnel of

- an approved provider, the affected person being the individual or the approved provider;
- a decision not to make a determination under new subsection 63-1E(3) of the Aged Care Act in relation to an approved provider, the affected person being the approved provider; and
 - a decision under new subsection 63-1F(1) of the Aged Care Act to vary or revoke a determination made under new subsection 63-1E(3) in relation to an approved provider, the affected person being the approved provider.

Part 2—Application and transitional provisions

Item 34 - Definitions

Item 34 provides new defined terms. The term “Aged Care Act” is defined as the Aged Care Act. The term “commencement day” is defined as 1 December 2022. The term “Commission Act” is defined as the Quality and Safety Commission Act.

Item 35 - Application—notification of change of circumstances

Item 35 provides that the amendments of section 9-1 of the Aged Care Act, as made by Items 2 to 5 of Part 1 to this Schedule, apply in relation to a change of circumstances that occurs on or after the commencement days. This means that the new 14 day period within which to notify the Commissioner does not apply if a change of circumstances occurs prior to 1 December 2022. As a result, if the change of circumstances occurs prior to 1 December 2022, the provider has 28 days to notify the Commissioner.

Item 36 - Application—responsibilities of approved providers relating to their governing bodies etc.

Existing approved providers

Subitem 36(1) provides that if a person is an approved provider immediately before the commencement day for Schedule 5, new section 63-1D of the Aged Care Act, as inserted by Item 16 of Part 1 of this Schedule, applies in relation to the person on and after 1 December 2023. This aims to ensure that there is sufficient time for existing approved providers to meet the new requirements, which may require the appointment of new governing body members through an annual cycle of meetings.

New approved providers

Subitem 36(2) provides that if a person becomes an approved provider on or after the commencement day for Schedule 5, section 63-1D of the Aged Care Act, as inserted by Item 16 of Part 1 of this Schedule, applies in relation to the person on and after the person becomes an approved provider. This will ensure that new providers entering the system will be required to comply with the new strengthened governance arrangements.

Item 37 - Application—responsibility relating to the giving of information relating to reporting periods

Item 37 provides that if the reporting period for the provider starts on 1 July, as set out under new paragraph 63-1G(3)(a), the reporting period for that provider starts on 1 July 2022 and each later reporting period. This means the approved provider’s reporting period would commence on 1 July 2022 and each year thereafter beginning 1 July.

As the reporting period under this Item is the period of 12 months from 1 July 2022, providers will be required to give the information to the Secretary by 30 October 2023.

However, if the reporting period for an approved provider is another 12 month period, as set out under new paragraph 63-1G(3)(b), the reporting period for that approved provider starts on the first day determined for that approved provider and each later

reporting period. This means the reporting period for such a provider will begin on the same date each year. However, if a different 12 month reporting period is determined for the provider, it must still be on the first day of a month and determined in accordance with the Accountability Principles.

Item 38 - Application—responsibilities relating to constitution of certain approved providers

Existing approved providers

Subitem 38(1) provides that if a person is an approved provider immediately before the commencement day for Schedule 5, new section 63-1H of the Aged Care Act, as inserted by Item 16 of Part 1 of this Schedule, applies in relation to the person on and after 1 December 2023. This aims to ensure that companies have enough time to go through an annual cycle of meetings for the opportunity to make amendments to their constitutions if required.

New approved providers

Subitem 38(2) provides that if a person becomes an approved provider on or after the commencement day for Schedule 5, new section 63-1H of the Aged Care Act, as inserted by Item 16 of Part 1 of this Schedule, applies in relation to the person on and after the day the person becomes an approved provider. This will ensure that new providers entering the system will be required to comply with the new strengthened governance arrangements.

Item 39 - Application—new applications for approval of person as provider of aged care

Item 39 provides that the amendments of section 63D of the Quality and Safety Commission Act made by Items 27 and 28 of Part 1 of this Schedule apply in relation to an application that is made on or after the commencement day for Schedule 5. This means that the Commissioner will consider the suitability matters for applications made on or after 1 December 2022, and not the disqualified individual test.

Item 40 - Transitional—pending applications for approval of a person as provider of aged care

Item 40 provides that if an application under subsection 63B(1) of the Quality and Safety Commission Act was made before the commencement day (1 December 2022), and immediately before that day the Commissioner has not made a decision on the application, then section 63D of the Quality and Safety Commission Act, as in force immediately before the commencement day continues in relation to the application. This means that the current disqualified individual test continues to apply to all applications made prior to 1 December 2022.

Item 41 – Transitional rules

Sub-item 41(1) provides that the Minister may, by legislative instrument, make rules prescribing matters of a transitional nature (including saving or application provisions) relating to the amendments of section 10A-3 of the Aged Care Act made by Item 13 of Part 1 of Schedule 5.

Sub-item 41(2) provides that, to avoid doubt, the rules prescribing matters of a transitional nature may not create an offence or civil penalty, provide powers of arrest or detention or entry, search or seizure, impose a tax, set an amount to be appropriated

from the Consolidated Revenue Fund under an appropriation in this Act or directly amend the text of this Act.

Sub-item 41(3) provides that Part 2 of Schedule 5 (other than sub-item 41(2) above) does not limit the rules that must be made for the purposes of sub-item 41(1).

Currently section 10A-3 provides for the Secretary to apply to the Federal Court for remedial orders for the purposes of ensuring that an unacceptable key personnel situation ceases to exist. Since its commencement, this provision has primarily and effectively been used to deter a disqualified individual from being one of the key personnel of an approved provider and has less commonly been implemented. While it is possible that no applications under section 10A-3 will be pending when the revised arrangements commence on 1 December 2022, not including the allowance for transitional arrangements may undermine the preventative nature of the provision. Despite there being no matters applications currently on foot, Item 41 has been included to ensure transitional matters can be addressed, if an application is made prior to 1 December 2022. It is therefore considered reasonable that these matters be dealt with in delegated legislation.

Schedule 6 – Information sharing

Overview

Schedule 6 to the Bill amends the Aged Care Act, Quality and Safety Commission Act, *Veterans' Entitlements Act 1986*, *Military Rehabilitation and Compensation Act 2004*, and *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* to facilitate greater information sharing between Commonwealth bodies across the aged care, disability and veterans' affairs sectors and worker screening units in relation to providers and workers, particularly conduct that may put people who receive care, support or treatment at risk of harm.

Commonwealth bodies include the Department of Health and Aged Care, the Commission, the Department of Veterans' Affairs, the Military Rehabilitation and Compensation Commission and the Repatriation Commission. Commonwealth bodies may be also prescribed in a legislative instrument, which is intended to enable information sharing with other departments and authorities that have powers or functions related to the care and support sector.

This is a first step towards broader regulatory alignment across the care and support sector aimed at providing consistent quality and safety protections for consumers and reducing regulatory burden for cross-sector providers and workers.

Reciprocal information sharing arrangements about provider and worker conduct will also be in place under the NDIS.

Part 1—Amendments

Aged Care Act 1997

Item 1 - Before paragraph 86-3(1)(d)

Item 1 inserts new paragraph 86-3(1)(cd) to authorise the Secretary to disclose protected information (as defined under the Aged Care Act) to a “receiving Commonwealth body” where the Secretary believes on reasonable grounds that the information will assist in the performance of the functions, or the exercise of the powers, of that body, for the purposes of performing those functions or exercising those powers.

This amendment expands the Secretary's ability to share protected information with other Commonwealth bodies in certain circumstances. The aim of this amendment is to facilitate greater information sharing between Commonwealth bodies that have functions and powers relating to aged care, veterans' care and disability support (together, the care and support sector). It is designed to enable the receiving Commonwealth body to proactively identify, assess and respond to risks to those receiving care, support or treatment. For example, it may enable the sharing of information about the systemic neglect of care recipients by an approved provider of aged care that may also operate as an NDIS provider.

Item 2 - Subparagraph 86-3(1)(f)(i)

Item 2 amends subparagraph 86-3(1)(f)(i) to insert “or may breach” after “breaches”. This amendment expands the circumstances in which the Secretary will be able to disclose protected information to a body responsible for standards of conduct in the profession of which a person is a member. It will enable the Secretary to disclose protected information to such a body where the Secretary believes on reasonable grounds that the person’s conduct may breach a standard of professional conduct. It is also intended to cover situations where the Secretary may not necessarily be in a position to form a reasonable belief that the standards have been breached because that is an assessment that is ordinarily conducted by the professional standards body.

By inserting a reference to “or may breach”, there will still be a need for the Secretary to consider whether a breach of the professional standards may have occurred, but the Secretary will not need to be satisfied that it has occurred. This amendment is reasonable and appropriate to promote the safety, health and wellbeing of those receiving care. It allows for investigation and a decision to be made by the appropriate professional standards body.

A similar amendment will be made to the Commissioner’s powers of disclosure of protected information under the Quality and Safety Commission Act (see Item 6 below).

Item 3 - After section 86-3

This item inserts a new 86-3(4) to define a “receiving Commonwealth body”, as referred to in Item 1 above.

The term ‘receiving Commonwealth body’ is defined in such a way to allow for sharing of information between those who have functions or powers in relation to the care and support sector (including a regulatory or oversight role). Paragraph (h) of the definition allows for an additional Department of State, or another authority, of the Commonwealth to be prescribed in the Information Principles. An additional Department of State or another authority can only be so prescribed if that Department or authority has regulatory, compliance or enforcement functions in relation to the provision of care, support, treatment or other related services or assistance (including care, support, treatment or other related services or assistance provided through an arrangement, including a contractual arrangement).

The aim of these amendments is to enable broader information sharing among Commonwealth bodies in relation to the performance of providers and workers in the care and support sector, including where there is concern regarding their conduct and the services being provided. The amendments may also facilitate more efficient information collection, such as possible ‘report once’ arrangements in which information required by multiple Commonwealth bodies may be reported to one and shared with others, where appropriate, to reduce duplication.

Paragraph (h) of the definition of ‘receiving Commonwealth body’ has been included to allow flexibility to include additional bodies as appropriate. Although there is an existing power to prescribe additional bodies to whom protected information can be shared under paragraph 86-3(1)(j) of the Aged Care Act, the aim of this new

paragraph is to provide a clear indication of the types of bodies that may be prescribed as receiving Commonwealth bodies under the Information Principles.

Aged Care Quality and Safety Commission Act 2018

Item 4 – At the end of Division 2 of Part 7

Item 3A inserts new section 58A, which provides an additional purpose of the NDIS Worker Screening Database (as defined under the NDIS Act) under subsection 181Y(3) of the NDIS Act to include the sharing of information in that database with:

- a) the Commissioner for the purpose of assisting in the performance of their functions or exercising their powers; and
- b) the Secretary for the purpose of assisting in the performance of their functions or exercise of their powers under the Aged Care Act.

This provision expands the functions of the NDIS Worker Screening Database and is intended to ensure information sharing arrangements between the Commission and the NDIS Commission in relation to aged care workers who may also work in the NDIS sector. This is particularly important in relation to circumstances where those workers have been found by the Commissioner to have breached the Code of Conduct provided for under Schedule 3. This aims to help ensure the continued health, safety and well-being of care recipients and NDIS participants.

Item 5 - After paragraph 61(1)(d)

Item 4 inserts a new paragraph 61(1)(da). The new paragraph will permit the Commissioner to share protected information under the Quality and Safety Commission Act with a receiving Commonwealth body where the Commissioner believes on reasonable grounds that the information will assist in the performance of functions or the exercise of the powers of that body for the purpose of performing those functions or exercising those powers. A receiving Commonwealth body is defined in Item 8 below.

This paragraph expands the ability of the Commissioner to share protected information under the Quality and Safety Commission Act to specified receiving Commonwealth bodies for the powers and functions of those bodies. The aim of this amendment is to facilitate greater information sharing between Commonwealth bodies that have functions and powers relating to the care and support sector (including a regulatory or oversight role).

Item 6 – Subparagraph 61(1)(f)(i)

Item 6 amends subparagraph 61(1)(f)(i) to insert “or may breach” after “breaches”. This amendment expands the circumstances in which the Commissioner will be able to disclose protected information to a body responsible for standards of conduct in the profession of which a person is a member.

This amendment will enable the Commissioner to disclose protected information to such a body where the Commissioner believes on reasonable grounds that the person’s conduct may breach a standard of professional conduct. It is also intended to cover situations where the Commissioner may not necessarily be in a position to form a reasonable belief that the standards have been breached because that is an

assessment that is ordinarily conducted by the professional standards body. By inserting a reference to “or may breach”, there will still be a need for the Commissioner to consider whether a breach of the professional standards may have occurred, but the Commissioner will not need to be satisfied that it has occurred.

For example, where the Commissioner believes on grounds that a registered nurse may have breached one their standards of professional conduct, this amendment will allow the Commissioner to provide information about the registered nurse to the Australian Health Practitioner Regulation Agency and/or the Nursing and Midwifery National Board. This amendment is reasonable and appropriate to promote the safety, health and wellbeing of those receiving care. It allows for investigation and a decision to be made by the appropriate professional standards body.

This provision mirrors new subparagraph 86-3(1)(f)(i) of the Aged Care Act (see Item 2 above).

Item 7 - After paragraph 61(1)(i)

Item 6 inserts new paragraphs 61(1)(ia) and 61(1)(ib) to expand the Commissioner’s ability to disclose protected information (as defined in the Quality and Safety Commission Act) to persons or bodies that have the function, or functions that include the function of dealing with complaints or information about the provision of health or community services by a person or body, or the person or body performs functions or exercises powers under, or for the purposes of, and NDIS worker screening law, where the Commissioner believes on reasonable grounds that the information will assist in the performance of those functions or powers.

This amendment will allow the Commissioner to share protected information with State and Territory health complaints entities, entities performing functions under NDIS worker screening laws, and other bodies that have similar functions, such as the Health Care Complaints Commission in New South Wales, the Office of the Health Ombudsman in Queensland and the Health Complaints Commissioner and Mental Health Complaints Commissioner in Victoria, to assist them in the performance of their complaints functions or powers, including taking appropriate action against an individual. This aims to improve regulatory alignment across related sectors and professions to promote the health, safety and wellbeing of those receiving care. It will ensure that information can be referred to the appropriate entities for investigation and any necessary action at the earliest possible time. The disclosure will only be made for the purposes of the functions or powers of the person or body and therefore there will be limits on how the information, being protected information, can be used in accordance with section 62 of the Quality and Safety Commission Act.

Item 6 also inserts new paragraph 61(1)(ib) to expand the Commissioner’s ability to disclose protected information (as defined in the Quality and Safety Commission Act) to a person or body that performs functions or exercises powers under, or for the purposes, of an NDIS worker screening law (within the meaning of the NDIS Act) for the purposes of performing those functions or exercising those powers.

This ensures the Commission is able to share information, and in particular, monitoring advice and information about a breach of the Code by an aged care worker or governing person, with worker screening units for the purpose of their ongoing

monitoring of NDIS worker screening checks, including in relation to making a clearance or exclusion decision about an individual. This is because many individuals work across both sectors and such disclosure is intended to ensure the safety, health and well-being of care recipients and NDIS participants.

Item 8 – At the end of section 61

Item 8 inserts new subsection (3) at the end of section 61. This subsection provides a definition of receiving Commonwealth body for the purpose of section 61.

The term ‘receiving Commonwealth body’ is defined in such a way to allow for sharing of information between those who have functions or powers in relation to the care and support sector (including a regulatory or oversight role). Paragraph (g) of the definition also allows for an additional Department of State, or another authority, of the Commonwealth to be prescribed in the rules. An additional Department of State or another Commonwealth authority can only be so prescribed if that Department or authority has regulatory, compliance or enforcement functions in relation to the provision of care, support, treatment or other related services or assistance (including care, support, treatment or other related services or assistance provided through an arrangement, including a contractual arrangement).

New subsection 61(3) also defines the “Repatriation Commission” as the Repatriation Commission continued in existence by section 179 of the *Veterans’ Entitlements Act 1986*.

The aim of these amendments is to enable broader information sharing among Commonwealth bodies in relation to the conduct of providers and workers in the care and support sector, including where there is concern regarding their conduct and the services being provided.

Paragraph (g) of the definition of ‘receiving Commonwealth body’ has been included to allow flexibility to include additional bodies as appropriate.

Although there is an existing power to prescribe additional bodies to whom protected information can be shared under paragraph 61(1)(j) of the Quality and Safety Commission Act, the aim of this new paragraph is to provide a clear indication of the types of bodies that may be prescribed as receiving Commonwealth bodies under the Information Principles.

Military Rehabilitation and Compensation Act 2004

Item 9 – Subsection 409(2) (after table item 2C)

Item 9 inserts a new table item 2D in subsection 409(2) to allow the Military Rehabilitation and Compensation Commission (MRCC) (or a staff member assisting the MRCC) to provide information obtained in the performance of their duties under the *Military Rehabilitation and Compensation Act 2004* (MRC Act) to a ‘receiving Commonwealth body’ for a purpose relating to the performance of a function, or the exercise of a power, by that body.

Consistent with corresponding amendments in this Schedule, this amendment facilitates the sharing of information by the MRCC to specified receiving Commonwealth bodies for a purpose relating to the powers and functions of the body they are sharing the information with. The aim of this amendment is to facilitate greater information sharing between bodies that have functions and powers relating to the care and support sector (including a regulatory or oversight role).

Item 10 – After subsection 409(2)

Item 10 inserts new subsection 409(2A). This item expands the powers of the MRCC (or a staff member assisting the MRCC) to provide information relating to the provision of treatment to a receiving Commonwealth body for a purpose relating to the performance of a function or the exercise of a power of the receiving Commonwealth body where:

- (a) a person is entitled to treatment under Chapter 6 of the MRC Act; and
- (b) treatment is provided to the person through an arrangement, including a contractual arrangement, with a body that is not a corporate-Commonwealth entity or a non-corporate Commonwealth entity.

The definitions of “corporate Commonwealth-entity”, “non-corporate Commonwealth entity” and “receiving Commonwealth body” are set out in Item 11 below.

This amendment is intended to recognise that veterans’ care is generally provided under arrangements, including contractual arrangements. The amendments allow for information obtained under these arrangements to be shared with receiving Commonwealth bodies for a purpose relating to the performance of a power or function of those bodies. The aim of this amendment is to facilitate greater information sharing between bodies that have functions and powers relating to the care and support sector (including regulatory or oversight roles).

Item 11 - Subsection 409(5)

Item 11 inserts definitions of “corporate Commonwealth entity”, “non-corporate Commonwealth entity” and “receiving Commonwealth body” in subsection 409(5).

The term ‘receiving Commonwealth body’ is defined in such a way to allow for sharing of information between those who have functions or powers in relation to the care and support sector (including a regulatory or oversight role). Paragraph (h) of the definition of a “receiving Commonwealth body” also allows for an additional Department of State, or another authority, of the Commonwealth to be prescribed in the regulations. An additional Department of State or another Commonwealth authority can only be so prescribed if that Department or authority has regulatory, compliance or enforcement functions in relation to the provision of care, support, treatment or other related services or assistance (including care, support, treatment or other related services or assistance provided through an arrangement, including a contractual arrangement).

The aim of these amendments is to enable broader information sharing among Commonwealth bodies in relation to the conduct of providers and workers in the care and support sector, including where there is concern regarding their conduct and the services being provided.

Paragraph (h) of the definition of a “receiving Commonwealth body” has been included to allow flexibility to include additional bodies as appropriate. This is in addition to the existing power to prescribe additional bodies under Item 3 in the table under subsection 409(2). The aim of this new provision is to limit the types of additional bodies that may be prescribed under the regulations.

Safety, Rehabilitation and Compensation (Defence Related Claims) Act 1988

Item 12- Subsection 151A(1) (at the end of the table)

Item 12 inserts new table item 7 in subsection 151A(1) to allow the MRCC (or a staff member assisting the MRCC) to provide information obtained in the performance of their duties under the MRC Act to a ‘receiving Commonwealth body’ for a purpose relating to the performance of a function, or the exercise of a power, by that body.

Consistent with corresponding amendments in this Schedule, this amendment facilitates the sharing of information by the MRCC to specified receiving Commonwealth bodies for a purpose relating to the powers and functions of the body they are sharing the information with. The aim of this amendment is to facilitate greater information sharing between bodies that have functions and powers relating to the care and support sector (including a regulatory or oversight role).

Item 13 – After subsection 151A(1B)

Item 13 inserts new subsection 151A(1C). This item expands the powers of the MRCC (or a staff member assisting the MRCC) to provide information relating to the provision of treatment to a receiving Commonwealth body for a purpose relating to the performance of a function or the exercise of a power of the receiving Commonwealth body where:

- a) a person who is, or was, an employee is entitled to compensation for medical treatment under this Act; and
- b) the treatment is provided to the person through an arrangement, including a contractual arrangement, with a body that is not a corporate Commonwealth entity or a non-corporate Commonwealth entity.

The definitions of “corporate Commonwealth-entity”, “non-corporate Commonwealth entity” and “receiving Commonwealth body” are set out in Item 15 below.

This amendment is intended to recognise that veterans’ care is generally provided under arrangements, including contractual arrangements. The amendments allow for information obtained under these arrangements to be shared with receiving Commonwealth bodies for a purpose relating to the performance of a power or function of those bodies. The aim of this amendment is to facilitate greater information sharing between bodies that have functions and powers relating to the care and support sector (including regulatory or oversight roles).

Item 14 - Paragraphs 151A(2)(a) and (b)

Item 13 replaces references to “(1B)” with “(1B) or (1C)” in paragraphs 151A(2)(a) and (b), to effectively extend restrictions to use the information only for the purposes specified in subsection 151A(1) and on-disclose only for those purposes.

Item 15 – Subsection 151A(4)

Item 14 inserts definitions of “receiving Commonwealth body”, “corporate Commonwealth entity” and “non-corporate Commonwealth entity” in subsection 151A(4).

The term “receiving Commonwealth body” is defined in such a way to allow for sharing of information between those who have functions or powers in relation to the care and support sector (including a regulatory or oversight role). Paragraph (h) of the definition of a “receiving Commonwealth body” also allows for an additional Department of State, or another authority, of the Commonwealth to be prescribed in the regulations. An additional Department of State or another Commonwealth authority can only be so prescribed if that Department or authority has regulatory, compliance or enforcement functions in relation to the provision of care, support, treatment or other related services or assistance (including care, support, treatment or other related services or assistance provided through an arrangement, including a contractual arrangement).

The aim of these amendments is to enable broader information sharing among Commonwealth bodies in relation to the conduct of providers and workers in the care and support sector, including where there is concern regarding their conduct and the services being provided.

Paragraph (h) of the definition of a “receiving Commonwealth body” has been included to allow flexibility to include additional bodies as appropriate under the regulations.

Veterans’ Entitlements Act 1986

Item 16 – After subsection 130(2)

Item 16 inserts new subsection 130(2A). This item expands the powers of the Secretary of the Department of Veterans’ Affairs (DVA) (or an officer of the Department) to provide information relating to the provision of treatment to a receiving Commonwealth body for a purpose relating to the performance of a function or the exercise of a power by that body where:

- (a) an eligible person is entitled to treatment under Part V of the *Veterans’ Entitlement Act 1986* (VE Act); and
- (b) treatment is provided to the eligible person through an arrangement, including a contractual arrangement, with a body that is not a corporate-Commonwealth entity or a non-corporate Commonwealth entity.

The definitions of “corporate Commonwealth-entity”, “non-corporate Commonwealth entity” and “receiving Commonwealth body” are set out in Item 18 below.

This amendment is intended to recognise that veterans’ care is generally provided under arrangements, including contractual arrangements. The amendments allow for information obtained under these arrangements to be shared with Commonwealth bodies for a purpose relating to the exercise of a power or performance of a function of those bodies. The aim of this amendment is to facilitate greater information sharing

between bodies that have functions and powers relating to the care and support sector (including a regulatory or oversight role).

Item 17 – Subsection 130(3)

Item 16 inserts a reference to new subsection 130(2A) in subsection 130(3). The effect of this amendment is that information disclosed under new subsection 130(2A) is taken to be authorised by the VE Act for the purposes of the Australian Privacy Principles.

Item 18 – Section 131

Item 18 inserts definitions of “corporate Commonwealth entity”, “non-corporate Commonwealth entity” and “receiving Commonwealth body” in section 131.

The term “receiving Commonwealth body” is defined in such a way to allow for sharing of information between those who have functions or powers in relation to the care and support sector (including a regulatory or oversight role). Paragraph (h) of the definition of a “receiving Commonwealth body” also allows for an additional Department of State, or another authority, of the Commonwealth to be prescribed in the regulations. An additional Department of State or another Commonwealth authority can only be so prescribed if that Department or authority has regulatory, compliance or enforcement functions in relation to the provision of care, support, treatment or other related services or assistance (including care, support, treatment or other related services or assistance provided through an arrangement, including a contractual arrangement).

The aim of these amendments is to enable broader information sharing among Commonwealth bodies in relation to the conduct of providers and workers in the care and support sector, including where there is concern regarding their conduct and the services being provided.

Paragraph (h) of the definition of a “receiving Commonwealth body” has been included to allow flexibility to include additional bodies as appropriate under the regulations.

Part 2–Application provisions

Item 19 – Application – disclosure or provision of information

Item 19 makes clear that the amendments made to the various Acts by Schedule 6 apply to authorise disclosures that occur on or after the commencement of the item, regardless of whether the disclosures involve information that was obtained before, on or after that commencement.

Schedule 7—Use of refundable deposits and accommodation bonds

Overview

Schedule 7 to the Bill amends the Aged Care Act to enable the Secretary or Commissioner to request information or documents from a provider or borrower of a loan made using a refundable deposit or accommodation bond. The amendments create an offence for a borrower who does not comply with a request. Further, the period of liability for the existing offences for the misuse of refundable deposits and prior to an insolvency event for both providers and key personnel of providers will be extended from 2 years to 5 years.

Schedule 7 also amends the Quality and Safety Commission Act to enable the Commissioner to issue an infringement notice for a borrower that commits an offence for failing to comply with a request under these amendments.

The reforms implemented under schedule 7 to the Bill will form part of the second phase of a three phased plan to implement a new financial and prudential monitoring, compliance and intervention framework for the aged care sector.

Schedule 7 to the Bill responds to Royal Commission Recommendation 134.

PART 1 — AMENDMENTS

Aged Care Act 1997

Item 1 – Section 9-3B (heading)

This item amends the heading of section 9-3B by inserting “or documents” after “information”. This is consequential to the amendment at Item 2, and reflects that the Secretary or Commissioner may request information or documents under section 9-3B(2).

Item 2 – Subsection 9-3B(2)

This item amends subsection 9-3B(2) by inserting “or documents” after “information”. The effect of this amendment is to clarify that the Secretary or Commissioner may request documents as well as information from an approved provider under subsection 9-3B(2).

The purpose of this amendment is to support continued oversight of the use of refundable accommodation deposits and bonds to make a loan, noting that such use may impact on an approved provider’s financial viability. It will also assist in monitoring compliance with the requirements relating to the permitted uses of refundable accommodation deposits and bonds in section 52N-1 of the Aged Care Act.

Item 3 – After paragraph 9-3B(2)(d)

This item inserts a new paragraph 9-3B(2)(da), which provides that the Secretary or Commissioner may request an approved provider to give information or documents relating to “the use of a refundable deposit or accommodation bond by the approved provider to make a loan”.

The purpose of this amendment is to clarify that information and documents may be requested relating to an approved provider's use of refundable deposit or accommodation bonds to make a loan.

The purpose of this amendment is to support continued oversight of the use of refundable accommodation deposits and bonds to make a loan, noting that such use may impact on an approved provider's financial viability. It will also assist in monitoring compliance with the requirements relating to the permitted uses of refundable accommodation deposits and bonds in section 52N-1 of the Aged Care Act.

Item 4 – After subsection 9-3B(2)

This item inserts a new subsection 9-3B(2A) that sets out some of the kinds of information or documents that may be specified in a request under subsection 9-3B(2), pursuant to paragraph 9-3B(2)(da). This subsection is intended to give examples of the kinds of information or documents that may be specified in a request under subsection 9-3B(2) but is not intended to limit the power under paragraph 9-3B(2)(da). The kinds of information or documents include, but are not limited to:

- a copy of the agreement relating to the loan that has been executed, or entered into, by the parties to the agreement
- the amount of the loan
- details of any security in respect of the loan
- details of the term or life of the loan
- details of the rate of interest payable on the loan
- evidence that the rate of interest payable on the loan has been set on a commercial basis
- details of the loan repayments (including the amounts and frequency of those repayments)
- details of any review of the loan that must or may be conducted
- details of any other conditions or terms of the loan
- details of the commercial basis of the loan
- evidence of the use of the money loaned
- a copy of the financial statements (however described) of the borrower (including any such statements that have been audited)
- any other information or documents relating to the loan.

The purpose of this amendment is to support continued oversight of the use of refundable accommodation deposits and bonds to make a loan, noting that such use may impact on an approved provider's financial viability. It will also assist in monitoring compliance with the requirements relating to the permitted uses of refundable accommodation deposits and bonds in section 52N-1 of the Aged Care Act.

Item 5–Subsection 9-3B(3), Item 6–paragraph 9-3B(4)(b), and Item 7–paragraph 9-3B(5)(a)

These items make consequential amendments to reflect that the Secretary or Commissioner may request information or documents under subsection 9-3B(2) (see item 2).

Item 8 – After subsection 9-3B(5A)

This item inserts a new subsection 9-3B(5B). Subsection 9-3B(5B) is designed to make it clear that the offence at subsection 9-3B(5) does not apply where the information or documents requested under subsection 9-3B(2) are not in the possession, custody or control of the approved provider. The effect of this provision is to enable the approved provider to avoid criminal liability by showing it does not have the information or documents specified in a request under subsection 9-3B(2).

A note to the subsection clarifies that the exception places an evidential burden on an approved provider in accordance with subsection 13.3(3) of the *Criminal Code*. This requires the defendant to raise evidence about the exception. An evidential burden is appropriate as the offence carries a relatively low penalty and the facts relating to the exception would be peculiarly within the defendant's knowledge and not available to the prosecution.

This item does not displace the privilege against self-incrimination nor is there any policy intent for it to do so. To displace this right an express policy provision would generally be required, and as such a provision has not been included.

Item 9 – At the end of section 9-3B

This item inserts two new subsections 9-3B(7) and 9-3B(8). The effect is to provide a compensation mechanism that will apply if this provision results in an acquisition of property (within the meaning of paragraph 51(xxxi) of the Constitution) from a person other than on just terms.

These subsections state that if the operation of section 9-3B would result in an acquisition of property otherwise than on just terms, the Commonwealth is liable to pay a reasonable amount of compensation. In the event that the Commonwealth and the person do not agree on the amount of compensation, the person may institute proceedings in the Federal Court of Australia or the Supreme Court of a State or Territory.

Item 10 – Subparagraph 52N-1(2)(c)(iv)

This item amends subparagraph 52N-1(2)(c)(iv) by omitting “paragraph (a) or (b)” and substituting “paragraph (a), (b), (d) or (e)”. The effect of this amendment is to specify that an approved provider may only loan a refundable deposit or accommodation bond if it is a condition of the loan agreement that money loaned will only be used for a permitted purpose as mentioned in paragraphs 52N-1(2)(a), (b), (d) or (e).

The use of a refundable deposit or accommodation bond to make a loan for which it is a condition of the agreement that the money loaned will only be used as mentioned in paragraphs 52N-1(2)(d) or (e) is permitted by paragraph 63(b)(iv) of the *Fees and Payments Principles (No.2)*. The effect of this amendment is to consolidate the permitted purposes specified in subparagraph 63(b)(iv) of *Fees and Payments Principles 2014 (No. 2)* and subparagraph 52N-1(c)(iv) of the Aged Care Act by specifying both of these permitted uses in the Aged Care Act. This will improve the clarity of the law. Paragraph 63(b) of the *Fees and Payments Principles (No. 2)* will be repealed to account for this amendment.

Item 11 – Paragraphs 52N-2(1)(d) and (2)(g)

This item amends paragraphs 52N-2(1)(d) and (2)(g) by omitting “2 years” and substituting “5 years”. The effect of these amendments is that a corporation may be guilty of an offence if the corporation uses a refundable accommodation deposit or accommodation bond for a non-permitted use, and within 5 years of that use there is an insolvency event in relation to the corporation in circumstances where there has been at least one outstanding accommodation payment balance. This item also makes an equivalent amendment to the offence for an individual at paragraph 52-N(2)(g).

These amendments will support compliance with and enforcement of legislative requirements in relation to permitted uses of refundable accommodation deposits and bonds, noting that:

- loans involving refundable deposits or accommodation bonds may impact on an approved provider’s financial viability a number of years after the loan occurs
- extending the period of liability creates a stronger disincentive against the use a refundable deposit or accommodation bond for a purpose that is not permitted
- through the *Aged Care (Accommodation Payment Security) Act 2006* the Commonwealth is liable to refund any refundable deposit or accommodation bond in the event that a provider cannot do so.

Item 12 – At the end of Division 52N

This item will enable the Secretary and Commissioner to request information or documents from a borrower where that information cannot be obtained from an approved provider. The item also includes an offence provision to support compliance with the requirements set out in this provision. This purpose of this item is to support the power to request information and documents from an approved provider under subsection 9-3B(2) (see Item 2) and provide the Secretary and Commissioner with greater oversight of the use of refundable accommodation deposits and bonds by an approved provider and a borrower.

This item inserts a new section 52N-3. Subsection 52N-3(1) provides that if:

- an approved provider has used an accommodation bond to make a loan to a person (the borrower); and
- the Secretary or Commissioner believes on reasonable grounds that the borrower has information relating to that use;

the Secretary or Commissioner may request information or documents from the borrower that are in the borrower’s possession, custody or control.

New subsection 52N-3(2) specifies some of the kinds of information or documents that may be specified in a request under subsection 52N-3(1).

New subsection 52N-3(3) enables a request for information or documents to be made on a periodic basis. This will enable the Secretary or Commissioner to be updated periodically on the status of a loan where appropriate. This provision is consistent with the equivalent provision under section 9- 3B(3).

New subsection 52N-3(4) provides that a request must be made in writing and must specify the period for complying with the request. The request must state that failure to comply with the request is an offence.

New subsection 52N-3(5) specifies the period in which a borrower must comply with the request. The default period is 28 days; however, a request may specify a shorter period or, if the request is on a periodic basis, the time or times before which the request must be complied with.

New subsection 52N-3(6) makes it a strict liability offence for a borrower not to comply with a request made under s 52N-3(1). It is appropriate that the prosecution does not need to prove fault for the elements of this offence, on the basis that the state of mind of the defendant is not relevant, the elements of the offence are objective, and the offence is minor and deterrent in nature. The borrower will also be placed on notice that failure to comply with a request is an offence of strict liability. Further, the fact that fault is not required to be proven is likely to significantly enhance the effectiveness of the enforcement regime in deterring failure to comply with requests and, more generally, deterring non-permitted uses of refundable deposits or accommodation bonds.

New subsections 52-3N(7) and (8) provide a compensation mechanism that will apply if this provision results in an acquisition of property (within the meaning of paragraph 51(xxxi) of the Constitution) from a person other than on just terms.

These subsections provide that if the operation of section 52N-3 would result in an acquisition of property otherwise than on just terms, the Commonwealth is liable to pay a reasonable amount of compensation. In the event that the Commonwealth and the person do not agree on the amount of compensation, the person may institute proceedings in the Federal Court of Australia or the Supreme Court of a State or Territory.

Item 13 – Clause 1 of Schedule 1

This item inserts definitions of *acquisition of property* and *just terms* to provide that these terms take their meaning from the Constitution. This has the effect of clarifying the meaning of terms used in Items 9 and 12.

Aged Care Quality and Safety Commission Act 2018

Item 14 – Paragraph 74EB(1)(d)

This item amends paragraph 74EB(1)(d) to enable the Commissioner to issue an infringement notice to a borrower for failing to comply with a request under new section 52N-3 of the Aged Care Act (see Item 12). This will reduce the administrative burden on the Government and the courts, as it will enable a penalty to be issued without a need to go to court.

Infringement notice provisions provide an alternative to prosecution for an offence or litigation of a civil matter. The infringement notice will give the person to whom the notice is issued the option to pay the fine specified in the notice in full, or elect to have the offence heard by a court. The option of issuing an infringement notice is

considered appropriate in relation to a failure to comply with a request under new section 52N-3 because it is a relatively minor offence, is an offence of strict liability and it is considered that the ability to impose a penalty quickly will act as a deterrent for borrowers and assist the Commissioner to enforce requests. This is consistent with the approach recommended in the *Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*.

This amendment is also consistent with the Commissioner's power to issue an infringement for failing to comply with a request under section 9-3B(2).

Part 2—Application provisions

Item 15 – Definitions

This item specifies that for Part 2, references to the 'Aged Care Act' 'mean the *Aged Care Act 1997*, and references to 'commencement day' mean 1 July 2022.

Item 16 – Application—approved provider may be requested to give information or documents

This item specifies that section 9-3B as amended by Part 1 of this Schedule, applies in relation to a use of a refundable deposit or accommodation bond that occurs before, on or after the commencement day. The effect of this provision is that the Secretary or Commissioner may request information or documents under subsection 9-3B(2) that relate to a use of a refundable deposit or accommodation bond that occurred before the commencement day. This is appropriate to support compliance with and enable effective monitoring of the regulatory scheme relating to refundable accommodation deposits and bonds, noting that:

- this will more effectively enable the Secretary or Commissioner to monitor compliance with legislative requirements prior to the commencement day; and
- the use of a refundable deposit or accommodation bond to make a loan may occur a number of years before an approved provider experiences viability issues, even in situations in which the loan causes the viability issue.

Item 17 – Application—offences relating to refundable deposits and accommodation bonds

This item specifies that the amendment made by Item 11 applies in relation to a use of a refundable deposit or accommodation bond that occurs on or after commencement day. This is to clarify that the extension of the period between a use of a deposit or bond and an insolvency event does not apply to uses that occurred before the commencement day.

Item 18 – Application—request to give information or documents

This item specifies that the amendment by Item 12 applies in relation to a use of a refundable deposit or accommodation bond that occurs before, on or after the commencement day. This purpose of this is to clarify that a request under 52N-3 may apply to loans made before, on or after the commencement day, even if the loan has lapsed or been repaid. This is appropriate to support compliance with and enable effective monitoring of the regulatory scheme relating to refundable accommodation deposits and bonds, noting that:

- this will more effectively enable the Secretary or Commissioner to monitor compliance with legislative requirements prior to the commencement day; and

- in many cases the use of a refundable deposit or accommodation bond to make a loan may occur a number of years before an approved provider experiences viability issues, even in situations in which the loan causes the viability issue.

Schedule 8 — Independent Health and Aged Care Pricing Authority

Overview

Schedule 8 to the Bill amends the *National Health Reform Act 2011* (National Health Reform Act) and the Aged Care Act to expand the functions of a renamed Independent Health and Aged Care Pricing Authority (Pricing Authority) to include the provision of advice on health care pricing and costing matters, provision of advice on aged care pricing and costing matters and the performance of certain functions conferred in the Aged Care Act. The amendments also establish new governance arrangements for the Pricing Authority. The new governance arrangements will reflect the enhanced responsibilities and integrated functions of the Pricing Authority.

Schedule 8 also amends the National Health Reform Act, the Aged Care Act and the Quality and Safety Commission Act to ensure appropriate use and disclosure of information required for the Pricing Authority to perform its new functions.

Schedule 8 to the Bill responds to Recommendations 6, 11, 115 and 139 of the Final Report.

Schedule 8 to the Bill amends the National Health Reform Act and the Aged Care Act to expand the functions of the Pricing Authority to include the provision of advice on health pricing and costing matters, the provision of advice on aged care pricing and costing matters and the performance of functions conferred in it under the Aged Care Act, and to establish new governance arrangements.

Schedule 8 also amends the National Health Reform Act, the Aged Care Act and the Quality and Safety Commission Act to ensure appropriate use and disclosure of information required for the Pricing Authority to perform its new functions.

The new health care pricing and costing functions are:

- if the Minister with responsibility for the National Health Reform Act or the Secretary of the Department of Health and Aged Care requests, in writing, the Pricing Authority to do so—to advise the Commonwealth in relation to one or more health care pricing or costing matters (whether or not the matters relate to health care services provided by public hospitals);
- to conduct, or arrange for the conduct of, costing and other studies for the purpose of performing the above function, or if the Minister or the Secretary requests, in writing, the Pricing Authority to conduct such studies;
- to publish (whether on the internet or otherwise) reports and papers relating to the above functions;
- to do anything incidental to or conducive to the performance of any of the above functions.

The existing Clinical Advisory Committee and Jurisdictional Advisory Committee may assist the Pricing Authority to perform its health care pricing and costing advice functions. The Pricing Authority may create other committees, for example technical working groups, to assist it in relation to the performance of its health pricing and costing advice functions.

To support the new health care pricing and costing advice function, the existing Deputy Chair of the Pricing Authority will be renamed Deputy Chair (Hospital Pricing). The current Deputy Chair will continue in their role as the Deputy Chair (Hospital Pricing) for the balance of their term.

The amendments in relation to the Pricing Authority's aged care pricing and costing advice functions and to functions conferred on it by the Aged Care Act respond to Recommendations 6, 11, 115, 128 and 139 of the Royal Commission's Final Report.

The Pricing Authority's new aged care pricing and costing advice functions and functions conferred on it under the Aged Care Act are:

- to provide advice to each relevant Commonwealth Minister (that is, the Minister administering the National Health Reform Act and, if different, the Minister administering the Aged Care Act) in relation to one or more aged care pricing or costing matters, including in relation to methods for calculating amounts of subsidies (including but not limited to basic subsidy, primary supplements and other supplements) to be paid under the Aged Care Act or the Transitional Act;
- such functions relating to aged care pricing (if any) as are specified in regulations;
- to conduct, or arrange for the conduct of, the collection and review of data, costing and other studies, and consultation for the purpose of performing an aged care pricing function or related function;
- to perform such functions ("Aged Care Act functions") as are conferred on the Pricing Authority by the Aged Care Act or a legislative instrument made under the Aged Care Act, or otherwise specified in regulations. Amendments to the Aged Care Act made by the Bill will confer those functions currently performed by the Aged Care Pricing Commissioner on the Pricing Authority;
- to do anything incidental to or conducive to the performance of the above functions.

To support the new aged care pricing and costing advice functions, a new position of Deputy Chair (Aged Care Pricing) of the Pricing Authority will be created. The total number of members on the Pricing Authority will remain unchanged at nine, by reducing the number of ordinary members from seven to six.

To support the Pricing Authority to perform the new aged care pricing and costing advice functions, a new Aged Care Advisory Committee will be established, chaired by the new Deputy Chair (Aged Care Pricing) of the Pricing Authority. The Aged Care Advisory Committee will include one other member who is a member of the Pricing Authority and five other members with relevant experience and expertise.

The Aged Care Advisory Committee may create subcommittees to assist it to perform its aged care pricing advice functions. Consistent with existing legislation, the Pricing

Authority may also create other committees, for example technical working groups, to assist the Pricing Authority in relation to performance of its aged care pricing and costing advice functions.

To enable the Pricing Authority's performance of its aged care pricing and costing advice functions, the amendments introduce two new responsibilities for approved providers to allow people carrying out the Pricing Authority's aged care pricing and costing advice functions access (with prior notice) to aged care services and to provide assistance to those persons. Additional details in relation to those new responsibilities will be specified in the Accountability Principles.

To enable the Pricing Authority's performance of its aged care pricing and costing advice functions and Aged Care Act functions, the Secretary of the Department of Health and Aged Care and the Commissioner may provide the Pricing Authority with protected information, in particular information relating to the affairs of approved providers of aged care, subject to the secrecy regimes in the Aged Care Act and the Quality and Safety Commission Act.

To enable performance of their respective functions, the Pricing Authority may also provide the Secretary of the Department of Health and Aged Care and the Commissioner with protected information about the performance of the Pricing Authority's Aged Care Act functions, in particular information relating to the affairs of approved providers of aged care, subject to the secrecy regime in the Aged Care Act.

Part 1—Amendment of the National Health Reform Act 2011

Item 1 – Paragraph 3(c)

This item amends section 3 of the National Health Reform Act, which sets out the objects of the Act, so that the reference to the Independent Hospital Pricing Authority in paragraph 3(c) is changed to a reference to the Independent Health and Aged Care Pricing Authority. The new name reflects the new scope of the body.

Item 2 – Section 4

Section 4 of the National Health Reform Act provides a simplified outline for the Act. This item amends section 4 to provide for references to the Independent Hospital Pricing Authority throughout the section to be changed to references to the Independent Health and Aged Care Pricing Authority. The new name reflects the new scope of the body.

Item 3 – Section 4 and Item 4 – Section 4

These items amend the simplified outline in section 4 to reflect that certain functions of the Pricing Authority are only in relation to public hospitals and health care pricing and costing, namely:

- to determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis;
- to determine the efficient cost for health care services provided by public hospitals where the services are block funded;

- to publish the efficient cost and national efficient price, and other information, for the purpose of informing decision makers in relation to the funding of public hospitals;
- if requested by the Minister or the Secretary, to advise the Commonwealth in relation to certain health care pricing and costing matters.

Item 5 – Section 4

This item amends section 4 to provide that certain functions of the Pricing Authority are only in relation to aged care, namely:

- to provide advice about certain aged care pricing and costing matters to each relevant Commonwealth Minister;
- to perform such functions as are conferred on the Pricing Authority by the Aged Care Act.

Item 6 – Section 5, Item 7 – Section 5 (paragraph (b) of the definition of *member of the Pricing Authority*), Item 8 – Section 5 (definition of *Pricing Authority*), Item 9 – Section 5 (at the end of the definition of *protected Pricing Authority information*) and Item 10 – Section 5

These items amend existing, or insert new, defined terms in section 5 of the National Health Reform Act.

Item 6 inserts the following new definitions:

- ***Aged Care Act*** means the *Aged Care Act 1997*.
- ***Aged Care Act function*** has the meaning given by paragraph 131A(1)(e), being a function conferred on the Pricing Authority by the Aged Care Act, a legislative instrument made under that Act, specified in regulations made for the purposes of new subparagraph 131A(1)(e)(ii) or a function incidental or conducive to such functions.
- ***aged care information*** means information (including *protected information* within the meaning of the Aged Care Act) obtained in the course of:
 - the performance of the following functions, or the exercising of powers for or in connection with the performance of the following functions:
 - a function of the Pricing Authority mentioned in subsection 131A(1) (other than an Aged Care Act function of the Pricing Authority);
 - a function of the Aged Care Advisory Committee (other than a function that relates to an Aged Care Act function of the Pricing Authority);
 - a function of a subcommittee established under section 204V to advise or assist the Aged Care Advisory Committee in the performance of a function of the Aged Care Advisory Committee;
 - a function of a committee established under section 205 to advise or assist the Pricing Authority in the performance of a function of the Pricing Authority mentioned in subsection 131A(1) (other than an Aged Care Act function of the Pricing Authority);

- assisting, under section 204Y, or section 207, in the performance of a function mentioned above in this definition.

This definition excludes from aged care information any information obtained in performing an Aged Care Act function. Together with the exclusion of protected information within the meaning of the Aged Care from being protected Pricing Authority information, Part 4.14 of the National Health Reform Act, which deals with secrecy of information obtained by officials of the Pricing Authority, does not apply to information obtained in performing an Aged Care Act function. Accordingly, information obtained in performing an Aged Care Act function is only subject to the Aged Care Act secrecy regime, as specified in Division 86 of the Aged Care Act. This is appropriate as an Aged Care Act function relates to the operation of the Aged Care Act.

Protected information within the meaning of the Aged Care Act means information that was acquired under or for the purposes of the Aged Care Act or the Transitional Provisions Act, and either is personal information within the meaning of the *Privacy Act 1988* or relates to the affairs of an approved provider within the meaning of the Aged Care Act, or relates to the affairs of an applicant for a grant under the Aged Care Act.

- ***health care pricing and costing information*** means information obtained in the course of:
 - the performance of the following functions, or the exercising of powers for or in connection with the performance of the following functions:
 - a function of the Pricing Authority mentioned in subsection 131(1A);
 - a function of the Clinical Advisory Committee mentioned in paragraph 177(ba);
 - a function of a subcommittee established under section 191 to advise or assist the Clinical Advisory Committee in the performance of a function of the Clinical Advisory Committee mentioned in paragraph 177(ba);
 - a function of the Jurisdictional Advisory Committee mentioned in subparagraph 196(1)(a)(va);
 - a function of a committee established under section 205 to advise or assist the Pricing Authority in the performance of a function of the Pricing Authority mentioned in subsection 131(1A);
 - assisting, under section 194, 204 or 207, in the performance of a function mentioned in paragraph (a) of this definition.
- ***Aged Care Minister*** means the Minister administering the Aged Care Act.
- ***member of the Aged Care Advisory Committee*** means a member of the new Aged Care Advisory Committee created by Part 4.11A of the National Health Reform Act. This includes the Chair of the Committee, who must also be the Deputy Chair (Aged Care Pricing) of the Pricing Authority, and six other members.

Item 7 amends the definition of ***member of the Pricing Authority*** as a consequence of the creation of the positions of Deputy Chair (Aged Care Pricing) and Deputy Chair

(Hospital Pricing). It has the effect that both Deputy Chairs are members of the Pricing Authority.

Item 8 amends the definition of **Pricing Authority** as a consequence of the renaming of the Independent Hospital Pricing Authority as the Independent Health and Aged Care Pricing Authority.

Item 9 amends the definition of **protected Pricing Authority information** so that it means information that:

- was obtained by a person in the person's capacity as an official of the Pricing Authority; and
- relates to the affairs of a person other than an official of the Pricing Authority; and
- does not include protected information (within the meaning of the Aged Care Act) that is not aged care information (within the meaning of the National Health Reform Act).

The exclusion of protected information that is not aged care information ensures that a provision in Part 4.14 of the National Health Reform Act that applies to protected Pricing Authority information does not apply to information that:

- was obtained by an official of the Pricing Authority in performing the Pricing Authority's Aged Care Act functions; and
- is protected information under the Aged Care Act.

The effect is to exclude protected information under the Aged Care Act obtained in the performance of Pricing Authority's Aged Care Act functions from the National Health Reform Act's secrecy provisions, so that it will only be subject to the Aged Care Act secrecy provisions, as specified in Division 86 of the Aged Care Act. This is appropriate as an Aged Care Act function relates to the operation of the Aged Care Act.

Item 10 inserts the following new definition:

- **relevant Commonwealth Minister** means the Minister with responsibility for the National Health Reform Act and, if that Minister is not also the Aged Care Minister, the Aged Care Minister.

Item 11 – Subsection 6(3)

This item amends subsection 6(3), which deals with vacancies on the Pricing Authority, as a consequence of reducing from seven to six the number of offices of members of the Pricing Authority that are in addition to the Chair and the two Deputy Chairs. The effect is to refer to the six offices of members, in addition to the Chair and the two Deputy Chairs.

Item 12 – Subsection 6(3)

This item amends subsection 6(3), which deals with vacancies on the Pricing Authority, as a consequence of the establishment of the new position of Deputy Chair (Aged Care Pricing) and the renaming of the existing position of Deputy Chair as Deputy Chair (Hospital Pricing). The effect is to refer to the two Deputy Chairs.

Item 13 – Chapter 4 (heading)

This item amends the title of Chapter 4 of the National Health Reform Act to refer to the renamed Independent Health and Aged Care Pricing Authority. The new name reflects the new scope of the body.

Item 14 – Section 128

This item amends section 128 of the National Health Reform Act, which provides for a simplified outline to Chapter 4 of the Act. The amendment provides for two references to the Independent Hospital Pricing Authority to be changed to a reference to the Independent Health and Aged Care Pricing Authority. The new name reflects the new scope of the body.

Item 15 – Section 128, Item 16 – Section 128

Section 128 provides a simplified outline to Chapter 4 of the National Health Reform Act. These items amend section 128 to provide that certain functions of the Pricing Authority are only in relation to public hospitals and health care pricing and costing, namely:

- to determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis;
- to determine the efficient cost for health care services provided by public hospitals where the services are block funded;
- to publish this, and other information, for the purpose of informing decision makers in relation to the funding of public hospitals;
- if requested by the Minister or the Secretary, to advise the Commonwealth in relation to certain health care pricing and costing matters.

Item 17 – Section 128

Item 17 amends section 128 to provide that certain functions of the Pricing Authority are only in relation to aged care, namely:

- to provide advice about certain aged care pricing and costing matters to each relevant Commonwealth Minister;
- to perform such functions as are conferred on the Pricing Authority by the Aged Care Act.

Item 17 also amends section 128 to provide that Chapter 4 sets up three committees to assist the Pricing Authority:

- the Clinical Advisory Committee (which already exists);
- the Jurisdictional Advisory Committee (which already exists);
- the Aged Care Advisory Committee (which is new) (see item 55).

Item 18 – Section 129 (heading)

This item amends the heading of section 129 to refer to the Pricing Authority by its new title, the Independent Health and Aged Care Pricing Authority. The new name reflects the new scope of the body.

Item 19 – Subsection 129(1)

This item repeals the existing subsection 129(1) and substitutes a new subsection 129(1) to make clear that the body formerly known as the Independent Hospital Pricing Authority is continued in existence with the new name of the Independent

Health and Aged Care Pricing Authority. The new name reflects the new scope of the body.

Item 20 – At the end of section 129

This item inserts a new subsection 129(3) which provides that in establishing the (renamed) Pricing Authority, the Parliament also intends that the body perform new functions relating to health care pricing and costing matters, and aged care matters. This reflects the expanded scope of the Pricing Authority’s functions, as section 129 currently only reflects its functions in relation to giving advice relevant for public hospital funding.

Item 21 – Section 130 and Item 22 – At the end of section 130

Section 130 of the Act deals with the objects of the Pricing Authority. These items amend section 130 to renumber the existing text as new subsection 130(1) and to insert a new subsection 130(2). The effect is to specify new objects of the Pricing Authority, to:

- on request, give independent advice to the Commonwealth in relation to health care pricing and costing matters; and
- give independent advice to the Commonwealth in relation to aged care pricing and costing matters; and
- perform other functions conferred on the Pricing Authority by the Aged Care Act or legislative instruments made under that Act.

Item 23 – Section 131 (at the end of the heading)

This item amends the heading of section 131 to limit the application of the section to the Pricing Authority’s public hospitals and health care pricing and costing functions.

Item 24 – After subsection 131(1)

This item inserts a new subsection 131(1A) which provides that the Pricing Authority’s functions also include, in addition to its public hospitals function specified in subsection 131(1):

- if the Minister or the Secretary requests, in writing, the Pricing Authority to do so—to advise the Commonwealth in relation to one or more health care pricing or costing matters (whether or not the matters relate to health care services provided by public hospitals);
- to conduct, or arrange for the conduct of, costing and other studies for the purpose of performing the function mentioned above or if the Minister or the Secretary requests, in writing, the Pricing Authority to do so;
- to publish (whether on the internet or otherwise) reports and papers relating to the functions mentioned above;
- to do anything incidental to or conducive to the performance of any of the above functions.

For example, this item enables the Pricing Authority to play a role in reforms to the Prostheses List, which are aimed at reducing the cost of private health insurance for the Australian public.

Item 25 – Subsection 131(3)

Subsection 131(3) provides certain matters to which the Pricing Authority must have regard in performing its functions. This item amends subsection 131(3) to provide that

the matters it lists only relate to the Pricing Authority's performance of its public hospitals function specified in subsection 131(1).

The matters set out in subsection 131(3) that the Pricing Authority must have regard to include the effectiveness, efficiency and financial stability of the public hospital system and the range of public hospitals and variables affecting the cost of providing care in each of those hospitals. It is not appropriate that the Pricing Authority would need to have regard to these matters when formulating advice about broader health care pricing and costing, particularly where such care is provided outside the public hospital system.

Item 26 – At the end of section 131

This item inserts a new subsection 131(4) that provides that a request to the Pricing Authority under paragraph 131(1A)(a), being to provide certain health care pricing or costing advice to the Commonwealth, or under subparagraph 131(1A)(b)(ii), being to conduct certain costing or other studies, is not a legislative instrument.

This provision is included to assist readers. The written request would not be a legislative instrument for the purposes of the Legislation Act, because Item 22 of the table in subsection 6(1) of the *Legislation (Exemptions and Other Matters) Regulation 2015* excludes requests and invitations from being legislative instruments.

Item 27 – after section 131

This item inserts a new section 131A to provide new aged care related functions for the Pricing Authority. The new functions are:

- to provide advice to each relevant Commonwealth Minister in relation to one or more aged care pricing or costing matters, including in relation to methods for calculating amounts of subsidies to be paid under the Aged Care Act or under the Transitional Act;
- such functions relating to aged care (if any) as are specified in regulations;
- to conduct, or arrange for the conduct of, the collection and review of data, costing and other studies and consultations for the purpose of performing a function mentioned above;
- to do anything incidental to or conducive to the performance of the above functions;
- such functions (an Aged Care Act function) as are:
 - conferred on the Pricing Authority by the Aged Care Act, or by a legislative instrument made under that Act; or
 - specified in regulations made for the purpose of subparagraph 131A(1)(e)(ii); or
 - incidental or conducive to the performance of these functions.

In performing all these functions, the Pricing Authority must have regard to the objects of the Aged Care Act and the Transitional Act.

Item 28 – Before subsection 132(1)

Section 132 currently requires the Pricing Authority to take any relevant Intergovernmental Agreements into account in performing its functions. This item inserts a new subsection 132(1A) to provide that section 132 applies only to the

existing hospital functions of the Pricing Authority mentioned in subsection 131(1), that is its functions relating to funding for public hospital services.

Section 132 is not relevant to broader health care pricing and costing functions, as this clause was originally introduced to ensure that the Pricing Authority would perform its public hospital pricing functions in accordance with agreements made between the Commonwealth and the States and Territories, which share funding responsibility for public hospital services.

Section 132 is not relevant to broader aged care functions, as Schedule F of the National Health Reform Agreement specifies that the Commonwealth has taken full funding, policy, management and delivery responsibility for a consistent and unified aged care system covering basic home care through to residential care.

Item 29 – Before subsection 133(1)

Section 133 enables COAG to give policy principles to the Pricing Authority. This item inserts a new subsection 133(1A) to provide that section 133 applies only to the existing public hospital functions of the Pricing Authority mentioned in subsection 131(1).

Section 133 is not relevant to broader health care pricing and costing functions, as this clause was originally introduced to ensure that the Pricing Authority would perform its public hospital pricing functions in accordance with agreements made between the Commonwealth and the States and Territories, which share funding responsibility for public hospital services.

Section 133 is not relevant to aged care functions, as Schedule F of the National Health Reform Agreement specifies that the Commonwealth has taken full funding, policy, management and delivery responsibility for a consistent and unified aged care system covering basic home care through to residential care.

Item 30 – Section 134

This item repeals and replaces the existing section, which deals with the constitutional limits on the Pricing Authority's performance of its functions.

With the expansion of the Pricing Authority's functions, reference has been added to also allow it to undertake its functions with respect to insurance to which paragraph 51(xiv) of the Constitution applies. The Pricing Authority can already undertake its functions with respect to a variety of matters including, but not limited to, the provision of pharmaceutical, sickness or hospital benefits or the provision of medical or dental services, with respect to corporations to which paragraph 51(xx) of the Constitution applies and with respect to the grants of financial assistance to the States.

This item otherwise makes non-substantive amendments to update the section for modern drafting standards.

New subsection 134(2) provides that a term used in section 134 and in the Constitution has the same meaning in the section as it has in the Constitution.

Item 31 – Paragraph 143(b)

This item repeals paragraph 143(b), which deals with membership of the Pricing Authority, and substitutes new paragraph 143(b), which renames the existing position of Deputy Chair as Deputy Chair (Hospital Pricing), and new paragraph 143(ba), to establish the new position of Deputy Chair (Aged Care Pricing). This new position will ensure that the Pricing Authority has the expertise and experience to deal effectively with its new aged care powers and functions.

Item 32 – Paragraph 143(c)

This item amends paragraph 143(c), which deals with membership of the Pricing Authority, to provide that the Pricing Authority has six members other than the Chair and the two Deputy Chairs. The effect, taken with Item 31, is to maintain the total number of members of the Pricing Authority at nine members.

Item 33 – Section 143 (note)

This item amends the note to section 143, which deals with membership of the Pricing Authority, as a consequence of the establishment of the new position of Deputy Chair (Aged Care Pricing) and the renaming of the existing position of Deputy Chair as Deputy Chair (Hospital Pricing). The effect is to refer to each Deputy Chair.

Item 34 – Subsection 144(2), Item 35 – Subsection 144(3), Item 36 – After subsection 144(3)

Section 144 provides for appointment of members of the Pricing Authority.

These items amend the subsections which dealt with the appointment of the Deputy Chair of the Pricing Authority and members of the Pricing Authority (other than the Chair and or the Deputy Chair).

The effect of the amendments is to reflect in appointments arrangements that the positions of a Deputy Chair (Hospital Pricing) and a Deputy Chair (Aged Care Pricing) will replace a Deputy Chair position (see Item 31). The Deputy Chair (Hospital Pricing) is to be appointed with the agreement of the Premiers of the States, and the Australian Capital Territory, and the Northern Territory. The Deputy Chair (Aged Care Pricing) is to be appointed by the Minister. Other appointment arrangements will remain unchanged.

These items also prescribe the required experience of the Deputy Chair (Hospital Pricing), the Deputy Chair (Aged Care Pricing), and other members of the Pricing Authority as follows:

- The Minister must ensure that the Deputy Chair (Hospital Pricing) and at least one other member of the Pricing Authority has substantial experience or knowledge; and significant standing in either or both of the following fields: public hospital strategic leadership or operational management; or public hospital pricing and costing.
- The Minister must ensure that the Deputy Chair (Aged Care Pricing) and at least one other member of the Pricing Authority has substantial experience or knowledge; and significant standing; in either or both of the following fields: aged care strategic leadership or operational management; or aged care pricing and costing.

The new provisions for qualification of members are appropriate to ensure that the Pricing Authority has the right mix of knowledge and experience to perform its expanded functions.

Item 37 – Subsection 146(2) (heading) and Item 38 – Subsection 146(2)

These items amend the heading and text of subsection 146(2), which deals with acting members of the Pricing Authority, as a consequence of the establishment of the new position of Deputy Chair (Aged Care Pricing) and the renaming of the existing position of Deputy Chair as Deputy Chair (Hospital Pricing). The effect is to limit the subsection to dealing with the Deputy Chair (Hospital Pricing). No substantive change to the appointment process has been made.

Item 39 – After subsection 146(2)

This item inserts a new heading, Acting Deputy Chair (Aged Care Pricing) of the Pricing Authority, and a new subsection 146(2A) which provides that the Minister may appoint a person to act as the Deputy Chair (Aged Care Pricing) of the Pricing Authority during a vacancy in the office of the substantive Deputy Chair (Aged Care Pricing) of the Pricing Authority (whether or not an appointment has previously been made to the office), or during any period, or during all periods, when the Deputy Chair (Aged Care Pricing) of the Pricing Authority is absent from duty or Australia, or is, for any reason, unable to perform the duties of the office.

These arrangements for appointing an acting Deputy Chair (Aged Care Pricing) reflect those to appoint an acting Deputy Chair (Hospital Pricing) of the Pricing Authority.

Item 40 – Subsection 146(3) (heading) and Item 41 – Subsection 146(3)

These items amend the heading and text of subsection 146(3), which deals with acting members of the Pricing Authority (other than in the position of Chair or a Deputy Chair of the Pricing Authority), as a consequence of the establishment of the new position of Deputy Chair (Aged Care Pricing) and the renaming of the existing position of Deputy Chair as Deputy Chair (Hospital Pricing). The effect is to refer to each Deputy Chair.

Item 42 – Subsection 146(4)

This item amends subsection 146(4), which provides that appointments of acting members of the Pricing Authority are to be made by written instrument, to also refer to new subsection 146(2A), which deals with appointment of an acting Deputy Chair (Aged Care Pricing).

Item 43 – Subsection 152(1), Item 44 – Subsection 152(2) and Item 45 – Subsection 152(3)

Section 152 deals with termination of appointment of members of the Pricing Authority.

Item 43 amends subsection 152(1) to provide that the Minister may at any time terminate the appointment of the Chair of the Pricing Authority and of the new Deputy Chair (Aged Care Pricing). The Minister may currently terminate the appointment of the Chair of the Pricing Authority at any time. It is appropriate for

this to also apply to the Deputy Chair (Aged Care Pricing) as, under section 146 of the Act, the Minister may appoint both positions without consultation with others.

Item 44 amends subsection 152(2) to amend references to the Deputy Chair to references to the Deputy Chair (Hospital Pricing), as a consequence of the renaming of the existing position of Deputy Chair as Deputy Chair (Hospital Pricing).

Item 45 amends subsection 152(3) to amend references to the Deputy Chair to references to a Deputy Chair, as a consequence of the establishment of the new position of Deputy Chair (Aged Care Pricing) and the renaming of the existing position of Deputy Chair as Deputy Chair (Hospital Pricing). The effect is to refer to each Deputy Chair.

Item 46 – Subsection 155(2) and Item 47 – After subsection 155(2)

These items amend subsection 155(2), which deals with presiding at meetings of the Pricing Authority, and insert a new subsection 155(2A) as a consequence of the establishment of the new position of Deputy Chair (Aged Care Pricing) and the renaming of the existing position of Deputy Chair as Deputy Chair (Hospital Pricing).

The effect is to specify that if the Chair of the Pricing Authority is not present at a meeting and the Deputy Chair (Hospital Pricing) is present at the meeting, then the Deputy Chair (Hospital Pricing) is to preside. If neither the Chair of the Pricing Authority nor the Deputy Chair (Hospital Pricing) of the Pricing Authority is present at a meeting, and if the Deputy Chair (Aged Care Pricing) of the Pricing Authority is present at the meeting, then the Deputy Chair (Aged Care Pricing) of the Pricing Authority is to preside.

Item 48 – Subsection 155(3)

This item amends subsection 155(3), which deals with presiding at meetings of the Pricing Authority, as a consequence of the establishment of the new position of Deputy Chair (Aged Care Pricing) and the renaming of the existing position of Deputy Chair as Deputy Chair (Hospital Pricing). The effect is to refer to each Deputy Chair.

The effect is that if neither the Chair, nor any Deputy Chair, of the Pricing Authority is present at a meeting, the members of the Pricing Authority present must appoint one of themselves to preside.

Item 49 – Subsection 157(2)

This item amends section 157, which deals with voting at meetings of the Pricing Authority, to provide that the person presiding at a meeting has both a deliberative vote and, if votes are equal, a casting vote.

Item 50 – Subsection 161(1) and Item 51 – Subsections 161(2) and (3)

Section 161 deals with delegation by the Pricing Authority.

Item 50 amends subsection 161(1) to clarify that subsection 161(1) operates subject to the operation of subsections 161(3) and (4).

Item 51 repeals the existing subsections 161(2) and (3), substitutes new subsections 161(2) and (3), and inserts new subsections 161(4) and (5) as a consequence of the

Pricing Authority having new functions for which delegation rules are required. The effect is to limit to whom the Pricing Authority can delegate certain functions.

New subsection 161(2) provides that, subject to limitations in subsection 161(4), the Pricing Authority may in writing delegate a function to an officer or employee mentioned in paragraph 174(a) or (b) who is an SES employee or acting SES employee and whose services are made available to the Pricing Authority in connection with the performance of a function of the Pricing Authority.

New subsection 161(3) provides that the Pricing Authority must not delegate an Aged Care Act function to a member of the Pricing Authority.

New subsection 161(4) provides that the Pricing Authority must not delegate any of the following functions or powers:

- a function set out in any of paragraphs 131(1)(a) to (f) or paragraph 131(1)(j);
- a function set out in paragraph 131(1A)(a);
- a function set out in paragraph 131A(1)(a);
- any other function that involves giving advice to the Minister;
- a function or power under Part 4.8;
- the power to make, vary or revoke a legislative instrument.

The functions set out in paragraphs 131(1)(a) to (f) and (j) are to:

- to determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis;
- to determine the efficient cost for health care services provided by public hospitals where the services are block funded;
- to develop and specify classification systems for health care and other services provided by public hospitals;
- to determine adjustments to the national efficient price to reflect legitimate and unavoidable variations in the costs of delivering health care services;
- to determine data requirements and data standards to apply in relation to data to be provided by States and Territories, including:
 - data and coding standards to support uniform provision of data; and
 - requirements and standards relating to patient demographic characteristics and other information relevant to classifying, costing and paying for public hospital functions;
- except where otherwise agreed between the Commonwealth and a State or Territory—to determine the public hospital functions that are to be funded in the State or Territory by the Commonwealth;
- such functions as are conferred on the Pricing Authority by Part 4.3 of this Act (cost-shifting disputes and cross-border disputes).

A function set out in paragraph 131(1A)(a) deals with providing health care pricing and costing advice. A function set out in paragraph 131A(1)(a) deals with providing aged care pricing and costing advice. A function or power under Part 4.8 deals with matters relating to the Chief Executive Officer of the Pricing Authority.

New subsection 161(5) provides that in performing a delegated function or exercising a delegated power, the delegate must comply with any written directions of the Pricing Authority. This reflects previous subsection 161(2).

Item 52 – Subparagraph 177(b)(i)

Section 177 deals with the functions of the Clinical Advisory Committee, an existing committee that may provide advice to the Pricing Authority. This item inserts “mentioned in subsection 131(1)” in subparagraph 177(b)(i). The effect is to limit the Clinical Advisory Committee’s function under paragraph 177(b) to providing advice to the Pricing Authority on matters that are referred to it by the Pricing Authority and which relate to the Pricing Authority’s existing public hospital functions mentioned in subsection 131(1).

Item 53 – After subparagraph 177(b)

This item inserts a new subparagraph 177(ba) conferring an additional function on the Clinical Advisory Committee. The effect of this subparagraph is that the Clinical Advisory Committee also has the function of advising the Pricing Authority in relation to matters that relate to the health care pricing and costing functions of the Pricing Authority mentioned in subsection 131(1A).

Together, Items 52 and 53 provide that the functions of the Clinical Advisory Committee include advising on matters that relate to the Pricing Authority’s public hospital functions in subsection 131(1) and its health care pricing and costing functions in subsection 131(1A), but not its aged care pricing functions in section 131A. In the case of aged care pricing, the Aged Care Advisory Committee will provide expert advice to the Pricing Authority.

Item 54 – After subparagraph 196(1)(a)(v)

Section 196 deals with the functions of the Jurisdictional Advisory Committee, an existing committee that may provide advice to the Pricing Authority. This item inserts a new subparagraph 196(1)(a)(va) to provide that a function of the Jurisdictional Advisory Committee is to advise the Pricing Authority in relation to matters that relate to the health care pricing and costing functions of the Pricing Authority mentioned in subsection 131(1A). This reflects the expanded functions of the Pricing Authority and the expertise of the Jurisdictional Advisory Committee.

Item 55 – After Part 4.11

This item inserts a new Part 4.11A—Aged Care Advisory Committee that includes Divisions relating to a new Advisory Committee of the Pricing Authority.

Division 1—Establishment and functions of the Aged Care Advisory Committee

Section 204A establishes the Aged Care Advisory Committee.

Section 204B provides that the functions of the Aged Care Advisory Committee are:

- to advise the Pricing Authority in relation to the Pricing Authority’s function under in paragraph 131A(1)(a) (paragraph 204B(a));
- to advise the Pricing Authority in relation to matters that relate to the Pricing Authority’s functions under paragraph 131A(1)(b) or (c) that are referred to the Committee by the Pricing Authority (paragraph 204B(b));

- to do anything incidental to or conducive to the performance of the above functions (paragraph 204B(c)).

This provision will allow the Pricing Authority to capitalise on the experience of the Aged Care Advisory Committee to advise on matters that relate to the Pricing Authority's aged care functions, excluding its Aged Care Act functions. The Aged Care Advisory Committee does not need to have any functions in relation to the Pricing Authority's Aged Care Act functions, as the Aged Care Act functions do not involve the giving of advice.

Division 2—Membership of the Aged Care Advisory Committee

Section 204C provides that the membership of the Aged Care Advisory Committee consists of:

- a Chair, who must be the Deputy Chair (Aged Care Pricing) of the Pricing Authority; and
- six other members appointed by the Minister, one of whom must be a member of the Pricing Authority (other than the Chair or the Deputy Chair (Hospital Pricing)).

Section 204D provides that the Minister is to appoint the members of the Aged Care Advisory Committee, other than the member who is the Deputy Chair (Aged Care Pricing) of the Pricing Authority, by written instrument. A note to subsection 204D(1) indicates that a member of the Committee may be reappointed in accordance with section 33AA of the *Acts Interpretation Act 1901*.

Section 204D also provides certain conditions for members of the Aged Care Advisory Committee, other than the Deputy Chair (Aged Care Pricing), being that the member:

- holds office on a part-time basis; and
- holds office for the period specified in the instrument of appointment, which must not exceed five years.

Section 204E provides that the Minister may, by written instrument, appoint a person to act as a member of the Aged Care Advisory Committee, other than the Chair, in the following circumstances:

- when there is a vacancy in the office of a member other than the Chair, whether or not a person has previously been appointed to the office; or
- during any or all periods when a member of the Aged Care Advisory Committee, other than the Chair, is absent from duty or from Australia, or is otherwise unable to perform the duties of the office.

A note to section 204E indicates that rules in sections 33A and 33AB of the *Acts Interpretation Act 1901* apply to acting appointments.

Section 204F provides that remuneration of members of the Aged Care Advisory Committee is determined by the Remuneration Tribunal, or in the absence of such a determination the amount prescribed by regulation. Members' allowances are as prescribed by regulation. Subsection 204F(3) provides that section 204F has effect subject to the *Remuneration Tribunal Act 1973*.

Section 204G provides that a member of the Aged Care Advisory Committee must give written notice to the Minister and the Pricing Authority of all interests, pecuniary or otherwise, that conflict or could conflict with the proper performance of the member's function. Members of the Aged Care Advisory Committee who are also members of the Pricing Authority must still give this written notice, as the functions of the Committee are not coterminous with the functions of the Pricing Authority.

Section 204H provides that a member of the Aged Care Advisory Committee must disclose to meetings of the Committee any interest, pecuniary or otherwise, in a matter being or about to be considered by that body (the relevant matter). This disclosure must be made as soon as possible after the member becomes aware of the relevant facts and must be recorded in the minutes of that meeting.

The member must not be present during deliberation on the relevant matter or take part in a decision on it, unless the Aged Care Advisory Committee determines otherwise. The member must not be present during any deliberation of the Committee for the purpose of determining whether the member can take part in a decision on the relevant matter and must not take part in making that determination. A determination by the Committee of whether the member can be present during, or take part in, any deliberations on the relevant matter must be recorded in the minutes of the meeting.

Section 204J provides for leave of absence arrangements for members of the Aged Care Advisory Committee. The section provides that the Chair of the Aged Care Advisory Committee may grant leave of absence to another Committee member on the terms and conditions that the Chair determines.

Section 204K provides that a member of the Aged Care Advisory Committee may resign their appointment by giving the Minister a written resignation, with that resignation taking effect either on the day it is received by the Minister or on a later day specified in the resignation (if any).

Section 204L provides that the Minister may at any time terminate the appointment of a member of the Aged Care Advisory Committee.

This provision is consistent with the Minister's existing power under section 189 of the National Health Reform Act to terminate the appointment of a member of the Clinical Advisory Committee at any time. Similarly, under section 200 of the National Health Reform Act the Secretary of the Department of Health and Aged Care and each State or Territory Health Minister can terminate the appointment of their respective Commonwealth or jurisdictional representatives on the Jurisdictional Advisory Committee.

Section 204M provides that a member of the Aged Care Advisory Committee holds office on the terms and conditions (if any) the Minister determines in relation to matters not covered by the National Health Reform Act.

Division 3—Decision-making by the Aged Care Advisory Committee

Section 204N provides that the Aged Care Advisory Committee is to hold meetings as necessary to perform its functions, and that the Chair of the Committee may convene a meeting at any time.

Section 204P provides that the Chair of the Aged Care Advisory Committee presides at all meetings at which they are present, and when not present the members present must appoint one of themselves to preside.

Section 204Q provides that the quorum for a meeting of the Aged Care Advisory Committee is four members.

Section 204R provides that a question at a meeting of the Aged Care Advisory Committee is decided by a majority of the votes of members present and voting. The person presiding has a deliberative vote and, if votes are equal, a casting vote.

Section 204S deals with decisions of the Aged Care Advisory Committee without meetings. Subsection 204S(1) sets out circumstances in which the Aged Care Advisory Committee will be taken to have made a decision at a meeting, despite not meeting.

These circumstances are:

- without meeting, a majority of the members who are entitled to vote on the proposed decision have indicated agreement with the decision in accordance with a method determined by the Aged Care Advisory Committee, and
- all the members were informed of the proposed decision, or reasonable efforts were made to inform all the members of the proposed decision.

However, subsection 204S(2) provides that subsection 204S(1) will not apply unless the Aged Care Advisory Committee has determined that it may make decisions of a kind without meeting and has determined the method by which members are to indicate agreement with proposed decisions.

Subsection 204S(3) provides that a member is not entitled to vote on a proposed decision if the member would not have been entitled to vote on that proposal if the matter had been considered at a meeting of the Aged Care Advisory Committee.

Section 204T provides that, subject to the Act, the Aged Care Advisory Committee may regulate proceedings at its meetings as it considers appropriate. A note to this section directs readers to section 33B of the *Acts Interpretation Act 1901*, which provides for participation in meetings by telephone, closed-circuit television or any other means of communication.

Section 204U provides that the Aged Care Advisory Committee must keep minutes of its meetings.

Division 4—Subcommittees

Subsection 204V(1) provides that the Aged Care Advisory Committee may, with the written approval of the Pricing Authority CEO, establish subcommittees to advise or assist the Aged Care Advisory Committee in the performance of its functions.

Subsection 204V(2) provides that a subcommittee is to be constituted partly by a combination of one or more members of the Aged Care Advisory Committee and partly by one or more other persons.

Subsection 204V(3) provides that the Pricing Authority may determine any such subcommittee's terms of reference, the terms and conditions of appointment of the members of the subcommittee, and the procedures to be followed by the subcommittee.

Section 204W deals with remuneration and allowances for members of a subcommittee established under section 204V. The arrangements in 204W are modelled on those in place for the existing Clinical Advisory Committee.

Subsections 204W(1) and 204W(2) taken together provide that if a committee is established under section 204V, remuneration of its members is determined by the Remuneration Tribunal, or in the absence of such a determination, the amount prescribed by regulation. Members' allowances are prescribed by regulation. For members of the Aged Care Advisory Committee who are also members of the subcommittee additional fees will not be payable.

In accordance with subsection 204W(3) a member is also not entitled to be paid remuneration if the committee member holds an office or appointment, or is otherwise employed, on a full time basis in the service or employment of a State, a public statutory corporation (other than a tertiary education institution), or a company beneficially owned by a State or a public statutory corporation.

A note to this section clarifies that a similar rule applies to a committee member who has a similar relationship with the Commonwealth or a Territory, in accordance with subsection 7(11) of the *Remuneration Tribunal Act 1973*.

Subsection 204W(4) provides that a subcommittee member is to be paid the allowances that are prescribed by the regulations.

Subsection 204W(5) provides that section 204W (other than subsection 204W(3)) has effect subject to the *Remuneration Tribunal Act 1973*.

This new Division is consistent with the arrangements for subcommittees of the Clinical Advisory Committee set out in Division 3 of Part 4.10, and will enable the Aged Care Advisory Committee to be assisted by such subcommittees as the Aged Care Advisory Committee and Pricing Authority CEO consider necessary.

Division 5—Annual Report

Section 204X provides that the Chair of the Aged Care Advisory Committee must, as soon as practicable after the end of each financial year, prepare and give to the Minister responsible for administering the National Health Reform Act an annual report for presentation to Parliament. Such an annual report must include details on the operations of the Committee during that year.

A note to this section clarifies that section 34C of the *Acts Interpretation Act 1901* contains extra rules about annual reports which also apply.

Division 6—Pricing Authority may assist the Aged Care Advisory Committee and its subcommittees

Section 204Y provides that the Pricing Authority may assist the Aged Care Advisory Committee and its subcommittees in the performance of their functions, and that the assistance may include providing information and making available resources and facilities, including (though not limited to) secretariat services and clerical assistance.

Item 56 – Before section 208

Within Part 4.13—Reporting and planning, this item inserts a new Division marking, Division 1—Requirements for functions in relation to hospitals, to distinguish reporting and planning matters that relate to the Pricing Authority’s hospitals functions from those that relate to its new health care pricing and costing and aged care functions.

Item 57 – Before subsection 208(1)

Section 208 enables the Minister or a State or Territory Health Minister to require the Pricing Authority to prepare reports or give specified information on matters relating to its functions. This item inserts a new subsection 208(1A) to provide that this section only applies in relation to the Pricing Authority’s public hospital functions set out in section 131(1), but not its new health care pricing and costing or aged care functions.

Item 58 – Subsection 209(2)

Section 209 of the Act provides that the Pricing Authority must keep the Standing Council on Health informed of its operations. This item amends subsection 209(2) to provide that the Pricing Authority is not required to keep the Standing Council on Health informed about the following matters:

- the performance of the Pricing Authority’s new health care pricing and costing functions set out in subsection 131(1A) or its new aged care functions set out in subsection 131A(1), or the exercise of powers for or in connection with those functions; or
- the performance of the functions or exercise of related powers of the Clinical Advisory Committee; or
- the performance of the functions or exercise of related powers of the Jurisdictional Advisory Committee; or
- the performance of the functions or exercise of related powers of the Aged Care Advisory Committee; or
- the performance of functions or exercise of powers under the *Public Governance, Performance and Accountability Act 2013*.

It is not necessary to inform the Standing Council on Health of the Pricing Authority’s performance of the new health care pricing and costing functions, or the Clinical Advisory Committee and Jurisdictional Advisory Committee’s performance of their health care pricing and costing functions. That requirement is intended to ensure that the Pricing Authority performs its public hospital pricing functions in accordance with agreements made between the Commonwealth and the States and Territories, which share funding responsibility for public hospital services. These agreements do not relate to the new health care pricing and costing functions of the Pricing Authority.

It is also not necessary to inform the Standing Council on Health about the performance of the Pricing Authority's aged care functions or the functions of the Aged Care Advisory Committee as the States and Territories are not responsible for the funding of aged care services under the Aged Care Act.

Item 59 – Before subsection 210(1)

Section 210 of the National Health Reform Act deals with the requirements of the Pricing Authority to report to Parliament. This item amends section 210 to insert a new subsection 210(1A) providing that the section only applies to information and advice given by the Pricing Authority in relation to its function established under subsection 131(1) (that is, its public hospital functions).

Item 60 – At the end of section 211

Section 211 of the National Health Reform Act currently prevents the Pricing Authority and the Pricing Authority CEO from reporting publicly unless the Commonwealth and each State and Territory Health Minister has been given 45 days to consider and comment on any such report.

This item amends section 211 to add a new subsection 211(3) that provides that the section does not apply in relation to a report given under Division 2 of Part 4.13, relating to the Pricing Authority's new health care pricing and costing functions, and does not apply in relation to a report given under Division 3 of Part 4.13, relating to the Pricing Authority's new aged care functions. This is appropriate as the aged care functions do not relate to the responsibilities of the States and Territories, and as agreements made between the Commonwealth and the States and Territories to share funding responsibility for public hospital services do not relate to the new health care pricing and costing functions of the Pricing Authority.

Item 61 – After section 211

Within Part 4.13, this item inserts a new Division 2—Requirements for functions in relation to health care pricing and costing, and a new Division 3—Requirements for functions in relation to aged care.

Division 2—Requirements for functions in relation to health care pricing and costing

New section 211A provides that the Minister may, by written notice, require the Pricing Authority to:

- prepare reports or in document form give information about one or more specified matters relating to the aged care functions of the Pricing Authority; and
- give copies to the Minister within the period specified in the notice.

The Pricing Authority must comply with such a notice, and after receiving a report or a document in response the Minister may cause that report or document to be published whether on the internet or otherwise.

New section 211B provides that the Pricing Authority must, as soon as practicable after the end of each financial year, prepare and give to the Minister responsible for administering the Act an annual report. The annual report must include details of the advice (if any) given by the Pricing Authority in that year in relation to the performance of a health care pricing and costing function or power of the Pricing Authority mentioned in subsection 131(1A) for presentation to Parliament. Such an

annual report must include details of when the advice was given to the Minister and the content of the advice that was given.

A note to subsection 211B(3) clarifies that section 34C of the *Acts Interpretation Act 1901* contains extra rules about annual reports which also apply.

Division 3—Requirements for functions in relation to aged care

New section 211C provides that a relevant Commonwealth Minister may, by written notice, require the Pricing Authority to:

- prepare reports or in document form give information about one or more specified matters relating to the aged care functions of the Pricing Authority mentioned in new subsection 131A(1); and
- give copies of the report to the relevant Commonwealth Minister within the period specified in the notice.

After receiving a report or a document in response to a notice, the relevant Commonwealth Minister may by written notice also direct the Pricing Authority to publish that report or document whether on the internet or otherwise. The Pricing Authority must comply with a written notice under new section 211C.

However, subsection 211C(5) provides that, in publishing a report or document, the Pricing Authority must not publish any part of a report or document that contains protected Pricing Authority information that is aged care information, or protected information within the meaning of the Aged Care Act that is not aged care information.

Aged care information means information, including protected information within the meaning of the Aged Care Act, that was obtained in the course of the performance of an aged care function by the Pricing Authority, or the performance of a function of the Aged Care Advisory Committee or a committee established under section 205 to advise or assist the Pricing Authority in the performance of an aged care function, excluding functions conferred on the Pricing Authority under the Aged Care Act.

The effect of subsection 211C(5) is that parts of a report or document containing personal information about care recipients and information about the affairs of an approved provider or an applicant for a grant under the Aged Care Act should not be published under section 211C.

New subsection 211D(1) provides that the Pricing Authority must, as soon as practicable after the end of each financial year, prepare and give to the Minister an annual report for presentation to Parliament. The annual report must include details of the advice (if any) given by the Pricing Authority in that year in relation to the performance of an aged care function or power of the Pricing Authority mentioned in subsection 131A(1).

New subsection 211D(2) provides that such an annual report must include details of when the advice was given to each relevant Commonwealth Minister and the content of the advice that was given.

New subsection 211D(2) also provides that such an annual report must also include with respect to the Pricing Authority's Aged Care Act functions:

- the number of applications under section 52G-4 of the Aged Care Act that were made to the Pricing Authority during the financial year for approval to charge an accommodation payment higher than the maximum amount;
- the number of such applications that were approved, rejected or withdrawn during the financial year;
- the number of applications under Division 35 of that Act that were made to the Pricing Authority during the financial year for approval to charge an extra service fee;
- any other details required by regulations made for the purpose.

A note to this subsection clarifies that section 34C of the *Acts Interpretation Act 1901* contains extra rules about annual reports which also apply.

The effect of subsection 211D(2) is to give the Pricing Authority reporting obligations in relation to Aged Care Act functions that previously sat with the Aged Care Pricing Commissioner.

Item 62 – Paragraph 213(2)(b) and Item 63 – After paragraph 213(2)(b)

Existing subsection 213(1) provides that it is an offence for a person who is or has been an official of the Pricing Authority to use or disclose protected Pricing Authority information that the person obtained in their capacity as an official of the Pricing Authority, subject to certain exceptions.

Items 62 and 63 amend the exception to this offence at paragraph 213(2)(b) and insert new exceptions at subsections 213(2)(c) and (d). The effect of Item 62 is to specify that the exception at paragraph 213(2)(b), which previously provided an authorisation for disclosure or use in compliance with a Commonwealth law or a prescribed law of a State or Territory, only applies to protected Pricing Authority information that is not health care pricing and costing information or aged care information.

The effect of Item 63 is to specify that, for protected Pricing Authority information that is health care pricing and costing information or aged care information, it is an exception to the offence at subsection 213(1) if the disclosure or use is in compliance with a requirement under a law of the Commonwealth.

As a result, for protected Pricing Authority information that is health care pricing and costing information or aged care information the authorisation for use or disclosure in compliance with a requirement under a prescribed law of a State or a Territory does not apply.

In relation to aged care information, States and Territories are not responsible for the funding of aged care services under the Aged Care Act or the administration or enforcement of that Act. It is therefore not necessary or appropriate for the exception to the offence in subsection 213(1) relating to use or disclosure in compliance with a prescribed State or Territory law to apply in relation to protected Pricing Authority information that is aged care information.

In relation to health care pricing and costing information, the information that the Pricing Authority will use for its the health care pricing and costing functions will largely be confidential information protected under Commonwealth legislation. To maintain the confidentiality of this information and ensure the integrity of those protections, it is appropriate to not to authorise use or disclosure that is done in compliance with a prescribed State or a Territory law.

Item 64 – Section 215 (at the end of the heading) and Item 65 – Subsection 215(1)

Item 64 amends the heading of the section 215 to add “—general”, while item 65 amends subsection 215(1) to provide that this subsection applies to protected Pricing Authority information that is not aged care information.

Section 215 currently authorises an official of the Pricing Authority to disclose protected Pricing Authority information to the Clinical Advisory Committee, a subcommittee established under section 191 to assist the Clinical Advisory

Committee, the Jurisdictional Advisory Committee, or a committee established under section 205 to assist the Jurisdictional Advisory Committee.

The amendments limit the application of section 215 so that the authorisation on disclosure does not apply to protected Pricing Authority information that is aged care information. This is appropriate as the Clinical Advisory Committee and the Jurisdictional Advisory Committee do not have any functions that relate to the Pricing Authority's aged care functions in section 131A.

Item 66 – After section 215

This item inserts a new section 215A authorising the disclosure of protected Pricing Authority information that is aged care information to certain committees.

Subsection 215A(1) provides that an official of the Pricing Authority may disclose to the Aged Care Advisory Committee or a committee established under section 205 protected Pricing Authority information that is aged care information.

Section 215A also provides that a person commits an offence if:

- the person is a member of the Aged Care Advisory Committee or a committee established under section 205; and
- protected Pricing Authority information that is aged care information has been disclosed to the committee by an official of the Pricing Authority; and
- the person discloses the information to another person or uses the information unless:
 - the disclosure or use is for the purposes of this Act; or
 - the disclosure or use is for the purposes of the performance of the functions of the relevant committee under this Act; or
 - the disclosure or use is in the course of the person's service as a member of the committee.

The penalty for an offence is imprisonment for 2 years or 120 penalty units, or both, and a note to this section clarifies that the defendant bears an evidential burden under subsection 13.3(3) of the *Criminal Code Act 1995*.

It is appropriate that specific rules apply to the use and disclosure of protected Pricing Authority information that is aged care information as that information is relevant only to the aged care pricing functions, and not to the hospital pricing functions or the health care pricing and costing functions.

It is also appropriate that unauthorised use or disclosure of protected pricing information that is aged care information should give rise to an offence. That information may include either or both personal information (including *health information* within the meaning of the Privacy Act) relating to care recipients and commercially sensitive information about the affairs of approved providers of aged care, including matters such as operators' detailed operating costs.

Unauthorised use or disclosure of protected Pricing Authority information that is aged care information may cause significant harm to care recipients and/or approved providers of aged care. In particular, unauthorised disclosure of commercially sensitive information could harm the relationship of trust between the government and

approved providers, which may prevent or discourage approved providers from sharing this information with government. This could impact the ability of the Pricing Authority to perform its functions.

Further, it is appropriate to impose an evidential burden in relation to an exception because the purpose of the use or disclosure would be peculiarly within the defendant's knowledge and not available to the prosecution. This is also consistent with the current offence and exception provisions in relation to use and disclosure in the National Health Reform Act.

Item 67 – After Section 216

This item inserts a new section 216A—Disclosure to Aged Care Minister that deals with disclosure of protected Pricing Authority information that is aged care information to the Aged Care Minister, being the Minister responsible for administering the Aged Care Act.

Section 216 provides that an official of the Pricing Authority may disclose protected Pricing Authority information that is aged care information to the Aged Care Minister, if the Minister with responsibility for the National Health Reform Act is not also the Aged Care Minister.

Item 68 – Section 217 and Item 69 – At the end of section 217

Section 217 deals with disclosure of protected Pricing Authority information to a State or Territory Health Minister. These items insert a new subsection 217(2) and make a consequential amendment to renumber the existing text as subsection 217(1).

The effect is to provide that this section does not authorise the disclosure of protected Pricing Authority information that is health care pricing and costing information or aged care information to a State or Territory Health Minister.

In relation to health care pricing and costing information, the information that the Pricing Authority will use for its the health care pricing and costing functions will largely be confidential information protected under Commonwealth legislation. To maintain the confidentiality of this information and ensure the integrity of those protections, it is appropriate that the general authorisation for disclosure of such information a State or Territory Health Minister should not apply.

In relation to aged care information, this is appropriate as the States and Territories are not responsible for the funding of aged care services under the Aged Care Act.

Item 70 – Section 218

This item repeals and substitutes section 218, which deals with disclosure of protected Pricing Authority information to the Secretary of the Department administering the Act or the head (however described) of the Health Department of a State or Territory.

The effect is to provide that an official of the Pricing Authority may only disclose protected Pricing Authority information that is health care pricing and costing information or aged care information to the Secretary, and not to the head (however described) of the Health Department of a State or Territory.

In relation to health care pricing and costing information, the information that the Pricing Authority will use for its the health care pricing and costing functions will largely be confidential information protected under Commonwealth legislation. To maintain the confidentiality of this information and ensure the integrity of those protections, it is appropriate that the authorisation to disclose such information to the head (however described) of the Health Department of a State or Territory does not apply.

In relation to aged care information, this is appropriate as the States and Territories are not responsible for the funding of aged care services under the Aged Care Act.

Item 71 – Section 220 (at the end of the heading) and Item 72 – At the end of section 220

These items amend the heading of the section to 220—Disclosure to certain agencies, bodies or persons—general and insert a new subsection 220(5). Section 220 currently authorises the disclosure of protected Pricing Authority information to certain agencies or bodies mentioned in the section, including the Australian Commission on Safety and Quality in Health Care, the National Health Funding Body and any State or Territory government body with functions relating to health care.

The effect of the amendments to section 220 is to specify that it does not authorise the disclosure of protected Pricing Authority information that is health care pricing and costing information or aged care information to those agencies or bodies or persons.

Item 73 – After Section 220

This item inserts a new section 220A—Disclosure to relevant bodies or persons—aged care information.

The effect of the new section 220A is to authorise the disclosure of protected Pricing Authority information that is health care pricing and costing information or aged care information to relevant bodies or persons, specified in subsection 220A(4) as the Australian Institute of Health and Welfare and the Australian Statistician.

Section 220A specifies that the section applies if the Chair of the Pricing Authority is satisfied that particular protected Pricing Authority information that is health care pricing and costing information or aged care information will enable or assist a relevant body or person to perform or exercise any of their functions or powers.

An official of the Pricing Authority, if authorised by the Chair of the Pricing Authority in writing for the purposes of section 220A, may disclose that health care pricing and costing information or aged care information to a relevant body or person.

The relevant body or person must not disclose or use the health care pricing and costing information or aged care information they have received for a purpose other than the purpose for which the information was disclosed.

In addition, use and disclosure of any information that has been disclosed to the Australian Institute of Health and Welfare or the Australian Statistician may be protected by relevant provisions of the *Census and Statistics Act 1905*, the *Australian*

Institute of Health and Welfare Act 1987, the Privacy Act and other legislation as relevant.

The new section 220A ensures protections are in place to prevent the unauthorised disclosure of protected Pricing Authority information that is health care pricing and costing information or aged care information, while providing that the information can still be disclosed to a relevant body or person where it will assist that body or person to perform or exercise any of their functions or powers. This will support continued research into and analysis of health care and aged care without undermining the confidentiality of protected Pricing Authority information that is health care pricing and costing information or aged care information.

Item 74 – At the end of section 221

Section 221 currently authorises the disclosure of protected Pricing Authority information for research purposes in certain circumstances. This item inserts a new subsection 221(4), specifying that the section does not authorise the disclosure of protected Pricing Authority information that is health care pricing and costing information or aged care information to researchers.

An additional disclosure regime through the National Health Reform Act for research purposes is considered unnecessary and may increase uncertainty for persons to whom the information relates about the protection of their information.

Item 75 – Section 226 (at the end of the heading) and Item 76 – Before subsection 226(1)

Section 226 provides that the Minister may, by legislative instrument, give directions to the Pricing Authority in relation to the performance of its functions and the exercise of its powers.

Item 75 amends the heading of the section to add “—functions in relation to hospitals”, while item 76 inserts a new subsection (1A) to provide that this section only applies in relation to the Pricing Authority’s public hospital functions set out in subsection 131(1) and related powers (but not its new health care pricing and costing functions or its new aged care functions).

Item 77 – After section 226

This item inserts a new section 226A. The effect is to provide that the Minister may, by legislative instrument, give directions to the Pricing Authority in relation to the performance of its functions and the exercise of its powers in relation to health care pricing and costing and aged care. Consistent with the requirements in section 226, a direction must be of a general nature only, and the Pricing Authority must comply with such a direction.

A note to the section clarifies that subsection 33(3) of the *Acts Interpretation Act 1901* applies in relation to the variation or revocation of a direction given under the section.

Item 78 – the end of section 279

This item inserts a new subsection in section 279, which relates to the protection of patient confidentiality. The section provides that the Pricing Authority, the Australian Commission of Safety and Quality in Health Care, the National Health Funding Body

and the Administrator of the National Health Funding Pool must not publish or disseminate information that is likely to enable the identification of a particular patient in the performance of their powers or functions.

New subsection 279(5) provides that the section applies in relation to a care recipient (within the meaning of the Aged Care Act) and a continuing care recipient (within the meaning of the Aged Care Act) in the same way as it applies in relation to a patient. This is appropriate as aged care information may include information in relation to a care recipient or a continuing care recipient.

Part 2—Amendments of Other Acts

Aged Care Act 1997

The majority of amendments to the Aged Care Act relate to the conferral on the Pricing Authority of functions previously undertaken by the Aged Care Pricing Commissioner. These functions relate to deciding applications for extra service fees for residential aged care places and the approval of higher maximum accommodation payments than the maximum amount of accommodation payment determined by the Minister.

Item 79 – Paragraph 32-3(2)(f) and Item 80 – After subsection 32-3(2)

Division 32 of the Aged Care Act enables a person to make an application for extra service status in respect of a residential care service, or a distinct part of a residential care service, on certain conditions.

Item 79 inserts “(an *extra service fees application*)” after “an application” in paragraph 32-3(2)(f) to define the term extra service fees application, which is used in new subsection 32-3(2A) created by Item 80.

Applications for extra service status are made to the Secretary of the Department and may also include an application for approval of extra service fees.

Item 80 inserts a new subsection 32-3(2A), which provides that if an application for extra service status in respect of a residential care service, or a distinct part of a residential care service, includes an extra service fees application for approval under Division 35, as mentioned in paragraph 32-3(2)(f), the Secretary must give the extra service fees application to the Pricing Authority.

These items are consequential to the Pricing Authority being responsible for approving extra service fees applications under Division 35 through amendments in Items 81 to 86.

Item 81 – Subsection 35-1(1), Item 82 – Subsection 35-1(2), Item 83 – Paragraphs 35-1(2)(c) and (d), Item 84 – Subsection 35-2(1), Item 85 – Section 35-3 and Item 86 – Section 35-4

Division 35 of the Aged Care Act provides for how extra service fees are approved. These items amend Division 35 so that each reference to the Aged Care Pricing Commissioner is omitted and substituted with a reference to the Pricing Authority.

The effect of these items is that the former function of the Aged Care Pricing Commissioner to approve extra service fees is conferred on the Pricing Authority.

For the purposes of the National Health Reform Act, as amended, this function conferred on the Pricing Authority is an Aged Care Act function.

Item 87 – Paragraph 52G-2(c), Item 88 – 52G-4 (heading), Item 89 – Subsections 52G-4(1), (2) and (3), Item 90 – Subsection 52G-4(3) and Item 91 – Subsections 52G-4(5) and (6)

Subdivision 52G-A of the Aged Care Act, which contains sections 52G-2, 52G-3, 52G-4 and 52G-5, provides for rules about accommodation payments. These items amend subdivision 52G-A so that each reference to the Aged Care Pricing Commissioner (or “the Commissioner”) is omitted and substituted with a reference to the Pricing Authority.

Item 87 amends paragraph 52G-2(c) to provide that an accommodation payment must not exceed the maximum amount determined by the Minister under section 52G-3, or such higher amount as approved by the Pricing Authority under section 52G-4.

Item 88 amends the heading of section 52G-4 and Items 89, 90 and 91 amend the body of section 52G-4 throughout to provide that the Pricing Authority may approve a higher maximum amount of accommodation payment than the maximum amount determined by the Minister under section 52G-3.

The effect of these items is that the former function of the Aged Care Pricing Commissioner to approve a higher maximum amount of accommodation payment than the maximum amount determined by the Minister under section 52G-3 is conferred on the Pricing Authority.

For the purposes of the National Health Reform Act, as amended, this function conferred on the Pricing Authority is an Aged Care Act function.

Item 92 – After paragraph 63-1(1)(ha)

Item 92 creates two new responsibilities of approved providers in relation to accountability for the aged care provided by the provider through an aged care service.

These responsibilities are necessary to permit the Pricing Authority to carry out activities relating to its new aged care pricing and costing advice functions:

- under new paragraph 63-1(1)(hb), the responsibility to allow persons performing an activity mentioned in paragraph 131A(1)(c) of the National Health Reform Act access to the service, as required under the Accountability Principles, for the purposes of the Pricing Authority performing the function mentioned in paragraph 131A(1)(a) of that Act;
- under new paragraph 63-1(1)(hc), the responsibility to provide persons performing an activity mentioned in paragraph 131A(1)(c) of the National Health Reform Act with all reasonable facilities and assistance necessary, as required under the Accountability Principles, for the purposes of the Pricing Authority performing the function mentioned in paragraph 131A(1)(a) of that Act.

The activities mentioned in paragraph 131A(1)(c) of the National Health Reform Act are for the Pricing Authority to conduct, or arrange for the conduct of, the collection and review of data, costing and other studies and consultations for the purpose of performing a function under new paragraph 131A(1)(a) or (c). The function mentioned in paragraph 131A(1)(a) is to provide advice to each relevant Commonwealth Minister in relation to one or more aged care pricing or costing matters (see Item 27).

Item 93 – paragraph 84-1(h)

Section 84-1 provides an overview of Chapter 6. Chapter 6 deals with matters relating to the administration of the Aged Care Act, including in relation to the Aged Care Pricing Commissioner. This item amends section 84-1 to repeal references to the former functions of the Aged Care Pricing Commissioner.

This item is consequential to Items 79 to 91, which confer all former functions of the Aged Care Pricing Commissioner on the Pricing Authority, and to the repeal of provisions establishing the office of the Aged Care Pricing Commissioner.

This item repeals paragraph 84-1(h) with the effect of repealing the reference to the office of the Aged Care Pricing Commissioner and its former functions.

Item 94 – Paragraph 85-2(2)(a), Item 95 – Paragraph 85-2(2)(c), Item 96 – Paragraph 85-2(2)(c), Item 97 – Subsection 85-2(2), Item 98 – Section 85-3, Item 99 – Subsection 85-4(1A), Item 100 – Subsection 85-4(1A), Item 101 – Subsections 85-4(3), (4), (5) and (6), Item 102 – Subsection 85-5(1A), Item 103 – Paragraph 85-5(3)(b), Item 104 – Paragraph 85-5(3)(b), Item 105 – Subsections 85-5(5) and (6), Item 106 – Subsection 85-5(7), Item 107 – Subsection 85-5(7), Item 108 – Subsection 85-5(8), Item 109 – Subsection 85-5(8)

Division 85 provides for the reconsideration and review of decisions made under the Aged Care Act. These items amend Division 85 throughout to omit references to the Aged Care Pricing Commissioner and substitute references to the Pricing Commissioner.

The effect is that functions relating to reconsideration and review of decisions that previously applied to the Aged Care Pricing Commissioner will be conferred on the Pricing Authority. These functions are in respect of:

- the reviewable decision at Item 33 of the table in section 85-1—to reject an application for approval of extra services fees; and
- the reviewable decision at Item 53E of the table in section 85-1—to refuse to approve a higher maximum amount of accommodation payment than the maximum amount of accommodation payment determined by the Minister under section 52G-3

These items are consequential to Items 79 to 91, which confer on the Pricing Authority the functions under the Aged Care Act that relate to the reviewable decisions at Item 33 and Item 53E of the table in section 85-1.

Transitional arrangements in Division 3 to the Bill provide for the handling of the review of decisions made by the Pricing Commissioner following the transfer of functions to the Pricing Authority.

Item 110 – After paragraph 86-3(1)(cb)

Section 86-3 provides that the Secretary may disclose protected information within the meaning of the Aged Care Act for certain “other purposes”.

This item inserts a new paragraph 86-3(1)(cc) to enable the Secretary to disclose protected information within the meaning of the Aged Care Act to the Pricing Authority to assist in the performance of the functions mentioned in subsection 131A(1) of the National Health Reform Act, or the exercise of powers for or in connection with those functions.

Under section 86-1 of the Aged Care Act, protected information means information acquired under or for the purposes of that Act or Transitional Act and which is personal information (within the meaning of the *Privacy Act 1988*), or information that relates to the affairs of an approved provider (within the meaning of the Aged Care Act) or the affairs of an applicant for a grant under Chapter 5 of the Aged Care Act.

The functions of the Pricing Authority mentioned in subsection 131A(1) are:

- to provide advice to each relevant Commonwealth Minister is to provide advice to each relevant Commonwealth Minister in relation to one or more aged care pricing or costing matters, including in relation to methods for calculating amounts of subsidies to be paid under the Aged Care Act or the Transitional Act;
- such functions relating to aged care (if any) as are specified in regulations;
- to collect and review data, undertake costing and other studies and undertake consultations for the purpose of performing a function mentioned above;
- to do anything incidental or conducive to the above functions;
- such functions (an Aged Care Act function) as are:
 - conferred on the Pricing Authority by the Aged Care Act or a legislative instrument made under that Act; or
 - specified in regulations made for subparagraph 131A(1)(e)(ii) of the National Health Reform Act;
 - incidental to or conducive to the performance of these functions.

This item is consequential to the former functions of the Aged Care Pricing Commissioner under the Aged Care Act being conferred on the Pricing Authority, and to other aged care functions being created for the Pricing Authority through amendments to the National Health Reform Act.

Item 111 – After section 86-4

Item 111 inserts new section 86-4A, dealing with the disclosure of certain protected information by officials of the Pricing Authority. This section provides, that an official of the Pricing Authority (within the meaning of the National Health Reform Act) may disclose protected information (within the meaning of the Aged Care Act) to either of the Secretary (within the meaning of the Aged Care Act) or the Aged Care Quality and Safety Commissioner (within the meaning of the Quality and Safety Commission Act) if the information was obtained while performing of an Aged Care Act function (within the meaning of the National Health Reform Act).

This power complements the amended powers of the Secretary (see Item 111) and the Commissioner (see Item 121) to disclose certain protected information under the Aged Care Act and the Quality and Safety Commission Act with the Pricing Authority to assist in the performance of its Aged Care Act functions.

The type of information relating to performance of the Pricing Authority's Aged Care Act functions that may be disclosed by the Pricing Authority may include (but is not limited to):

Extra service fees information

- the amount of any extra service fee approved by the Pricing Authority under Division 35 of the Aged Care Act;
- the residential care service in respect of which the extra service fee was approved;
- the accommodation, food and services that are to be provided to a care recipient for the approved extra service fee;
- the date on which the extra service fee was approved;
- any other information relating to approved extra service fees required by the Secretary to assist the Secretary to perform a function or duty, or exercise a power, under the Act or the Transitional Act.

Accommodation payment information

- the amount of any accommodation payment approved by the Pricing Authority under section 52G- 4 of the Aged Care Act;
- the residential care service or flexible care service in respect of which the accommodation payment was approved;
- the date on which the accommodation payment was approved;
- any other information relating to approved accommodation payments required by the Secretary to assist the Secretary to perform a function or duty, or exercise a power, under the Aged Care Act or the Transitional Act.

Item 112 – Section 86-5 (heading) and Item 113 – Paragraph 86-5(b)

Section 86-5 provides for limits on use of information disclosed under section 86-3 or 86-4. Item 112 and Item 113 amend the section 86-5 heading and paragraph 86-5(b) to extend the section's limits on use of information disclosed under the new section 86-4A (see Item 111). This is appropriate as sections 86-3, 86-4 and 86-4A all deal with the disclosure of protected information.

Item 114 – Part 6.7

This item repeals Part 6.7, which deals with the office of the Aged Care Pricing Commissioner, and has the effect of abolishing the office of the Aged Care Pricing Commissioner.

Item 115 – Section 96-1 (table item 9A)

Section 96-1 provides that the Minister may, by legislative instrument, make Principles (a form of legislative instrument) under the Aged Care Act. Principles relate to Parts, Divisions, sections etc. of the Aged Care Act.

This item repeals table item 9A, Commissioner Principles, which relates to Division 95B of the Aged Care Act. This repeal is consequential to Item 114 repealing Part 6.7 of the Aged Care Act, which contains Division 95B.

Item 116 – Subsection 96-2(3)

This item amends section 96-2 of the Aged Care Act, which deals with the delegation of powers and functions of the Secretary under the Aged Care Act.

This item repeals and substitutes subsection 96-2(3) so that the Secretary may, in writing, delegate to the Pricing Authority the powers and functions of the Secretary that the Secretary considers necessary for the Pricing Authority to perform the Pricing Authority's (new) functions under the Aged Care Act.

This item also inserts a new subsection 96-2(3A) so that the Pricing Authority may, in writing, sub-delegate the power or function to a person referred to in subsection 161(1) or 161(2) of the National Health Reform Act, other than a member of the Pricing Authority.

The persons to whom the Pricing Authority may sub-delegate the power or function are:

- the Pricing Authority CEO; or
- a person who is a member of the staff of the Pricing Authority and is an SES employee or acting SES employee; or
- an SES or acting SES employee who is also an officer or employee of an APS agency or Commonwealth authority who is assisting the Pricing Authority in relation to its functions under the National Health Reform Act.

This item is consequential to the former functions of the Aged Care Pricing Commissioner under the Aged Care Act being conferred on the Pricing Authority, and the abolition of the office of the Aged Care Pricing Commissioner.

Item 117 – Clause 1 of Schedule 1 (definition of *Aged Care Pricing Commissioner*)

This item repeals the definition of *Aged Care Pricing Commissioner* in Clause 1 of Schedule 1.

This item is consequential to the former functions of the Aged Care Pricing Commissioner under the Aged Care Act being conferred on the Pricing Authority, and the abolition of the office of the Aged Care Pricing Commissioner.

Item 118 – Clause 1 of Schedule 1

This item inserts a definition of Pricing Authority, so that *Pricing Authority* has the same meaning as in the National Health Reform Act.

This item has the effect that references to *Pricing Authority* in the Aged Care Act mean the Pricing Authority.

Aged Care Quality and Safety Commission Act 2018

Item 119 – Section 7 (definition of *Aged Care Pricing Commissioner*)

This item repeals the definition of *Aged Care Pricing Commissioner* in section 7 of the Quality and Safety Commission Act.

This item is consequential to the former functions of the Aged Care Pricing Commissioner under the Aged Care Act being conferred on the Pricing Authority, and the abolition of the office of the Aged Care Pricing Commissioner.

Item 120 – Section 7

This item inserts a definition of Pricing Authority, so that *Pricing Authority* has the same meaning as in the National Health Reform Act.

This item has the effect that references to *Pricing Authority* in the Quality and Safety Commission Act mean the Pricing Authority.

Item 121 – Paragraph 61(1)(i)

Section 61 of the Quality and Safety Commission Act provides that the Commissioner may disclose protected information within the meaning of that Act in certain circumstances.

This item repeals and substitutes paragraph 61(1)(i) so that the Commissioner may disclose protected information within the meaning of the Quality and Safety Commission Act to the Pricing Authority to assist in the performance of Aged Care Act functions (within the meaning of the National Health Reform Act) of the Pricing Authority.

Protected information within the meaning of the Quality and Safety Commission Act is information acquired under, or for the purposes of, that Act or the rules made under that Act that:

- is personal information; or
- relates to the affairs of an approved provider or a service provider of a Commonwealth- funded aged care service; or
- relates to the affairs of an applicant for approval as a provider of aged care under section 63B of that Act.

Aged Care Act functions within the meaning of the National Health Reform Act are functions conferred on the Pricing Authority by the Aged Care Act or otherwise specified in regulations under the National Health Reform Act.

This item is consequential to the former functions of the Aged Care Pricing Commissioner under the Aged Care Act being conferred on the Pricing Authority.

Part 3—Application, saving and transitional provisions

Division 1—Preliminary

Item 122 – Definitions

This item defines the following terms for the purposes of this Part:

amended Aged Care Act means the *Aged Care Act 1997*, as amended by this Schedule.

commencement day means the day on which this Schedule commences, which is the 7th day after the *Aged Care Legislation Amendment (Royal Commission Response) Act 2022* receives the Royal Assent.

National Health Reform Act means the *National Health Reform Act 2011*.

old Aged Care Act means the *Aged Care Act 1997* as in force immediately before the commencement day.

rules means rules made under Item 137.

Division 2—Application etc. provisions relating to the National Health Reform Act 2011

Item 123 – Members of the Pricing Authority

This item provides that, subject to Item 124, a person holding office as a member of the Pricing Authority immediately before the commencement day continues, on and after that commencement, to hold office as a member of the Pricing Authority for the balance of the person's term of appointment that remains immediately before that time. The effect of this item is to ensure that existing members of the Pricing Authority retain their membership under the amended National Health Reform Act.

Item 124 – Deputy Chair of the Pricing Authority

This item provides that a person holding office as the Deputy Chair of the Pricing Authority immediately before the commencement day holds office, on and after that commencement, as the Deputy Chair (Hospital Pricing) of the Pricing Authority.

This item also provides that the person continues, on and after the commencement day, to hold office as the Deputy Chair (Hospital Pricing) of the Pricing Authority for the balance of the person's term of appointment as the Deputy Chair of the Pricing Authority that remains immediately before that time.

This ensures the change to the title of the Deputy Chair of the Pricing Authority does not affect the continuation of the appointment of the current office holder.

Item 125 – Appointment of members of the Pricing Authority

Section 144 of the National Health Reform Act provides for the appointment of members of the Pricing Authority. This item provides that subsections 144(2) and (3) of the National Health Reform Act, as substituted by Part 1 of this Schedule, apply only in relation to an appointment that is made on or after the commencement day.

This item also provides that subsection 144(3A) of the National Health Reform Act, as inserted by Part 1 of this Schedule and as it relates to the Deputy Chair (Hospital Pricing), applies only in relation to an appointment that is made on or after the commencement day.

The effect of this item is that the new requirements in relation to consultation before appointing ordinary members of the Pricing Authority and requirements for the

experience, knowledge and standing of the Deputy Chairs apply only in relation to an appointment that is made on or after the commencement day.

Item 126 – Reporting to Parliament

This item provides that section 210 of the National Health Reform Act, as amended by Part 1 of this Schedule, and new sections 204X, 211B and 211D of the National Health Reform Act, as inserted by Part 1 of this Schedule, which deal with annual reporting to the Minister by the Pricing Authority and by the Aged Care Advisory Committee about the performance of their functions, applies in relation to the financial year starting on 1 July 2022 and later financial years.

This item also provides that for the purposes of the financial year starting on 1 July 2022, annual reporting about the Pricing Authority’s aged care functions applies as if a reference to “the Pricing Authority” were also a reference to “the Pricing Authority or the Aged Care Pricing Commissioner” for the purposes of reporting on the Aged Care Act functions conferred on the Pricing Authority.

The effect is that for the financial year starting on 1 July 2022, the Pricing Authority’s annual reporting on its performance of its Aged Care Act functions must also include performance of those functions during that financial year by the former Aged Care Pricing Commissioner prior to the commencement date.

Division 3—Application etc. provisions relating to the Aged Care Act 1997

Item 127 – Application—requirement to give certain applications to the Independent Health and Aged Care Pricing Authority

This item provides that subsection 32-3(2A) of the amended Aged Care Act applies in relation to an application that is made on or after the commencement day. The effect of this item is that the Secretary is only required, under subsection 32-3(3A), to give an extra service fees application to the Pricing Authority if such an application is included in an application for extra service status under section 32-3 that is made on or after the commencement day.

Item 128 – Saving—approvals under Division 35 of the Aged Care Act 1997

This item provides that an approval of extra service fees that is in force under Division 35 of the Aged Care Act immediately before the commencement day continues in force (and may be dealt with) as if it were an approval under Division 35 of the amended Aged Care Act, and the date of approval is taken to be the original date of approval. This preserves the operation of existing approvals for extra service fees.

Item 129 – Transitional—applications under Division 35 of the Aged Care Act 1997

This item provides that a valid application for approval of extra service fees made before the commencement day and for which no decision has been made, or for which a decision has been made but no notice of a decision has not been given to the applicant, prior to the commencement day, is to be dealt with by the Pricing Authority, including in relation to decisions, notification of decisions and reconsideration of reviewable decisions, on and from the commencement day.

A note provides that Item 134 of this Schedule (which provides that certain things done by the Aged Care Pricing Commissioner are taken to have been done by the Pricing Authority) is also relevant to this item.

Item 130 – Saving—approvals under section 52G-4 of the Aged Care Act 1997

This item provides that an approval of a higher maximum amount of accommodation payment than the maximum amount determined by the Minister under section 52G-3 that is in force under subsection 52G-4(5) of the Aged Care Act immediately before the commencement day continues in force, and may be dealt with, as if it were an approval under subsection 52G-4(5) of the amended Aged Care Act, and the date of approval is taken to be the original date of approval.

Item 131 – Transitional —applications under section 52G-4 of the Aged Care Act 1997

This item provides that a valid application for approval of a higher maximum amount of accommodation payment than the maximum amount determined by the Minister under section 52G-3 made before the commencement day but for which no decision has been made prior to the commencement day is to be dealt with by the Pricing Authority, including in relation to decisions, notification of decisions and reconsideration of reviewable decisions, on and from the commencement day.

A note provides that Item 134 of this Schedule (which provides that certain things done by the Aged Care Pricing Commissioner are taken to have been done by the Pricing Authority) is also relevant to this item.

Item 132 – Transitional—requests under subsection 85-5(1A) of the Aged Care Act 1997

This item provides that a request to reconsider a reviewable decision by a person whose interests are affected by a reviewable decision under Division 35 (extra service fees) or section 52G-4 (higher maximum amount of accommodation payment than the maximum amount determined by the Minister under section 52G-3) for which no decision has been made, or for which notice of a decision has not been given to the applicant, prior to the commencement day, is to be dealt with on and from the commencement day as if the request originally had been made to the Pricing Authority, including in relation to decisions and notification of decisions.

A note provides that item 134 of this Schedule (which provides that certain things done by the Aged Care Pricing Commissioner are taken to have been done by the Pricing Authority) is also relevant to this item.

Item 133 – Transitional—legal proceedings involving the Aged Care Pricing Commissioner

This item provides that on and from the commencement date the Pricing Authority is substituted as a party to any legal proceedings involving the Aged Care Pricing Commissioner that were pending in any court or tribunal immediately before the commencement day.

Item 134 – Things done by, or in relation to, the Aged Care Pricing Commissioner

Subitem (1) of this item provides that if, before the commencement day, a thing was done by, or in relation to, the Aged Care Pricing Commissioner for the purposes of the old Aged Care Act, a legislative instrument made under the old Aged Care Act or the *Aged Care Safety and Quality Commission Act 2018* as in force immediately before the commencement day, then the thing has effect, on and after the commencement day, as if it had been done by, or in relation to, the Pricing Authority.

This item also provides that transitional rules may provide that the arrangement set out in Subitem (1) does not apply in relation to a specified thing done by, or in relation to, the Aged Care Pricing Commissioner.

Item 135 – Transfer of records

This item provides that any records or documents that were in the possession of the Aged Care Pricing Commissioner immediately before the commencement day are to be transferred to the Pricing Authority on or after the commencement day.

Item 136 – References to the Aged Care Pricing Commissioner in instruments

Subitems (1) and (2) of this item provide that an instrument in force immediately before the commencement day that contains a reference to the Aged Care Pricing Commissioner has effect, on and after the commencement day as if a reference in the instrument to the Aged Care Pricing Commissioner were a reference to the Pricing Authority.

This item also provides that transitional rules may provide that the arrangement described in Subitems (1) and (2) does not apply in relation to a specified instrument or a specified reference, and that affected instruments can be from being amended or repealed after the commencement of this item.

This item also provides that an instrument includes:

- a contract, deed, undertaking, arrangement or agreement; and
- a notice, authority, order or instruction; and
- an instrument made under an Act or regulation.

Division 4—Transitional rules

Item 137 – Transitional rules

This item provides that the Minister may, by legislative instrument, make rules prescribing matters of a transitional nature (including prescribing any saving or application provisions) relating to the amendments or repeals made by Schedule 8 of this Bill.

However, the rules may not do the following:

- create an offence or civil penalty;
- provide powers of arrest or detention or entry, search or seizure;
- impose a tax;
- set an amount to be appropriated from the Consolidated Revenue Fund under an appropriation in this Act;

- directly amend the text of this Act.

This item does not otherwise limit the transitional rules that may be made.

Schedule 9 — Restrictive practices

Overview

Schedule 9 to the Bill revises the strengthened arrangements on the use of restrictive practices that commenced on 1 July 2021, to address unexpected outcomes in relation to the interaction with State and Territory guardianship and consent laws.

In response to Recommendation 17(1)(b)(v) of the Royal Commission’s Final Report, the strengthened arrangements require that prior to the use of restrictive practices, the care recipient or a person who is authorised by law to consent on the care recipient’s behalf has consented to the use of restrictive practices in accordance with relevant State or Territory laws. Specifically, if the care recipient lacks the capacity, consent must be given by the ‘restrictive practices substitute decision-maker’. This term is defined as a person or body that can give informed consent to the use of restrictive practices under the law of the State or Territory in which the care recipient is provided with aged care.

The strengthened arrangements were not intended to affect the operation of any State or Territory laws, and instead are intended to provide clarification on how the laws, intended to protect individuals from interference with their personal rights and liberties, intersect with the arrangements for restrictive practices.

Since the strengthened arrangements commenced, the Australian Government has received advice from States and Territories that in many jurisdictions, the relevant laws that authorise persons to consent on another’s behalf do not allow, and in some cases prevent, persons being recognised as a restrictive practices substitute decision-maker under the aged care legislation. Without clear consent arrangements in place across all jurisdictions, restrictive practices cannot be used in certain circumstances where it may otherwise be appropriate. This may result in harm to care recipients and others. It may also result in providers refusing to take care recipients with complex needs into their care and increased hospital admissions where providers believe they have no other workable options.

The amendments introduce interim arrangements to address this issue until State and Territory laws can be amended. The amendments would allow for the Quality of Care Principles to make further provision for the giving of informed consent to the use of restrictive practices in circumstances where a care recipient does not have capacity to consent. This would include the authorisation of a person to consent to the use of a restrictive practice on a care recipient’s behalf, where State and Territory laws do not clearly provide for a person to consent to the use of restrictive practices. In order to support these interim arrangements, the amendments also insert an immunity provision where approved providers have relied on the consent given by the restrictive practices substitute decision maker.

Introducing these arrangements will ensure that approved providers will be able to meet the strengthened requirements on the use of restrictive practices in jurisdictions where legal limitations with consent and guardianship laws exist.

Aged Care Act 1997

Item 1 – After subsection 54-10(1)

Item 1 to Schedule 9 to the Bill inserts new subsection 54-10(1A) after subsection 54-10(1) of the Aged Care Act. This new subsection provides that the Quality of Care Principles, made for the purposes of paragraph 54-1(1)(f), may make provision for or in relation to the persons or bodies who may give informed consent to the use of a restrictive practice in relation to a care recipient (if that care recipient lacks the capacity to give consent themselves).

Paragraph 54-1(1)(f) sets out the responsibility of approved providers to ensure a restrictive practice in relation to a care recipient is only used in circumstances set out in the Quality of Care Principles. For the purposes of paragraph 54-1(1)(f) of the Aged Care Act, paragraphs 15FA(1)(f) and 15FC(1)(c) of the Quality of Care Principles currently provide that to use a restrictive practice in relation to a care recipient, informed consent must be given to the use by the care recipient, or if the care recipient lacks capacity, by the ‘restrictive practices substitute decision-maker’. The definition of a ‘restrictive practices substitute decision-maker’ is in section 4 of the Quality of Care Principles.

To address issues raised regarding the interaction with current State and Territory consent and guardianship laws, Item 1 will allow for the Quality of Care Principles to authorise a person or body to consent to the use of restrictive practices where it is not clear that State and Territory laws currently provide for this authorisation. It is proposed that the Quality of Care Principles will include a hierarchy of people who would be authorised to provide consent to the use of a restrictive practice in relation to a care recipient where the care recipient lacks the requisite capacity to consent to the use of the restrictive practice themselves. It is intended that this will be a temporary interim solution to apply while State and Territory governments establish new legislative arrangements to address the current issues, and will ensure that appropriate individuals are authorised to consent to the use of restrictive practices nationally.

It is appropriate that these matters be dealt with in delegated legislation as they will deal with operational matters and will be co-located with the existing restrictive practices framework. Including these matters in delegated legislation will also ensure flexibility for prompt modifications if the arrangements have any unintended consequences that may impact the health, safety and well-being of care recipients. The Government will continue to monitor these arrangements and will review whether they should be included on the face of the Aged Care Act as part of the current project to introduce a new aged care legislation.

In response to the recommendations of the Royal Commission’s Final Report, the Government committed to immediately commence work on a new consumer-focused Aged Care Act. Work on the new Act is underway, and it will replace the existing aged care legislative framework. As part of the project, the Government will consider how existing aged care arrangements should be dealt with under the new legislative structure, including whether certain arrangements should be included on the face of the Act, rather than in delegated legislation.

Item 2 – Subsection 54-10(3)

Item 2 amends subsection 54-10(3) to also add a reference to new subsection 54-10(1A). Subsection 54-10(3) currently provides that subsections 54-10(1) and (2), which relate to matters that the Quality of Care Principles must require for the purposes of paragraph 54-1(1)(f), do not limit the matters that may be specified in the Quality of Care Principles for the purposes of paragraph 54-1(1)(f). The inclusion of new subsections 54-10(1A) to 54-10(3) will ensure that it also does not limit the matters that may be specified in the Quality of Care Principles for the purposes of paragraph 54-1(1)(f).

Item 3 – At the end of Division 54

Item 3 inserts new section 54-11 at the end of Division 54. New section 54-11 provides immunity from civil or criminal liability that may arise in relation to the use of a restrictive practice in particular circumstances and where certain conditions are met. This new section is inserted to ensure that an approved provider or individual who used or assisted in the use of a restrictive practice in relation to a care recipient can rely on the informed consent of a person authorised to provide that consent under the Quality of Care Principles, where the care recipient does not have the capacity to consent themselves.

New subsection 54-11(1) provides that this section applies if an approved provider provides aged care of a particular kind to a care recipient and a restrictive practice is used in relation to a care recipient and the care recipient lacked the capacity to give informed consent themselves.

New subsection 54-11(2) provides that in such circumstances, a ‘protected entity’ is not subject to any civil or criminal liability for, or in relation to, the use of a restrictive practice in relation to a care recipient if:

- informed consent to the use of restrictive practices was given by a person or body specified in the Quality of Care Principles; and
- the restrictive practice was used in circumstances set out in the Quality of Care Principles made for the purposes of paragraph 54-1(1)(f).

New subsection 54-11(3) provides that a ‘protected entity’ is:

- the approved provider that provides aged care of a kind specified in the Quality of Care Principles made for the purposes of paragraph 54-1(1)(f), which in accordance with current section 15DA of the Quality of Care Principles, is an approved provider of residential care, or flexible care in the form of short term restorative care provided in a residential setting, or
- an individual who used, or assisted in the use of, the restrictive practice in relation to the care recipient (for example, a staff member of the provider, an individual who volunteers for the provider, or a nurse or medical practitioner assisting the provider).

The purpose of new section 54-11 is to ensure that approved providers and relevant individuals are not liable to any civil or criminal action in circumstances where they have adhered to the obligations on the use of restrictive practices under aged care law. This is because the proposed consent arrangements may result in an approved provider, or relevant individual, relying on consent by a person who is authorised to give that consent under the Commonwealth's aged care laws, but who may not have the requisite authority under the relevant State or Territory laws.

This immunity will only apply where restrictive practices have been used in a way that is consistent with the requirements under the Quality of Care Principles. For example, the Quality of Care Principles require that restrictive practices must only be used as a last resort, only to the extent that is necessary, for the shortest time and in the least restrictive form, and to prevent harm to the care recipient. The immunity afforded by this provision will not apply to the use of restrictive practices that does not comply with these and any other requirements relating to the use of restrictive practices in the Quality of Care Principles.

It is proposed that as part of the amendments to the Quality of Care Principles to introduce the interim arrangements described above, amendments will also be made to ensure that a restrictive practice may only be used in accordance with the consent that has been provided (e.g. the particular type of restrictive practice, for the time specified). This will mean that if, for example, consent is given to the use of a restrictive practice for a particular period of time and it is used for longer than that specified period, it will not have been used in the circumstances set out in the Quality of Care Principles and therefore those involved will not be able to rely on the immunity in this provision. A further example where the provision is not designed to provide immunity is where consent was provided to the use of a chemical restraint but a higher dose of the relevant medication than what is specified in the behaviour support plan is administered. This will provide additional protections to care recipients and ensure that the scope of this immunity is limited to use that aligns with the consent that has been provided.

This provision is not intended to provide a broad immunity to negligence in respect of the use of a restrictive practice. It is intended to permit approved providers and those involved in the use to rely on consent from a restrictive practices substitute decision maker.

Item 4 – Clause 1 of Schedule 1

Item 4 inserts the new definition of 'protected entity' into Clause 1 of Schedule 1 (the Dictionary). This definition has the same meaning given by new subsection 54-11(3).

Certification of independent reviews equivalent to a Regulation Impact Statement



Australian Government
Department of Health

Mr Jason Lange
Executive Director
Office of Best Practice Regulation
Department of the Prime Minister and Cabinet
1 National Circuit
BARTON ACT 2600

Email: helpdesk-OBPR@pmc.gov.au

Dear Mr Lange

Certification of independent reviews: *Initial response to the Royal Commission (Quality and Safety) – Strengthening providers; New Aged Care Act.*

I am writing to certify that the attached independent reviews (**Attachment A**) have undertaken a process and analysis equivalent to a Regulation Impact Statement (RIS) for a number of aged care quality measures currently being considered by Government.

These documents are submitted to the Office of Best Practice Regulation for the purposes of satisfying the regulatory impact analysis requirements of the Government's initial response to the Royal Commission into Aged Care Quality and Safety (Royal Commission).

The scope of the certified reviews cover the scope of the policy proposal, with the exceptions of implementation and evaluation measures. Given the Government's existing commitment to implementation of relevant Royal Commission recommendations, the Department will remain alert to opportunities to embed evaluation into the policy proposal. Therefore I am satisfied that with this addition, the scope of the certified documents matches the policy proposal and answers all seven RIS questions.

Where fewer than three policy options have been examined, the Department's assessment is that this was feasible in light of the well-established policy problem and the extensive review processes that have informed this policy proposal.

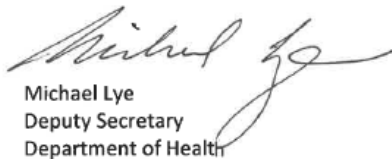
The regulatory burden to business, community organisations or individuals is quantified using the Australian Government's *Regulatory Burden Measurement* framework and is provided below.

I note that the implementation of this proposal will increase the regulatory burden. A search was undertaken across the Department, but no offset measures were identified. The Department will remain alert to opportunities to reduce the regulatory burden for affected stakeholders.

Regulatory burden estimate table				
Average annual regulatory costs (from business as usual)				
Change in costs	Business	Community organisations	Individuals	Total change in costs
Total, by sector	\$1, 446, 662	\$3, 708, 295	\$0	\$5, 154, 957

Accordingly, I am satisfied that the attached report is consistent with the *Australian Government Guide to Regulatory Impact Analysis*.

Yours sincerely



Michael Lye
Deputy Secretary
Department of Health
4 February 2021

Attachment A: Independent Reviews for certification of initial response to the Royal Commission into Aged Care (Quality and Safety).

Independent reviews for certification of initial response to the Royal Commission into Aged Care (Quality and Safety)

1. Royal Commission into Aged Care Quality and Safety, *Counsel Assisting's Proposed Recommendations at Final Hearing*, 22 October 2020
Available at: <https://agedcare.royalcommission.gov.au/media/29098>
2. Royal Commission Aged Care Quality and Safety Hearing, *Interim Report*, 31 October 2019
Available at: <https://agedcare.royalcommission.gov.au/publications/interim-report>
3. Royal Commission into Aged Care Quality and Safety Hearing, Transcript of proceedings, Hobart, 15 November 2019
Available at: <https://agedcare.royalcommission.gov.au/media/13646>
4. Human Rights Watch, *"Fading Away" How Aged Care Facilities in Australia Chemically Restrain Older People with Dementia*, October 15, 2019
Available at: <https://www.hrw.org/report/2019/10/15/fading-away/how-aged-care-facilities-australia-chemically-restrain-older-people>
5. Senate Community Affairs References Committee, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised - Final Report (April 2019)*
Available at:
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality
6. *Review of National Aged Care Quality Regulatory Processes Report*, Carnell, K and Paterson, R, October 2017
Available at: <https://www.health.gov.au/resources/publications/review-of-national-aged-care-quality-regulatory-processes-report>
7. Australian Law Reform Commission, *Elder Abuse—A National Legal Response (ALRC Report 131)* June 2017
Available at: <https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-alrc-report-131/>



Australian Government

Department of Health

Mr Jason Lange
Executive Director
Office of Best Practice Regulation
Department of the Prime Minister and Cabinet
1 National Circuit
BARTON ACT 2600

Email: helpdesk-OBPR@pmc.gov.au

Dear Mr Lange

Certification of independent reviews: *Response to the Royal Commission into Aged Care Quality and Safety*

I am writing to certify that the attached independent reviews (**Attachment A**) have undertaken a process and analysis equivalent to a Regulation Impact Statement (RIS) for a number of aged care quality measures currently being considered by Government.

These documents are submitted to the Office of Best Practice Regulation for the purposes of satisfying the regulatory impact analysis requirements of the Government's response to the Royal Commission into Aged Care Quality and Safety (Royal Commission).

The scope of the certified reviews cover the scope of the policy proposals, with the exceptions of implementation and evaluation measures. While implementation of some measures is expected to occur in the short term, for some of the larger and more complex challenging reforms, implementation is expected to be staged over several years as part of a progressive rollout in consultation with stakeholders, with ongoing evaluation and refinement of detailed settings as part of implementation. Therefore I am satisfied that with this addition, the scope of the certified documents matches the policy proposal and answers all seven RIS questions.

Where fewer than three policy options have been examined, the Department's assessment is that this was feasible in light of the well-established policy problem and the extensive review processes which have informed this policy proposal.

The regulatory burden to business, community organisations or individuals is quantified using the Australian Government's *Regulatory Burden Measurement* framework and is provided below.

I note that the implementation of this proposal will increase the regulatory burden. A search was undertaken across the Department, but no offset measures were identified. The Department will remain alert to opportunities to reduce the regulatory burden for affected stakeholders.

Regulatory burden estimate table				
Average annual regulatory costs (from business as usual)				
Change in costs	Business	Community organisations	Individuals	Total change in costs
Total by sector	\$697,567,681	\$971,721,665	\$317,342,082	\$1,986,631,428

Accordingly, I am satisfied that the attached report is consistent with the *Australian Government Guide to Regulatory Impact Analysis*.

Yours sincerely



Michael Lye
Deputy Secretary
Department of Health
March 2021

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Attachment A: Independent Reviews for certification of response to the Royal Commission into Aged Care Quality and Safety.

Attachment A

Independent reviews for certification of response to the Royal Commission into Aged Care Quality and Safety

1. Royal Commission into Aged Care Quality and Safety, *Final Report*, 26 February 2021 Available at:
<https://agedcare.royalcommission.gov.au/publications/final-report>
2. Royal Commission into Aged Care Quality and Safety, *Counsel Assisting's Proposed Recommendations at Final Hearing*, 22 October 2020
Available at: <https://agedcare.royalcommission.gov.au/media/29098>
3. Royal Commission Aged Care Quality and Safety Hearing, *Interim Report*, 31 October 2019
Available at:
<https://agedcare.royalcommission.gov.au/publications/interim-report>
4. Human Rights Watch, *"Fading Away" How Aged Care Facilities in Australia Chemically Restrain Older People with Dementia*, October 15, 2019
Available at: <https://www.hrw.org/report/2019/10/15/fading-away/how-aged-care-facilities-australia-chemically-restrain-older-people>
5. Senate Community Affairs References Committee, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised - Final Report (April 2019)*
Available at:
https://www.apf.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality
6. *Review of National Aged Care Quality Regulatory Processes Report*, Carnell, K and Paterson, R, October 2017
Available at: <https://www.health.gov.au/resources/publications/review-of-national-aged-care-quality-regulatory-processes-report>
7. Australian Law Reform Commission, *Elder Abuse-A National Legal Response {ALRC Report 131}* June 2017
Available at: <https://www.alrc.gov.au/publication/elder-abuse-a-national-legal-response-a-lrc-report-131/>
8. Legislated Review of Aged Care, *Final Report 2017*
Available at: <https://www.health.gov.au/resources/publications/legislated-review-of-aged-care-2017-report>

1. Senate Community Affairs Reference Committee, *Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia - Final Report*, 2014

Available at:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Dementia/Report/index

2. House of Representatives Standing Committee on Health and Ageing, *Thinking Ahead, Report on the inquiry into dementia: early diagnosis and intervention*, 2013

Available at: <https://www.health.gov.au/resources/publications/thinking-ahead-report-on-the-inquiry-into-dementia-early-diagnosis-and-intervention>

3. Department of Health and Aged Care, *Inquiry into Events at Earle Haven*, 2019

Available at: <https://www.health.gov.au/resources/publications/inquiry-into-events-at-earle-haven>

4. Productivity Commission, *Caring for Older Australians*, 2011

Available at: <https://www.pc.gov.au/inquiries/completed/aged-care/report>

5. Australian Skills Quality Authority, *Training for Aged and Community Care in Australia, A national strategic review of registered training organisations offering aged and community care sector training*, 2013

Available at:

https://www.asqa.gov.au/sites/default/files/Strategic_Reviews_2013_Aged_Care_Report.pdf?v=1508135481

14. Aged Care Strategy Taskforce, *A matter of care, Australia's aged care Workforce Strategy*, 2018

Available at:

<https://www.health.gov.au/resources/publications/a-matter-of-care-australias-aged-care-workforce-strategy>



Australian Government
Department of Health

Deputy Secretary

Mr Jason Lange
Executive Director
Office of Best Practice Regulation
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1 National Circuit
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Dear Mr Lange

**Certification of independent reviews in lieu of a Regulatory Impact Statement:
Care Workforce Reform - National Care and Support Worker Regulation**

This letter certifies that the Productivity Commission report, the *National Disability Insurance Scheme Costs*, released on 19 October 2017, and the *A Matter of Care - Australia's Aged Care Workforce Strategy Report*, released in June 2018, have undertaken similar processes and analyses to that required for a Regulation Impact Statement (RIS), as set out in the *Australian Government Guide to Regulation*. This built upon previous consultation and analysis undertaken by the Productivity Commission, as detailed below.

The introduction of the National Disability Insurance Scheme (NDIS) was informed by thorough analysis that showed the significant benefits of a national scheme. This was followed by the 2017 Productivity Commission report into NDIS Costs that identified factors that were inhibiting the efficiency of the disability care sector, and suggested further reforms to improve whole-of-economy care outcomes across the broader care sectors. In particular, the report recommended Government focus on areas that affect demand and supply of workers from an economy-wide perspective (p. 339). Screening arrangements, thin markets, and a lack of market information were identified as key impediments to labour market growth (pp. 2, 36, 38). This aligned with the analysis conducted by the 2006 Productivity Commission report, *Rethinking Regulation*, for the Taskforce on Reducing Regulatory Burdens on Business, which recommended the development and adoption of minimum effective national standards for licensing and registration across a range of industries and sectors (Recommendation 4.33).

Complementary work undertaken by the Productivity Commission in 2011 resulted in the report *Caring for Older Australians*, which clearly identified the need to improve regulatory settings and better align the interface between the NDIS and the aged care sector (Recommendation 9.7).

The 2018 report by the Aged Care Workforce Strategy Taskforce recommended centralising registration for all care staff and volunteers, and standardising workforce architecture to strengthen the industry-wide employee value proposition (p. 42). Further, the Department of Health engaged in extensive industry consultation in 2019-20, confirming industry views that for programs, such as worker screening, it is better to leverage off NDIS worker screening rules.

I certify that the reports by the Productivity Commission and the 2018 Aged Care Workforce Strategy Taskforce have adequately addressed all seven RIS questions. The total regulatory impact on businesses, community organisations and individuals of measures associated with both of these reviews has been quantified according to the Australian Government's Regulatory Burden Measurement framework. The estimated net reduction in annual regulatory burden is provided below.

Average annual regulatory costs (from business as usual)			
Change in costs	Business and Community Organisations	Individuals	Total change in cost
Total, by sector	-\$12.496m	-\$9.396m	-\$21,892m

I am satisfied that the Productivity Commission reports, complemented by the Aged Care Workforce Taskforce report, meet best practice, consistent with the *Australian Government Guide to Regulation*.

Yours sincerely



Michael Lye
Ageing & Aged Care

3 March 2021

Authority measure- Regulatory Impact Statement

Introduction

This Regulatory Impact Statement (RIS) has been prepared by the Department of Health and Aged Care (the Department) to inform a Cabinet decision as part of the 2020-21 Budget process on residential aged care funding reform. This RIS builds on the draft RIS 'subject to Early Assessment by the Office of Best Practice Regulation (OBPR)' prepared early in 2020. This draft RIS informed the decision to invest in preparatory funding for the Australian National Aged Care Classification (AN-ACC), including the development of a new residential aged care payment system.

The Australian Government is the major funder of residential aged care services in Australia, contributing approximately \$13.4 billion in 2019-20 to cover the basic subsidy and supplements. The majority of this funding is allocated based on the classification of residents from the Aged Care Funding Instrument (ACFI).

Under the current residential aged care funding arrangements, funding is not aligned to the care needs of residents, is not contemporary and leads to funding volatility for the sector and the Australian Government. In addition, the incentives in the funding model can lead to perverse or negative quality outcomes, and inequality in funding between regions.

The causes of these issues relate to the design of the current ACFI and indexation not aligning to changes in residential aged care costs. In addition, funding for respite care in residential aged care settings no longer aligns with permanent residential care funding, creating distortions that favour use of beds for permanent care and limiting access to respite care.

Extensive work has been undertaken since 2016 to investigate and develop robust alternatives to the current funding arrangements. This RIS explores three potential options:

1. keep the existing ACFI model
2. adopt the Australian National Aged Care Classification (AN-ACC) model with independent assessors, and
3. amend the ACFI to make it better align with contemporary care practices

Option 2, the AN-ACC funding model, aligns care needs and cost drivers in residential aged care to ensure funds are directed where they are needed. The introduction of this model would address the issues with the ACFI, support delivery of better quality care for older Australians and improve funding certainty for the Australian Government, providers and investors. This approach is estimated to reduce the regulatory burden by approximately \$191 million each year.

Background

Residential aged care in Australia

Residential care provides support and accommodation for people who have been assessed as needing higher levels of care, and choose or need to be cared for in an aged care facility. Residential care is provided on either a permanent or a temporary (respite) basis and is governed by the *Aged Care Act 1997* (the Act) and subsidised by the Australian Government.

In 2019-20, 244,363 people received permanent residential aged care at some point during the year and 66,873 people received residential respite care. At 30 June 2020, there were 183,989 care recipients in permanent residential care (81 per cent of operational capacity). As at 30 June 2020, there were 845 residential care providers operating in Australia with 2,722 residential care services, 2,605 of which also provided residential respite services.

These providers are a mix of for-profit and not-for-profit and state and local government organisations.

Current residential aged care funding arrangements

Funding overview

The Australian Government contributes to care funding on behalf of eligible Australians to residential aged care providers (providers). Funding is used by providers to deliver care in accordance with the Act. The Australian Government determines its contributions for care funding on behalf of permanent residents in residential care by setting:

- The basic care subsidy; a payment to support the costs of providing personal and nursing services for permanent residents. It is calculated based on the assessed needs of residents as determined by the provider applying the ACFI.
- The rates of supplements paid to support various aspects of residential aged care. These are paid in addition to the basic subsidy and are either primary supplements that provide additional funds to meet specific care needs or other supplements that assist providers with the operation of the facility.

In 2020 the Australian Government contributed around \$13.4 billion to residential care to cover the basic subsidy and supplements, an increase of 6.6 per cent over the previous year. This amounts to approximately \$69,055 per resident in care per annum. The vast majority of the Australian Government funding is paid through the basic subsidy (\$11.9 billion in 2018-19). A breakdown of subsidy and supplements payments is at Table 1.

Table 1: Summary of Australian Government payments by subsidies and supplements for residential aged care

Type of Payment		2015–16 \$M	2016–17 \$M	2017-18 \$M	2018–19 \$M	2019-20 \$M
Basic Subsidy	Permanent	10,507.7	11,024.2	11,163.5	11,947.4	12,012.7
	Respite	264.4	280.6	312.3	348.8	371.3
Primary Care Supplements	Oxygen	16.5	17.5	18.3	18.3	16.8
	Enteral Feeding	6.3	5.9	5.9	5.2	5.0
	Respite Incentive	29.0	30.1	34.6	40.6	46.8
Other Supplements	Viability	35.6	43.2	55.8	62.0	82.3
	Veterans'	1.8	1.1	1.6	1.7	1.5
	Homeless	7.6	8.3	8.6	9.8	13.3
Hardship	Hardship	5.2	4.9	4.0	3.9	6.5
	Hardship Accommodation	3.6	2.9	2.6	2.5	1.9
Accommodation Supplements	Accommodation Supplement	845.7	907.5	1,029.6	1,134.2	1225.1
Supplements related to Grandparenting	Concessional	64.0	64.0	55.6	51.3	40.2
	Transitional	6.0	4.8	3.8	3.2	2.6
	Accommodation Charge Top-up	2.1	1.4	1.0	0.7	0.4
	Charge Exempt	3.8	2.0	1.8	1.7	1.4
	Pension	36.3	27.2	20.7	16.3	12.8
	Basic Daily Fee	0.6	0.4	0.3	0.2	0.1
	Transitional Accommodation Supplement	22.3	15.5	10.7	7.6	5.4
Reductions	Means Testing Reduction*	-455.7	-560.8	-564.0	-627.2	-648.2
	Other	-31.5	31.5	42.0	-9.1	231.7
Total (\$million)		11,371.4	11,903.8	12,204.2	13,014.5	13,429.7

* New means testing arrangements (combined income and asset assessments) were introduced on 1 July 2014. Prior to these arrangements residents were subject to income testing only.

The Aged Care Funding Instrument (ACFI)

The basic subsidy is currently determined by the ACFI. On entry to a residential aged care facility, the ACFI is completed by facility staff and this initial assessment results in the resident being classified on each ACFI domain to one of four levels of need – nil, low, medium or high need. The ACFI domains are:

- *Activities of Daily Living (ADL)* – covering nutrition, personal hygiene, mobility, toileting and continence
- *Behavioural Domain (BEH)* – covering cognitive skills, cognition, wandering, verbal and physical behaviour and depression, and
- *Complex Health Care (CHC)* – covering medications and complex health care needs.

The daily ACFI subsidy rates from 1 July 2020 to 30 June 2021 July 2020 are:

Level	Activities of daily living	Behaviour	Complex Health Care
Nil	\$0.00	\$0.00	\$0.00
Low	\$38.28	\$8.75	\$16.98
Medium	\$83.36	\$18.14	\$48.37
High	\$115.49	\$37.81	\$69.84

Aged care residents are appraised by their residential aged care provider using the ACFI tool once the resident has been in the facility for a minimum of seven days. Appraisers are typically registered or enrolled nurses or external consultants with equivalent clinical qualifications. All new entrants to a facility are appraised using ACFI and it is the industry norm to reappraise all residents regularly throughout the year as well as when the resident's circumstances change in ways that may affect their care needs.

Most residential aged care providers have responded to the ACFI by employing dedicated staff that manage ACFI records. Most residential aged care providers use specialised software to assist them in performing the ACFI appraisals and record-keeping.

Under the Act, ACFI appraisals must be retained by providers for two years. The Department can request access to client information within those appraisals at any time during this period.

Data collected from 80 providers by aged care accountancy firm StewartBrown shows that in 2018-19 providers spent an average of \$842 per bed on staff working in specialist ACFI roles and on external ACFI consultants. When extrapolated this would equate to approximately \$200 million per year across all providers which represents approximately 1.4 per cent of the ACFI subsidy.

The Department runs an ACFI Review Program to ensure the validity of ACFI claims. Approximately 50 staff are employed in the Health Grants and Network Division to deliver ACFI review and reconsideration processes. ACFI Review Officers are responsible for conducting reviews of resident classification under the ACFI. They respond to incorrect claiming through the ACFI and manage any merits review (reconsideration) requests and appeals that may arise from these reviews.

Table 2 shows the number of ACFI reviews conducted in the third quarter of 2018-19, the number of ACFI appraisals that were re-classified (downgraded or upgraded) and those that were unchanged. This data illustrates that over 42 per cent of ACFI appraisals reviewed were found to have over-stated the care needs of the resident and consequently, over-claimed subsidy. The downgrading of those appraisals represented \$75 million in subsidy adjustments in 2018-19.

Table 2: ACFI Review statistics for 2018-19, by state/territory (Source: ACFI Quarterly Reports)

ACFI Review statistics for 1 April 2019 to 30 June 2019, by state/territory								
State	Downgraded		Unchanged		Upgraded		Total	No. of Services
	Reviews	%	Reviews	%	Reviews	%		
NSW/ACT	387	51.3	366	48.5	1	0.1	754	72
VIC	110	33.4	216	65.7	3	0.9	329	52
QLD	108	29.1	261	70.4	2	0.5	371	49
SA/NT	40	38.8	62	60.2	1	1.0	103	12
WA	50	24.0	158	76.0	0	0.0	208	31
TAS	13	30.2	30	69.8	0	0.0	43	5
Total	708	39.2	1,093	60.5	7	0.4	1,808	221

Overall the ACFI can be characterised as highly prescriptive, and as placing a high regulatory burden, both through the appraisal process and complying with rules around retention of records and review processes.

Respite funding

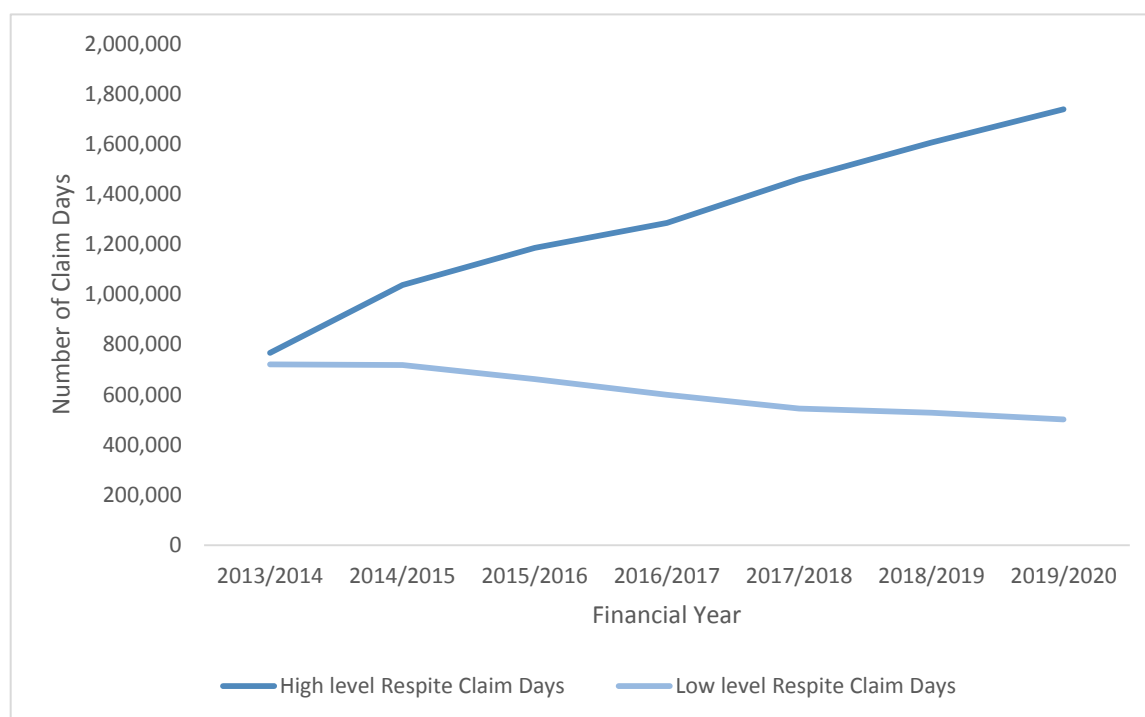
Respite care is defined in the Act as ‘residential care or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short-term break from their usual care arrangement’.

A person is eligible to use residential respite services following a face-to-face assessment by an Aged Care Assessment Team (ACAT). Respite users are entitled to 63 days of subsidised respite care in a financial year. This approval can be extended by an ACAT for up to 21 days at a time.

Residential respite approvals are issued at a *high* or a *low* level. As at July 2020, the total daily funding received by a provider for a resident classed as *high* is either \$230.09 or \$190.89 (depending on whether a provider uses more than 70 per cent of their respite allocation over a 12 month period, and excluding the temporary additional daily subsidy provided to August 2020 to assist with additional costs during the COVID-19 pandemic), whereas the total daily funding for resident classed as *low* is \$88.02.

Over recent years there has been a significant increase in *high* level respite claim days, while the number of *low* level respite claim days has decreased (see chart 1).

Chart 1: Provision of respite care days by high and low levels



Funding reform policy development to date

In 2016-17, the Australian Government announced it would look into strengthening residential aged care funding, including possibly replacing the existing funding assessment tool, the ACFI and considering options for external assessment. This was in response to an unexpected increase of \$3.8 billion over five years in the forward estimates for residential care expenditure.

As a first step in this reform process, the Australian Government commissioned two reports on residential aged care funding reform:

- Review of the ACFI by Applied Aged Care Solutions (AACS), and
- Alternative Aged Care Assessment, Classification System and Funding Models by the Australian Health Services Research Institute (AHSRI), University of Wollongong.

Review of the ACFI

Undertaken by AACS, this review of ACFI¹ made recommendations to align it with contemporary best practice as well as make it potentially suitable for external assessment. It proposed a revised ACFI (R-ACFI) and made a number of key recommendations including removing redundant items, attaching new weightings to items and mandating sign offs on ACFI appraisals.

¹ The Applied Aged Care Solution Review of the ACFI is available here: <https://www.health.gov.au/resources/publications/review-of-the-aged-care-funding-instrument-acfi>

The review made clear that there was no quick fix for ACFI and highlighted the difficulty of making meaningful reforms without disrupting the whole funding model. The report was released in October 2017 and was not well received by the sector, who were not convinced that the recommendations would address the issues in ACFI.

Alternative Aged Care Assessment, Classification System and Funding Models

AHSRI at the University of Wollongong was commissioned to undertake a study to develop options for future funding models that might be adopted for the residential aged care sector².

The study examined international evidence focusing on the assessment tools, classification systems and models for the allocation of funding for the provision of care and services in residential aged care.

The study explored five funding options:

- **Option one** – refinement of the current ACFI model
- **Option two** – a simplified model with four funding levels
- **Option three** – a simplified model with four funding levels, plus supplements and subject to external assessment
- **Option four** – a case-mix funding model with a branching classification
- **Option five** – a blended payment model with a variable (individualised) component based on residents care costs determined using a branching casemix classification, and a fixed (shared) component to account for care shared across all residents.

AHSRI's final report recommended that option five, the blended payment model, be adopted, and that a resource utilisation and classification study be undertaken to inform the development of the branching classification, and the proportion of fixed and variable costs.

Following the release of AHSRI's report, the Department consulted with the sector and the Australian public through a series of public events across ACT, NSW, VIC, SA, TAS, WA and QLD. Public feedback indicated an enthusiasm for funding reform, and further development of the proposed funding option.

The Resource Utilisation and Classification Study

² Alternative Aged Care Assessment, Classification System and Funding Models Final Reports are available here: <https://www.health.gov.au/resources/publications/alternative-aged-care-assessment-classification-system-and-funding-models-report>

In August 2017 AHSRI, following a competitive procurement process, was commissioned to undertake the 'Resource Utilisation and Classification Study' (RUCS) of residential aged care.

The RUCS was a landmark study to provide an evidence base and inform the development of future funding models for residential aged care in Australia. The aims of the RUCS were to:

- identify the clinical and need characteristics of aged care residents that influence the cost of care (cost drivers)
- identify the proportion of care costs that, on average, are shared across residents (shared costs) relative to those costs related to individual needs (individual costs)
- develop a casemix classification based on identified cost drivers that can underpin a funding model that recognises both shared and individual costs, and
- test the feasibility of implementing the recommended classification and funding model across the Australian residential aged care sector.

The RUCS was composed of four separate but closely related sub-studies and included more than 80 facilities and over 3,000 residents. The final RUCS reports were received in January 2019 and published on the Department's website in March 2019. There were 30 recommendations in the reports to reform residential aged care funding including the implementation of a new blended funding model (based on the recommended option five, from AHSRI's original report), the AN-ACC funding model. This model is described in detail in Section 5.

Consultation on the RUCS reports was held from March to May 2019. The Department received 91 submissions which highlighted strong enthusiasm for ongoing conversations on funding reform and that the aged care sector is keen to be involved in the reform journey, while also noting concerns regarding the overall level of funding for the sector.

The Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) was established on 8 October 2018 to look at the quality of aged care services and whether those services are meeting the needs of the Australian community. Further to this, the Royal Commission was tasked to examine the care provided in cities, as well as in regional and remote areas, and determine how aged care services could be improved.

The Royal Commission published its interim report on 31 October 2019, which was followed by the Counsel Assisting's Proposed Recommendations at Final Hearing on 22 October 2020. It is worth noting that the Counsel Assisting's Proposed Recommendations included support for the delivery of residential aged care through

a casemix classification system, which is consistent with the Department's preferred AN-ACC model.³

The Royal Commission's final report was handed to the Governor-General on 26 February 2021 and included a range of findings on aged care funding related issues. Of relevance to this RIS, the final report recommended:

- by 1 July 2022, The Australian Government should fund residential care providers through a casemix classification system such as the AN-ACC. **(Recommendation 120)**

The AN-ACC Trial

On 10 February 2019, the Prime Minister announced a \$4.6 million trial of the AN-ACC assessment model. The purpose of the AN-ACC trial was two-fold:

1. Collect data to validate the expected distribution of care recipient classification under the AN-ACC, as compared to the findings of the RUCS.
2. Field test the performance of:
 - a. the AN-ACC assessment tool, which when administered produces residential aged care recipient functional status data required to calculate AN-ACC classification levels for individuals
 - b. an independent assessment workforce trained to administer the tool, and
 - c. the training, clinical and IT supports developed to equip assessors undertake assessments.

The impact of the COVID-19 pandemic, which included restricting non-essential access to aged care homes, led to the early conclusion of the AN-ACC trial and fewer assessments completed of residents than the original target of up to 12,000 residents of voluntarily participating RACFs across Australia. In the final analysis, 7387 AN-ACC assessments were completed (7276 permanent residents, 111 respite residents), across 122 homes.

The trial of the AN-ACC assessment model concluded that it is fit for purpose, can be expanded to a national scale, and assessment can be efficiently completed by an external assessment workforce.

³ See Recommendation 88: Casemix-adjusted activity based funding in residential aged care: [Counsel Assisting's Proposed Recommendations](#)

The AN-ACC Shadow Assessment

A key preparatory step in the implementation of the AN-ACC, should it be approved, is the undertaking of independent care assessments for all new and existing permanent residential aged care recipients using the AN-ACC assessment tool. As such, the Australian Government is funding a year of 'shadow assessment' to start in April 2021.

During the shadow assessment phase, the ACFI will continue to operate and will be the mechanism through which funding assessments continue to be made. The AN-ACC shadow assessments, in which all residents will be assessed by an independent assessor using the AN-ACC assessment tools, will be occurring in parallel to ACFI assessments. There will be no changes to ACFI processes. The AN-ACC shadow assessment process will not impact on funding received by providers in relation to care recipients.

This work is necessary to ensure the Australian Government is prepared to respond flexibly to the Royal Commission's final report; it does not reflect final decisions to shift to the AN-ACC funding model, but rather a proactive approach to ensuring funding reform options are available to replace the outdated ACFI.

What is the problem you are trying to solve?

The current residential aged care funding model is no longer fit for purpose.

The model has contributed to a culture in the sector that focusses on funding ahead of care delivery. Funding levels determined by the ACFI are not aligned to the care needs of residents. The model has resulted in funding volatility for the sector and the Australian Government, has delivered unequal funding between regions and, in addition, the incentives it creates can lead to perverse or negative quality outcomes. The Aged Care Financing Authority (ACFA) observed in their 2018 annual report that:

'[T]he current ACFI tool may suffer from no longer being contemporary (such as incentivising certain, sometimes outdated, types and modes of care delivery), it could encourage inefficiencies (through providers focusing limited resources on ACFI claiming) and appears to lack stability (with a history of cycles of high growth followed by low or no growth as higher than expected provider claiming leads to Government taking measures to reduce funding growth rates back to estimated levels)' (ACFA 2018b, p188).

Moreover, funding for respite in residential aged care no longer aligns with funding for permanent residential aged care, which creates distortions that favour use of beds for permanent care and limits access to respite services.

It is clear from the Royal Commission's final report that there are problems in residential aged care that extend beyond the funding arrangements, and that reforms to these arrangements will need to be part of a suite of reforms to the sector to ensure the system is fit for purpose going forward. As the scope of this RIS

only extends to residential aged care funding arrangements, this section only provides analysis on problems that relate to such arrangements.

The remainder of this Section provides a detailed description of the different elements of the problem with the current funding model.

Problem element one – The ACFI incentivises poor and outdated modes of care

The ACFI directly links funding to the delivery of certain care activities. This has resulted in perverse incentives to deliver these care activities irrespective to whether they are necessary or appropriate to the resident. For example, four sets of twenty-minute pain management physiotherapy sessions are routinely provided to large numbers of residents due to the high level of ACFI funding they attract. However, this may not be in the residents' best interests, many residents have skin conditions such as paper thin skin which means such treatment can be detrimental and inflammatory to their condition. Alternative treatments such as light exercise may be better but are not offered to residents because they are not linked to specific additional funding under the ACFI.

ACFI can also incentivise dependence – for example, there is a perverse incentive to encourage dependency, such as immobility, in the resident as it may score higher in the ACFI, notwithstanding that the resident may benefit from greater re-ablement therapy to help them be more mobile.

Problem element two – Funding assessments detract from care planning and care provision

Providers currently use the ACFI tool to assess their own residents and so self-determine the funding they receive. The ACFI tool is heavily reliant on several detailed clinical assessments which require observational, multi-day measurements. Appraisers are typically registered or enrolled nurses or external consultants with equivalent clinical qualifications. Undertaking ACFI assessments and the completion of related paperwork consumes a substantial proportion of facilities' clinical resources, which would be better directed to providing quality care.

Data collected from 80 providers by aged care accountancy firm StewartBrown shows that in 2018-19 providers spent an average of \$842 per bed on staff working in specialist ACFI roles and external ACFI consultants. When extrapolated this would equate to around \$200 million per year across all providers which represents approximately 1.4 per cent of the ACFI subsidy.

Service providers indicated that the current ACFI processes takes the focus of care staff away from what they do best, delivering care, and requires them to undertake funding related 'paperwork'. Some providers even use external 'ACFI Consulting' services to perform the ACFI assessment. These businesses are increasingly operating under a 'no win no fee' business model. In addition, the Australian Government runs a costly and time consuming validation processes, ACFI Review Program, which has been one of the main sources of tension between providers and the Department.

Estimates from Section 6 of this RIS suggest that the regulatory burden on providers of undertaking and submitting ACFI assessments, reassessments and meeting ACFI record keeping requirements is around \$202 million per year. While any funding model providing care funding based on resident need will require resident assessments and reassessments, which under any model will place some regulatory burden on providers, the current model places a particularly excessive burden.

Problem element three – Inequity of funding to rural and remote

The distribution of funding across the sector is not equitable across geographic regions (see Chart 2). Daily average ACFI subsidies in 2018-19 were \$179.20 in metropolitan areas and between \$152.28 and \$163.53 in the outer regional to very remote areas of Australia. This represents a significant difference in funding per resident between metropolitan and rural and remote providers.

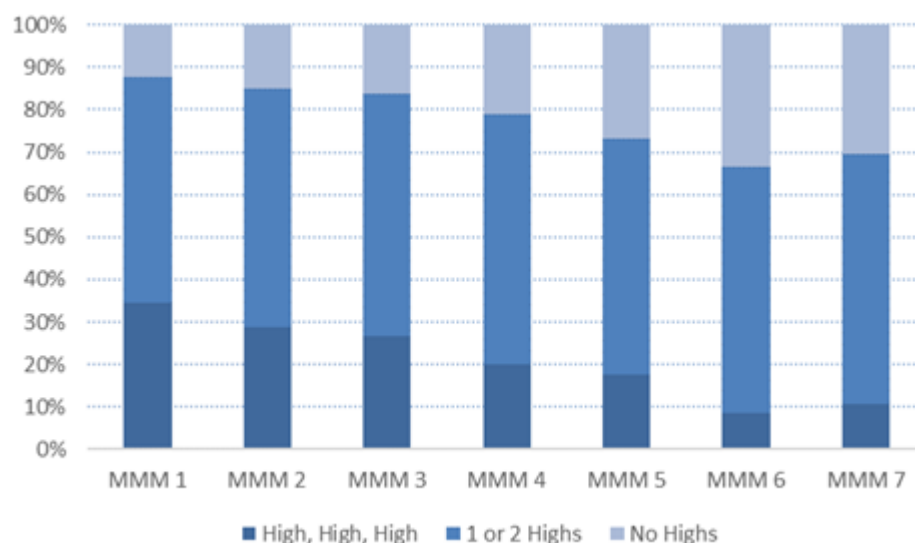
While it is possible that some of this difference in funding between regions can be attributed to genuine differences in resident characteristics, differences in ACFI claiming behaviour and less access to allied health professionals also contributes to lower subsidy rates in regional and remote areas.

Facilities (and providers) operating in outer regional, remote and very remote areas are often small in size and lack the economies of scale and scope which are found in more urban areas. Metropolitan providers can utilise these economies of scale to develop sophisticated approaches to maximising ACFI, including hiring specific staff to manage residents' ACFI scores across facilities to maximise funding.

In addition, in order to access the maximum funding under the ACFI, residents need to receive specific treatments from allied health professionals. Part of the reason for the lower ACFI scores in rural and remote areas relates to limited access to allied health professionals, to deliver these specific types of care.

Overall around 39 per cent of providers operate in only regional areas, and a further 10 per cent of providers operate in metropolitan and regional areas.

Chart 2: Proportion of ACFI classification mixes in claims from providers, by Modified Monash Model⁴ remoteness classification 2019-20 (Source: ACFI data)



Problem element four – ACFI can no longer distinguish care needs of residents

The two reviews of the ACFI in 2017 (ACFI Review 2017; AHSRI 2017a) and ACFA's latest analysis of residential aged care funding (ACFA 2018b) indicate that the ACFI's ability to reliably guide funding calculations for residential aged care subsidy has degraded. In particular:

- ACFI cannot properly distinguish the care needs of residents and consequent funding support required, and
- ACFI has not been re-calibrated to reflect contemporary residential aged care service offerings or delivery.

The ACFI does not satisfactorily discriminate between residents based on their care needs. AHSRI found that ACFI explained only 20 per cent of the variation in costs of providing care to residents, creating strong incentives for facilities to cherry-pick residents based on their ability to attract a high ACFI revenue stream relative to their actual care costs. This creates potential access issues for high cost residents, while also creating financial risk for providers who care for residents with high costs relative to the subsidy they attract.

Problem element five – ACFI design leads to funding volatility

In 2015 and 2016, the Australian Government increased the forward estimates for residential aged care funding by a total of \$3.8 billion over five years to 2019-20. This followed a similar, unexpected blow out in funding in 2012-13. As a result, the Australian Government announced in the 2016-17 Budget that it would examine

⁴ Remoteness here is defined using the Modified Monash Model (MMM), with MMM 6-7 defined as remote and very remote.

longer-term reform options as a way to ensure residential aged care spending does not fluctuate as it had previously.

The Australian Government has responded to these unexpected funding increases by making changes to indexation arrangements or the ACFI tool itself in order to ensure the sustainability of spending on aged care. This pattern has resulted in Budget uncertainty for the Commonwealth and funding uncertainty for aged care providers.

Analysis completed by the Department, and also supported by the Applied Aged Care Solutions Review of ACFI⁵, suggest that the increase in ACFI expenditure that led to the 2015-16 forward estimates adjustment did not appear to correlate with a commensurate overall increase in resident frailty.

The expense growth patterns are neither linear, nor consistent across all three domains of ACFI, falling predominantly within the CHC domain. These claiming patterns are not present across all parts of the sector. Applied Aged Care Solutions noted that the increase in claims coincided with benchmarking services becoming widely available, and specialist ACFI co-ordinator roles being established in most organisations.

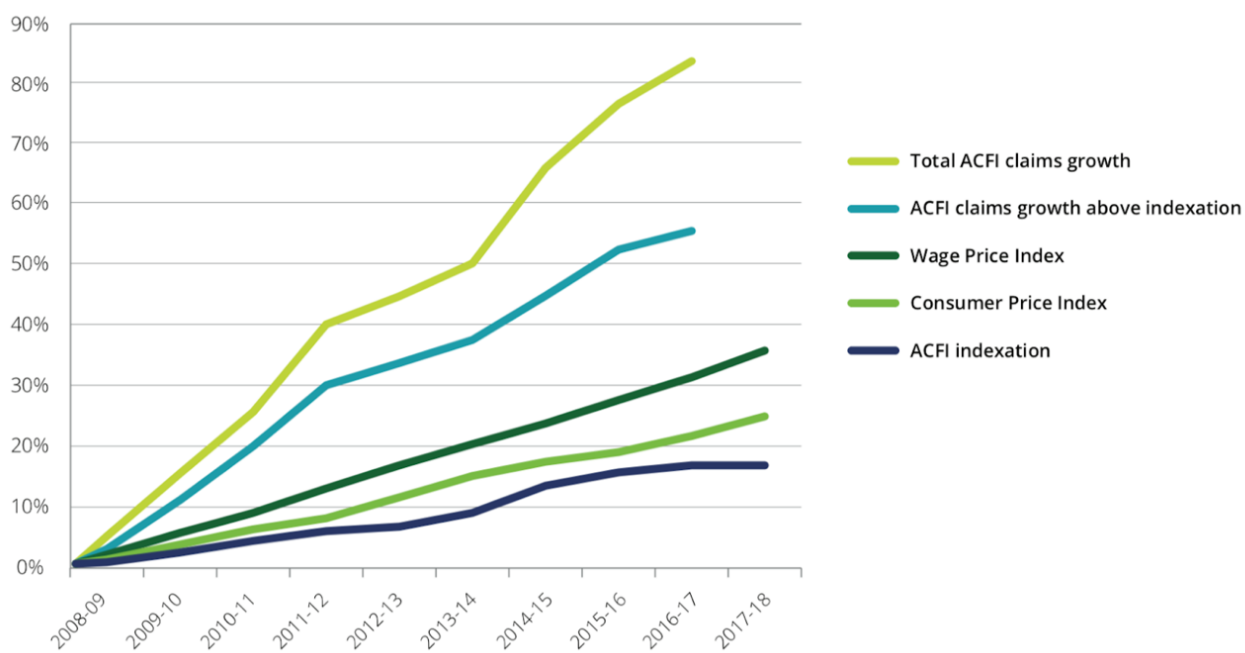
Together, this suggests that the ACFI is open to 'gaming' by providers seeking to maximise resident subsidies. This is further supported by the fact that 42 per cent of ACFI reviews in 2018-19 were found to have over-stated the care needs of the resident and consequently over-claimed subsidy.

Problem element six – Indexation does not align with changes in cost in residential aged care

The ACFA undertook a historical analysis of growth in ACFI subsidies and compared this to changes in cost indices. A key finding of their analysis was that the indexation applied to ACFI has been noticeably lower than the growth in a range of cost indices. Wages (which account for nearly 70 per cent of total costs) have grown approximately twice as fast as ACFI indexation. Noting that, overall, the actual average amount of ACFI subsidy paid to providers per resident per day has grown at nearly three times as much as wage and price indices. This growth reflects claiming behaviour under ACFI by providers.

⁵ See page 36 of https://www.health.gov.au/sites/default/files/documents/2019/11/review-of-the-aged-care-funding-instrument-acfi-review-of-the-aged-care-funding-instrument-acfi-part-2-main-report_0.pdf

Chart 3: Cumulative change in aged care subsidies and costs, 2008–09 to 2016–17



The current ACFI arrangements cannot satisfactorily resolve the extent to which resident’s care needs have been increasing over time compared with the extent to which providers have maximised the potential to use the ACFI tool to increase revenue growth (including as a response to low indexation).

ACFA considers the ability of the sector to gain revenue growth through ACFI claiming behaviours might be diminishing. This will put further pressure on the need for indexation arrangements to adequately reflect the growth in costs.

Policy problem seven – Respite funding does not align with permanent residential aged care funding

Respite provided in residential aged care currently operates on its own funding model without any relationship to the funding of permanent residential aged care. As providers have a set number of beds allocated by the Australian Government, which they are able to choose to offer to permanent residents or residential respite residents, this has led to issues around resident access to respite as providers favour more profitable permanent residential care beds.

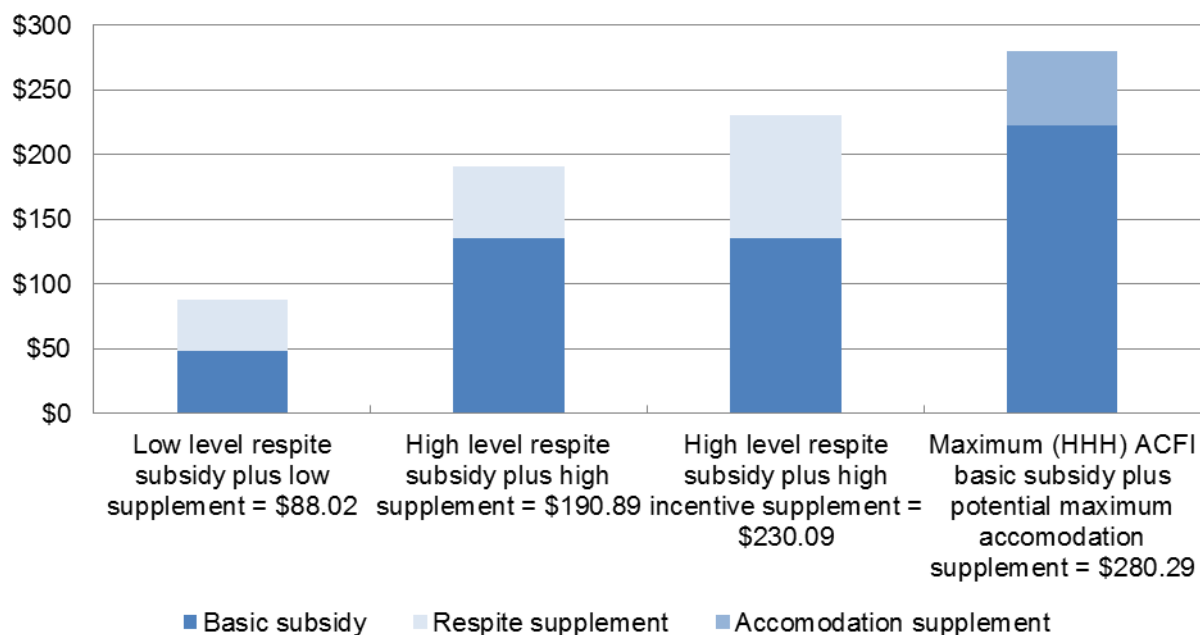
Stakeholder consultation by ACFA on respite in residential aged care noted concerns around the funding of respite, that it does not meet the costs of care and accommodation, has proportionally high administration costs compared to permanent residents and exposes providers to more financial risk compared to permanent residents.

The highest ACFI rate plus the accommodation supplement for permanent residential care residents is notably higher than the funding for respite including with the care supplement and the 70 per cent occupancy incentive (see Chart 4).

The ACFA consultations also found a significant decrease in the provision of *low* level respite days over the last few years (see Chart 1).

As a result of this consultation ACFA recommended that funding arrangements should be neutral between respite residents and permanent residents and not act as a disincentive to respite care. ACFA also recommended looking at how the outcomes of the RUCS could be used to align respite and permanent residential aged care.

Chart 4: Amount of respite care basic subsidy plus respite care supplement compared to the maximum permanent care ACFI basic subsidy and potential accommodation supplement at 1 July 2020



Why is government action needed?

The Australian Government has policy responsibility for funding and regulating residential aged care in Australia. The Australian Government’s funding of residential aged care is vital to ensuring residential aged care is affordable and available to all Australians who need it. Around three quarters of funding to residential aged care providers comes from the Australian Government, with the remainder coming from resident contributions (noting that these resident contributions are currently regulated and set by the Australian Government not aged care providers).

Without Australian Government action to reform the current residential aged care funding arrangements, the sector will continue to focus on funding before care. Funding arrangements need to:

- Be more contemporary, efficient and effective, allowing provider assessment resources to be devoted to assessment for care planning purposes and supporting delivery of the right types of care, and
- be stable, providing greater certainty of funding levels for government, providers and investors, encouraging investment in the sector to meet future demographic challenges as demand for aged care grows.

In addition, having a robust and equitable residential aged care funding model would allow any future funding increases to the sector, for example to support improved sector viability and the delivery of higher quality care, to be delivered with confidence that it is being distributed appropriately. This will be particularly important as the Government considers the appropriate funding level for the sector, and other potential changes in response to the Royal Commission's recommendations.

What policy options are you considering?

The Australian Government commenced investigating options to reform residential aged care funding arrangements in 2016. Since this time a number of options have been developed, considered, and based on earlier analysis are deemed to not be viable options for further detailed consideration.

The table below outlines these options:

Option	Assessment of option
Simplified model with four funding levels (see option two in AHSRI 2017 for further information)	Four funding levels means residents within each class are diverse in terms of their care needs and costs. This presents a financial risk to both providers and the Australian Government. This model also provides incentives for providers to select residents with low care costs relative to their funding class, creating access issues, especially for those with the highest care needs.
Simplified model with four funding levels, plus supplements and subject to external assessment (see option three in AHSRI 2017 for further information)	This model overcomes the issue of having residents with diverse care needs in the same payment bands by adding in a range of supplements. However it was determined to be quite complicated and a significant policy change to implement, without all the benefits provided by a casemix funding model.
A case-mix funding model with a branching classification (see option four in AHSRI 2017 for further information)	This model is very similar to the preferred option two in this RIS, but does not have the fixed /shared funding component. Given the RUCS showed that around 50 per cent of funding is shared between all residents, this option has been ruled out on the basis that a model which recognises this is fixed component is preferable.
R-ACFI with independent assessment upon entry to residential aged care and provider reassessment (see option one in AACS 2017)	It was determined that even with amendments to some items, the ACFI is not suited to independent assessment because it is too comprehensive to be undertaken effectively in a short period of time. In addition the changes to the ACFI to get the R-ACFI were considered very significant without a sufficient

benefit.

R- ACFI with independent assessment upon entry to residential aged care and a minimum of 25 per cent of reassessments (see option two in AACS 2017)

It was determined that even with amendments to some items, the ACFI is not suited to independent assessment because it is too comprehensive to be undertaken effectively in a short period of time. In addition the changes to the ACFI to get the R-ACFI were considered very significant without a sufficient benefit.

The remaining options to be explored in this RIS are:

Option one – Keep the existing ACFI model

Option two – Adopt the Australian National Aged Care Classification (AN-ACC) model with independent assessors

Option three – Amend the ACFI to make it better align with contemporary care practices

These options are outlined and assessed in detail below.

Option one – No policy change

If the Australian Government made no changes to residential aged care funding arrangements, the current model where residential aged care providers use the ACFI to assess residents, and then lodge claims for the subsidy based on the current ACFI scores would continue (outlined in detail in Section 2). ACFI Reviews would continue to be undertaken in this scenario.

Option two - The AN-ACC Model with independent assessors (the preferred option)

The AN-ACC model, derived from the University of Wollongong's RUCS, is based on real evidence on what drives relative care costs, and has an evidence-based methodology for determining funding increases.

Under the AN-ACC, the subsidy paid to the provider would consist of three components, a fixed component to account for costs across all residents, a variable/individualised casemix component based on each residents care needs, and an adjustment payment, paid on a time-limited basis when a new resident enters the facility. The staff time data collected in the RUCS indicated that close to 50 per cent of staff time was spent delivering care tailored to the specific needs of the resident, while the remaining 50 per cent was spent delivering shared care across all residents. This supports a payment model that includes a fixed per diem price for the costs of shared care and a variable price per day for the costs of individual resident care.

Resident assessments under the AN-ACC

A core element of the AN-ACC model is that resident assessments would be completed by external AN-ACC assessors (working for Assessment Management Organisations procured by the Department), within 28 days of a resident entering residential aged care.

Reassessments would also be undertaken by this workforce. These will be able to be requested by the provider where: (1) the resident has had a significant hospitalisation (2) the resident has a significant change in mobility; or (3) a standard time period has passed since the residents previous assessment (twelve months for Classes 2 to 8 (those classes with lower mortality rate) and six months for Classes 9 to 12 (classes for people who are not mobile and are expected to deteriorate at a higher rate).

Providers and residents would be able to request a reclassification. This assessor workforce would consist of qualified registered nurses, physiotherapists and occupational therapists with at least 5-years' experience in caring for older people, who have complete approved AN-ACC assessment training and comply with continuing professional development requirements. These are more stringent qualification requirements than are currently placed on those able to undertake ACFI assessments.

This is because undertaking AN-ACC assessments requires a high degree of professional judgement that takes into consideration variance in a person's abilities and behaviours over a 24 hour period, where assessors may have to 'piece together' sometimes conflicting information to make a judgements in a relatively short amount of time regarding the person's capabilities. Having a workforce that is suitably experienced and qualified to skilfully undertake AN-ACC assessments is important for ensuring the accuracy of assessments and therefore the distribution of funding under the AN-ACC.

As the Australian Government would fund the AN-ACC assessor workforce, providers would be free from bearing the costs of undertaking funding assessments; this would allow provider resources and staff to focus on care. Assessments related to care planning would continue to be undertaken by the residential aged care facility based on resident care needs and underpinned by consumer directed care principles.

The fixed funding component under the AN-ACC model

The fixed component reflects the costs of shared care for residents and includes costs of care that all residents generally benefit from equally. The fixed cost is the same for all residents in a particular facility.

Examples of fixed care include general supervision in common areas and night supervision. These costs are considered 'fixed' as they are not affected significantly by changes in individual resident care need.

Under the AN-ACC aged care homes will receive a per diem base care tariff (for fixed care) for all resident care days within the funding period. This fixed care tariff will

vary between certain classes of facilities. For example, it will be higher in very remote facilities and for services catering for the homeless in recognition of their higher fixed costs. The differences in fixed care tariffs between different types of facilities are determined based on cost data collected as part of the RUCS.

The variable funding component under the AN-ACC model

The variable component is the casemix classification portion of the subsidy. Each resident is allocated a class based on their characteristics. This component will be different for different residents in a facility. In addition, there will be no limits on the mix of cases an individual provider can provide. The classification system is a branching model which enables the factors that drive care cost to be addressed interactively rather than operate in isolation. For example, two residents have cognitive impairment but one is mobile and the other is not. In the current ACFI system, cognition and mobility are each considered separately. In the AN-ACC, they are considered in combination.

In order to determine the variable funding component residents will be externally assessed using the new AN-ACC assessment tool, and placed into one of thirteen AN-ACC classes (see RUCS report 2 for further information on the 13 classes).

The AN-ACC assessment tool has been designed to capture the core resident attributes that drive care costs in residential aged care. It is designed to be robust and concise and is able to be undertaken by an external expert clinician who is not familiar with the resident in around one hour. The assessment would be undertaken within 4 weeks of entry into care.

Under the AN-ACC there would not be any limit on the number (or proportion) of residents a provider (or facility) can have from each of the 13 classes at any time.

The adjustment payment component under the AN-ACC model

This payment recognises the additional, but time-limited, resource requirements when someone initially enters care. The time-limited additional costs cover the following activities:

- time spent getting to know the resident and their family
- individualised care planning
- behaviour management
- health care assessments
- facilitating health care arising from assessment e.g. pain management, and
- developing an advanced care directive in partnership with the resident and their family.

Annual costing study to inform price

Under the AN-ACC funding model, an annual costing study would be undertaken, involving the collection of cost data from all providers. This information will be used to inform an annual determination about increases in subsidy in the following year.

Integration of respite and permanent residential aged care funding models

The RUCS demonstrated that the mobility of residents explains much of the difference in individual costs of care, and this is the first branch of the AN-ACC classification tree.

Under the AN-ACC, mobility is measured by the De Morton Mobility Index (DEMMI) – modified. To provide a better gauge of respite care need, this assessment can be administered by ACATs at the time of eligibility assessment for respite care. The outcome of this assessment would classify individuals into three classes of mobile, mobile with assistance and immobile for respite purposes, with respite subsidy linked to the class.

This will effectively align respite with permanent residential aged care funding and ensure that both are indexed/priced using the same model, preventing the divergence in funding that is currently occurring.

Is it necessary to adopt all elements of the AN-ACC model?

While it would technically be possible to adopt some aspects of the AN-ACC model, and not others, this would significantly risk the success of the model, for example:

- if the AN-ACC classification and funding model was adopted without the introduction of an external assessment workforce (providers continued to undertake funding assessments) the model would likely be gamed by some providers, and so the issues with funding uncertainty with the current ACFI model would persist
- if the AN-ACC model was adopted without the annual costing study and price determination process, then the current issues with subsidy increases not reflecting changes in the costs of providing care would remain, and
- if the AN-ACC model was adopted without integrating respite funding arrangements with permanent residential aged care funding arrangements, then the disparity in funding between the two systems would remain, and likely become exacerbated over time, leading to further issues for older Australians seeking respite care.

Appendix 1 provides further detail on the AN-ACC model.

Transition fund

Finally, a short-term transition fund is to be established to support providers that may face a funding reduction in the move to AN-ACC.

Option three – Amend the ACFI to make it better align with contemporary care practices

This option is being considered because it brings incremental improvements from the current model, without major change to the system.

Under this option the key features of the current ACFI are maintained, including provider assessment and the ACFI Review process, but adjustments would be made to rationalise ACFI items and remove items found to be redundant, and better align the ACFI with contemporary care practices.

Redundant items that could be considered for removal include grooming checklist items, and some of the conditions in the CHC domain found to only be relevant for a very small number of residents. Removal of these items would have the benefit of making the ACFI assessment pack slightly quicker to complete.

The restrictions on the therapies that can be carried out to claim the pain management items (ACFI 12.4.a. and b.), would be replaced with a more broad based therapy program as was recommended in the Applied Aged Care Solutions review of ACFI (see AACS 2017 for further details). This program would be available to all residents, and would encompass a broad range of physical therapy interventions to manage pain, maintain general wellness, and where relevant re-able residents.

Providers would need to keep records (which would be audited) to prove that they are providing evidence based therapies, and to ensure therapies are indeed being provided where they are claimed to be.

Respite arrangements would not be amended under this option, and respite funding levels would continue to be determined externally to providers by the ACAT workforce, rather than the refined ACFI assessment. This is because having providers undertake ACFI assessments on respite residents is considered too administratively burdensome to be worthwhile for the short-term nature of respite stays.

Impact analysis

Option one: No policy change

Under this option, no change to residential aged care funding arrangements would be made by Government, and the current funding model would continue.

The regulation imposed on providers would remain unchanged, and there would be no better outcomes.

Option two: The AN-ACC model

Assessment of the benefits

Option two aligns care needs and cost drivers in residential aged care to ensure funds are directed where they are needed. In addition, the introduction of independent assessment of residents for funding purposes will remove incentives for providers to focus on funding over care, and will assist in driving a culture of quality. Option two addresses **all seven problem elements** with the current residential aged care funding system outlined earlier in this RIS.

Option two, it must be noted, does not address all of the problems that exist in the residential aged care sector as a whole; it is just focused on the funding element of the equation. In order to respond to the additional problems, a broader package of measures that accompanies the implementation of the AN-ACC (and enhanced reporting requirements) is required to make improvements in the sector at a holistic level.

The benefits of the AN-ACC model for **older Australians** include:

- better quality care driven by the removal of incentives for providers to focus on funding claims over care delivery (see **Policy problem two**)
- outdated and ineffective care no longer being incentivised by the funding model, which would encourage delivery of better care (see **Policy problem one**)
- more equitable access to care, particularly for residents with very high care needs as providers will have much lesser incentives to 'cherry pick' residents with relatively low care costs compared to funding level (see **Policy problem four**)
- more access to respite care as the funding is better aligned with permanent residential care, and (see **Policy problem seven**)
- the casemix resident classification system in the AN-ACC, which comprises 13 classes, provides a better measurement of care outcomes, which would drive improvements in care (see **Policy problem one**).

The benefits of the AN-ACC model for **residential aged care providers** include:

- The time consuming task of conducting and maintaining funding assessments would no longer need to be completed by providers, allowing more time for staff to focus on quality care provision (see **Policy problem two**)
- The variable/individual funding component for each resident is based on known cost drivers (based on evidence from the RUCS), so the subsidy each resident attracts aligns with care costs. This alignment of care costs with subsidy received leads to a reduction in financial risk and greater equity for providers (see **Policy problem five**)
- A shift to an annual costing process would also ensure that the subsidy is more aligned with changes in care costs overtime compared to the current indexation model, ensuring financial sustainability for providers (see **Policy problem six**).

The AN-ACC funding model provides fairer funding arrangements for rural and remote residential aged care providers (see **Policy problem three**), because:

- Facilities operating in MMM 6-7 regions would receive a greater amount of fixed funding per resident to account for the extra costs they face in providing care in these regions
- Rural and remote providers would not receive less funding because of reduced access to allied health professionals (under the AN-ACC, certain funding levels require specific treatments from allied health professionals, whereas the variable/individual funding component is solely determined by resident's characteristics)
- Smaller providers (often in rural and remote areas) who are less able to dedicate resources towards maximising their funding claims would not be disadvantaged under the AN-ACC because of the independent assessment process.

Allied health professionals working in residential aged care would also benefit from the AN-ACC model, as they will have a greater ability to provide care that is aligned with clinical best practice and residents' aspirations. However, there is a risk that providers reduce allied care services within residential aged care when the requirement to provide certain treatments to access additional funding is removed. This risk is minimised by the Aged Care Quality Standards requiring the delivery of clinical care in accordance with the consumer's needs, goals and preferences to optimise health and well-being.

The only group that would be affected negatively in a substantive way by the introduction of the AN-ACC model are companies that work on assisting aged care facilities with maximising their ACFI claims. Data collected from 80 providers by aged care accountancy firm StewartBrown show that around \$200 per operational place is spent on specialist ACFI consultants per year. If this level of spending exists more

broadly across the sector then this equates to around \$42 million spent on ACFI consultants per year.

Given ACFI consultants are generally qualified health professionals such as registered nurses, or physiotherapists, it is likely that this workforce would not have great difficulty gaining alternative employment. Indeed, some of these consultants may be employed in the aged care system as care givers (as providers spend some of the funding on care that they currently spend on ACFI assessments and record keeping), or become part of the AN-ACC funding assessment workforce.

Risks

The key risks with the AN-ACC model relate to implementation. The model represents a significant shift from the current model, and requires significant changes to legislation. Some of the implementation risks, however, have already been mitigated with the passage of legislation in December 2020 (the Aged Care Amendment (Aged Care Recipient Classification) Bill 2020) that has enabled the operation of the AN-ACC shadow assessment phase, which is scheduled to begin in April 2021. To undertake the shadow assessment phase, the Department has procured the services of six independent Assessment Management Organisations, a Registered Training Organisation to conduct training and is developing a new IT payments system.

The completion of the year-long AN-ACC shadow assessment phase will require careful management of the risk posed by COVID-19 transmission, particularly in residential aged care facilities. To manage and mitigate this risk, all assessors will be required to have been vaccinated against COVID -19 before undertaking assessments.

The risks of providers being able to 'game' the AN-ACC model to maximise funding above what is equitable is considered very low because of the external assessment process. While AN-ACC assessors do take into consideration clinical notes, and discussions with care and clinical staff in undertaking their assessments, they are trained to ensure any incongruence between what they are observing and the information they are being provided from those working in providers is fully explored. Furthermore, the annual costing process also limits the financial impact of any unjustified up-coding of residents.

The introduction of AN-ACC would bring about a redistribution of residential aged care funding between different providers. In general, the AN-ACC model will move some funding away from providers in major cities towards regional and remote areas. This is tied to expected changes in funding by resident classification (based on each individual resident's characteristics) and the introduction of the fixed funding component (which will cover the costs of care that are shared equally by all residents). This redistribution of funding is considered an acceptable outcome on the basis that it is correcting inequalities in the current funding model, and supports those providers currently facing the greatest threats to their viability. The extent to which any individual provider sees a reduction in funding under the AN-ACC will

depend on the overall level of residential aged care funding at the commencement of the new model.

Assessment of regulatory burden

The regulatory savings and costs of this model are outlined in table 3 below. The AN-ACC model would provide around \$191 million of regulatory saves, with \$107.6 million of this to not-for-profit providers and \$83.4 million to for profit providers.

Table 3: Regulatory costs and savings of AN-ACC model⁶

Activity	Regulatory impact
Providers no longer need to undertake and submit ACFI assessments, reassessments and meet ACFI record keeping requirements	<p>\$201.82 million <u>save</u> for providers per annum</p> <p>\$113.79 million to community organisations (not-for-profit providers)</p> <p>\$88.03 million to business (for-profit providers)</p> <p>Estimate is based on survey data from StewartBrown showing the average amount providers spend on specialist ACFI staff and consultants per bed per annum.</p>
Providers need to provide financial data to the Department at the facility level to enable the annual costing studies	<p>\$1.35 million <u>cost</u> to providers per annum on average</p> <p>\$0.77 million to community organisations</p> <p>\$0.58 million to business</p> <p>Estimate is based on the assumption that it will take providers approximately 5 hours of an accountant's time per facility per year.</p>
Having external assessors come to do AN-ACC assessments and reassessments	<p>\$9.25 million <u>cost</u> to providers per annum on average</p> <p>\$5.30 million to community organisations</p> <p>\$3.95 million to business</p> <p>Estimate is based on the assumption that it will take approximately 15 minutes of a nurse's time per resident per year.</p>
Participation in periodic studies to update the classification tool (every three years)	<p>\$138,852 <u>cost</u> to providers per annum on average</p> <p>\$79,551 to community organisations</p> <p>\$59,301 to business</p> <p>Estimate is based on the assumption that these studies will occur every three years, involving 30 facilities, and take approximately 150 hours of nurse time per facility.</p>
Administration work for new entrants categorised as Class 1 (Palliative)	<p>\$20,428 <u>cost</u> to providers per annum</p> <ul style="list-style-type: none"> \$11,704 to community organisations (not-for-profit providers) \$8,724 to business (for-profit providers) <p>Estimate is based on the assumption that it will take providers approximately 5 minutes of managerial/administration time per new entrant categorised as Class 1 (Palliative care) in a residential aged care facility.</p>
AN-ACC Temporary	\$18,994 <u>cost</u> to providers per annum

⁶ The regulatory costs included in this RIS include the costs to community organisations (i.e. not-for-profit providers, and to business (i.e. for-profit providers). The regulatory costs to state government residential aged care providers are excluded to ensure consistency with RIS costing guidelines.

Activity	Regulatory impact
Transition Program	<ul style="list-style-type: none"> • \$11,396 to community organisations (not-for-profit providers) • \$7,598 to business (for-profit providers)
	Estimate is based on the assumption that it will take 65 providers approximately 2 hours of managerial/administration time for two years (2022-23 and 2023-24)
Total regulatory burden	<p>\$191 million <u>save</u></p> <ul style="list-style-type: none"> • \$107.6 million to community organisations (not-for-profits) • \$83.4 million to business (for-profit providers)

Net impact of option two

Overall, this option provides a substantial reduction in regulatory burden while also addressing the seven problems with the current model, and providing substantial benefits to residents and providers. For this reason it is the recommended option.

Option three: Amend the ACFI to make it better align with contemporary care practice

This option provides modest benefits to providers, residents and allied health professionals.

Residents would benefit from receiving allied health care that is more clinically appropriate and in line with their preferences and aspirations.

Providers would benefit from greater freedom to provide clinically appropriate allied health care, and also by no longer having to spend time completing redundant ACFI items in ACFI appraisals and reappraisals.

Providers would, however, also face costs in maintaining records of allied health treatments for each resident, and ensuring these treatments meet the criteria to be funded.

Allied health professionals working in aged care would benefit from having greater ability to provide care that is aligned with clinical best practices.

While this option addresses problem element one, by reducing incentives for poor and outdated care, it does not address the other six problems with the current ACFI model.

Risks

This model remains open to significant gaming as it is a provider assessment model. This model would be inconsistent with the recommendations of the Royal Commission given its support for a casemix model. Furthermore, if the Australian Government were inclined to provide a significant funding boost to the sector in response to the Royal Commission, it would be near impossible to do it in an equitable way under an ACFI model that is open to gaming, and does not distribute funding based on known care costs.

There is also a very high risk that this model could exacerbate the funding disparity between metropolitan and rural and remote providers, as there is a shortage of

allied health professionals available in some rural and remote areas, and so providers in these areas would miss out on the additional funding to provide the therapy program included in this model.

Assessment of regulatory burden

The regulatory savings and costs of this model are outlined in table 4 below. The amended ACFI model would provide around \$13.39 million of regulatory saves, with \$7.67 million of this to not-for-profit providers and \$5.72 million to for-profit providers.

Table 4: Regulatory costs and savings of the amended ACFI model

Activity	Regulatory impact
Providers to provide evidence that the allied health therapies provided to residents are evidence based, relevant to each residents needs and actually provided.	<p>\$5.65 million <u>cost</u> for providers per annum</p> <p>\$3.2 million to community organisations</p> <p>\$2.4 million to business</p> <p>Estimate is based on the assumption that it will take approximately 15 minutes of a nurse’s time per resident per year.</p>
Providers no longer need to have to verify that they are providing one of the approved allied health treatments to claim 12.4 a or b in the CHC domain	<p>\$20.13 million <u>save</u> for providers per annum</p> <p>\$11.5 million to community organisations</p> <p>\$8.6 million to business</p> <p>Estimate is based on the assumption that it takes approximately one hour of a nurse’s time per resident per year.</p>
Providers no longer need to fill out a number of redundant ACFI items	<p>\$1.07 million <u>save</u> for providers per annum</p> <p>\$0.61 million to community organisations</p> <p>\$0.46 million to business</p> <p>Estimate is based on the assumption that it takes approximately 5 minutes of a nurse’s time per resident per year.</p>
Net regulatory burden	<p>\$13.39 million <u>save</u> for providers per annum</p> <p>\$7.67 million to community organisations</p> <p>\$5.72 million to business</p>

Net impact of option three

Overall, this option provides a reduction in regulatory burden to providers of \$13.39 million as well as some modest benefits to residents, providers and allied health professionals. However it does not address the majority of the problems with the current model outlined in Section 3.

Comparison of the regulatory impacts of the three options

Average Annual Regulatory Costs (from business as usual)				
Change in Costs (\$m)	Business	Community Organisations	Individuals	Total change in cost
Option one	0	0	NA	0
Option two	83.4	107.6	NA	191
Option three	5.72	7.67	NA	13.39

Consultation

Upon the announcement in 2016-17 that the Australian Government would investigate options to strengthen residential aged care funding, the Department commenced consultation with a broad range of internal and external stakeholders to gauge appetite for residential aged care funding reform.

A series of 10 roadshows and a webinar (held from May to July 2017), emphasised stakeholder's openness to reform. The internally prepared evaluation report on these events recorded strong support for a new approach to care classification and funding, and demonstrated a groundswell of disenchantment with ACFI. Through these events, stakeholders were first introduced to the concept of a fixed/variable funding model based on the findings from the University of Wollongong's Alternative Aged Care Assessment, Classification System and Funding Models. The Department also flagged with stakeholders that a resource utilisation classification study would be commissioned to inform the adoption of a fixed/variable model.

Upon commissioning the University of Wollongong to undertake the RUCS, the Department appointed a Resource Utilisation Classification Study Sector Reference Group (RUCS SRG) in 2017-2019 to provide a sounding board on the aged care sector's impressions of the RUCS early findings, and to discuss the practicalities of implementing a fixed/variable funding model via external assessment. Members were appointed based on their technical expertise and experience – and included a mix of aged care managers, clinicians, finance officers and other administrators.

In tandem, several stakeholder forums were held with a broader audience to communicate the RUCS findings, with all material published online for transparency.

RUCS SRG members were optimistic that the AN-ACC proposals would transform and improve the payment of residential care subsidy (permanent and respite), with many members volunteering to act as change champions should the Australian Government agree to the reform. This engagement signalled to the Department that the sector was ready to transition away from ACFI, and that the AN-ACC, recommended through RUCS, held broader appeal.

The Department also released a Consultation Paper in March 2019 (closing in May 2019) to explain the AN-ACC model in plain language, and seek sector feedback. 91 submissions were received. The majority of these submissions indicated general enthusiasm for the AN-ACC model and re-emphasised the sector's disenchantment with ACFI.

The idea of external assessment was also generally supported, although some submissions raised concerns over whether workforce could be found to efficiently undertake assessments in rural and remote areas. Other submissions questioned whether the external assessment process will significantly reduce the administrative burden on providers, given the external assessment process still involves some level of interaction and assistance from staff within a facility.

Most submissions also emphasised the need for the total level of funding to the sector to also be considered. The Australian Government would consider the

appropriateness of total funding levels in response to the Aged Care Royal Commission in early 2021 (prior to the implementation of the AN-ACC). Later in 2019, the RUCS SRG was superseded by a broader based committee in recognition that the RUCS research was now finalised, and a greater number of stakeholders needed to be engaged. The majority of members transitioned onto the new Residential and Aged Care Funding Reform Working Group. This group was inaugurated in November 2019 to advise The Department on residential aged care funding reform activities, including how to prepare the reform readiness of the residential aged care sector.

The Residential and Aged Care Funding Reform Working Group is made up of 26 members, and includes former RUCS SRG members, and also includes peak bodies, consumer representatives, academics and rural and remote representatives. This group is and will continue to be integral in helping the Department to finesse its approach to change and transition over time. Communiques of the meeting outcomes are published on the Department's website and members are encouraged to circulate these communiques more broadly with their networks.

The Department is also planning to undertake further consultation with the sector through the release of the changes to Principles as exposure drafts for consultation at the same time as introducing the primary legislation changes. This will allow for refinement of the finer details of the model following this consultation.

There would be additional opportunities for regular consultation with stakeholders on the operation of the AN-ACC through the evaluation strategy the Department would roll out. After two years of full operation in 2024, the Department would commission a broader review of the AN-ACC model, followed by a formal five-year Post Implementation Review by 2027, as per OBPR rules.

What is the best option from those you have considered?

As has been outlined in Section 3 and Section 4, the case for government intervention and significant reform to the current residential aged care funding arrangements is strong and compelling.

Option 2 (the AN-ACC model with independent assessors) is the best option of those considered in this RIS by a significant margin. This model clearly addresses all seven policy problems outlined in Section 3, and in doing so provides clear benefits to permanent and respite residents, residential aged care providers and the Australian Government.

This model also provides the largest regulatory savings of all options (\$191 million per annum).

How will you implement and evaluate your chosen option?

The aim of the preferred option is the staged introduction of the AN-ACC residential aged care funding system as an approach to funding residential aged care providers that, in comparison to current arrangements based around use of the ACFI, is:

- more contemporary, efficient and effective, allowing provider assessment resources to be devoted to assessment for care planning purposes and supporting delivery of the right types of care, and
- more stable, providing greater certainty of funding levels for the Australian government, providers and investors, encouraging investment in the sector to meet future demographic challenges as demand for aged care grows.

Stages in implementation

There are two stages in implementation of the new residential aged care funding model. During the first stage of implementation, at Budget 2020 (October 2020) the Australian Government announced policy authority to introduce required legislative changes (in the Spring 2020 session), and funding for ongoing operations, for an external workforce acting under delegation of the Secretary. This legislation passed in December 2020, now referred to as the *Aged Care Amendment (Aged Care Recipient Classification) Act 2020*. This workforce is to assess all recipients of residential aged care on and from 1 April 2021. This workforce will use a new AN-ACC assessment tool to produce data to inform the Secretary's care recipient classification decisions under a new AN-ACC classification framework.

During this 'shadow assessment' period, current procedures for care recipient appraisal and classification and for determining rates of subsidy for provision of residential aged care (that is, ACFI arrangements) will continue as normal.

Subject to a final decision by the Australian Government at Budget 2021 (May 2021), and to availability of required IT systems changes (development by Services Australia commenced May 2020), on and from 1 July 2022 a second stage of implementation will see a 'clean break' to a new residential aged care funding system.

At Budget 2021, the Australian Government will announce policy authority to introduce required legislative changes (in the Spring 2021 session), and funding for ongoing operations, to:

- continue the AN-ACC residential aged care recipient assessment and classification procedures introduced in 2020-21, while immediately ceasing the other procedures (ACFI, and other legacy procedures) that operated during and prior to 2020-21, and
- commence a new procedure to initially determine and thereafter annually review rates of subsidy for provision of residential aged care that, among other factors, will rely on the new AN-ACC residential aged care recipient classification levels.

Implementation governance

For both tranches, the responsible Minister is responsible for introducing and ensuring passage of enabling primary legislation changes.

For both tranches, the Minister with responsibility for Aged Care will be responsible for signing associated legislative instruments to establish detailed procedures for the new arrangements allowed by primary legislation.

For the first tranche, the Secretary of the Department, and other officers of the department as delegated, are responsible for operationalising the detailed assessment and classification procedures created by legislative instruments. This includes:

- procuring an assessment workforce to operate under formal delegation of the Secretary
- procuring an assessment workforce training content and delivery provider
- ensuring the quality and consistency of workforce and workforce training operations, and
- creating and maintaining departmental (predominantly My Aged Care-hosted) IT tools and systems to enable assessment activity and the processing of resulting data to determine care recipient AN-ACC classifications.

For the second tranche, the Secretary of the Department, and other officers of the department as delegated, are responsible for operationalising the detailed subsidy determination procedures created by legislative instruments. This includes:

- ceasing all ACFI-related activities, allowing for a transitional period to complete audits of ACFI claims made by providers close to the cut over date
- ensuring care recipient classification and other data required to calculate payments to providers is provided to Services Australia, and
- procuring the services of a suitable organisation (for example, the Independent Hospital Pricing Authority) to provide advice on initial subsidy levels and to carry out annual 'pricing' reviews to inform subsequent subsidy level adjustments.

For the second tranche, the Secretary of the Department of Human Services (through the CEO, Services Australia), is responsible for delivering, maintaining and operating subsidy payment capability.

For the second tranche, providers and care recipients of residential aged care are responsible (under legislated terms) for providing AN-ACC assessors with reasonable assistance to complete their assigned assessment tasks.

At an operational level, a departmental Funding Reform project board already exists, with reporting and escalation lines up through the department's internal governance structure. Once authority is granted to proceed with the first tranche, the project board will convene regularly until transition to business-as-usual management of the capability is completed.

Risks, Assumptions and Dependencies

The major risks outside the Department's control to the implementation of the AN-ACC are the timing of Australian Government decisions, and actual dates for passage of the two tranches of primary legislative changes. These risks are accepted and monitored closely for impact on the implementation timeframe.

The Department is confident that services required to implement the assessment and pricing review functions are readily available. In support of its confidence about sourcing an AN-ACC assessor workforce, the Department's evaluation of recently completed field trial of the assessment component of the AN-ACC model conducted at 122 participating facilities found:

- the AN-ACC assessment tool can be used to sustainably assess 5-6 residents per assessor per day and can, if necessary, be completed adequately even if a face-to-face interview is unable to be completed with a resident
- an appropriately qualified and experienced independent assessment workforce, employed through contracted assessment management organisations, is readily available to administer the AN-ACC Assessment Tool at the volumes required for national rollout, and
- support functions for training, clinical advice for using the assessment tool, IT, data sharing and measurement of assessor variation proved adequately effective, but require further development to support national rollout.

Consistent with the market demonstrating abundant capability and capacity to provide assessment services, for the AN-ACC assessment trial, tendered prices per assessment were generally significantly lower than estimated prices in the original business case.

Further development of training and IT functions is already resourced and planned. La Trobe University, in June 2020, handed over a detailed training development strategy to inform procurement of a training content and delivery provider. Data sharing arrangements and an assessment quality framework require further development before national rollout, but are included in forward planning.

The Department has commenced discussions with the Independent Hospital Pricing Authority on the possibility of it performing the annual pricing review function, given AN-ACC pricing arrangements are based on the 'nationally efficient price' model used for hospital funding.

The major dependency for implementation of the reform as planned is Services Australia delivering the new payment system capability to handle AN-ACC payments by 1 July 2022. The department is already working closely with Services Australia on

scope, design, build, test and delivery tasks, at both governance and operational levels.

Evaluation

The Department is planning a multi-level evaluation strategy, consistent with the systemic nature of the AN-ACC reform.

The contract with the workforce training provider would include a training evaluation and continuous improvement requirement, to be informed by quantitative and qualitative data sourced from assessor performance information and from assessor and provider experience interviews and surveys. The evaluation approach would be required to use both process and outcome measures.

Assessor performance would be monitored and evaluated, including for lessons learned about the ongoing suitability of the assessment tool and enabling IT. Methods would include management audit, peer review, and a formal, department-led programme of inter-rater reliability testing of the comparative consistency of assessments across the assessor cohort.

The Department is exploring the feasibility of publishing the de-identified data resulting from assessments, to encourage independent academic research on factors correlating with better practice care provision by providers and improved care experience for recipients.

The Department will monitor financial impacts through payment system data produced by Services Australia. The annual independent pricing review function will additionally use costs data supplied by a representative sample of providers as a key input in forming its recommendations about the overall funding envelope and specific subsidy rates within it.

At the overall level, the department would report various financial and output metrics annually in the Portfolio Budget Statement, the Annual Report and in the Report on the Operation of the Act.

While ACFI and other legacy funding arrangements would cease in July 2022, ACFI influences on provider behaviour would take some time to wash out of the system. The Department would undertake a review of the AN-ACC model as a whole after two years of full operation, once it becomes possible to assess accurately the extent to which it is achieving reform objectives.

Given the significance of the reform, OBPR rules also require the Department to produce a formal five-year Post Implementation Review by early 2027.

Appendix 1: Detailed overview of the AN-ACC model

The new assessment and funding model developed as part of the Resource Utilisation and Classification System (RUCS) has been termed the Australian National Aged Care Classification (AN-ACC) system. The AN-ACC assessment and funding model is based on six key design elements:

1. Resident assessment for funding to be separate from resident assessment for care planning purposes
2. Assessment for funding purposes to be undertaken by external assessors capturing the information necessary to assign a resident to a payment class
3. Assessment related to care planning to be undertaken by the residential aged care facility based on resident needs and underpinned by consumer directed care principles
4. Provision of a one off adjustment payment for each new resident that recognises additional, but time-limited, resource requirements when someone initially enters residential care
5. A fixed price per day for the costs of care that are shared equally by all residents. This may vary by location and other factors
6. A variable price per day for the costs of individualised care for each resident based on their AN-ACC casemix class.

Under the AN-ACC, the subsidy paid to the provider would consist of a fixed component and a variable component for each resident. Providers would also be paid an adjustment payment on a time-limited basis when a new resident enters the facility.

The staff time data collected in the RUCS indicated that close to 50 per cent of staff time was spent delivering care tailored to the specific needs of the resident, while the remaining 50 per cent was spent delivering shared care across all residents. This supports a payment model that includes a fixed per diem price for the costs of shared care and a variable price per day for the costs of individual resident care.

The fixed funding component under the AN-ACC model

The fixed component reflects the costs of shared care for residents and includes costs of care that all residents generally benefit from equally. The fixed cost is the same for all residents in a particular facility.

Separating the funding in this way has two benefits:

- Fixed care recognises that a large proportion of care costs within a facility are driven not by the individual care needs of the residents but by the care delivered equally to all residents

- Fixed care provides stability to the funding model as a large portion of the facility's funding is fixed regardless of changes in individual resident care needs.

Examples of fixed care include general supervision in common areas and night supervision. These costs are considered 'fixed' as they are not affected significantly by changes in individual resident care need.

Aged care homes will receive a per diem base care tariff (for fixed care) for all resident care days within the funding period. This fixed care tariff will vary between certain classes of facilities. For example, it will be higher in very remote facilities and for services catering for the homeless in recognition of their higher fixed costs. Base care tariffs are mutually exclusive and each facility can only qualify for payment under a single tariff.

The factors that were found by the RUCS to be associated with an increase in fixed care costs per day were:

- remote and very remote facilities that provide Indigenous care services
- non-Indigenous remote services that have less than 30 beds
- non-Indigenous remote services that have less than 30 beds, and
- specialised services to homeless people.

Remoteness here is defined using the Modified Monash Model (MMM), with MMM 6-7 defined as remote and very remote.

The variable funding component under the AN-ACC model

The variable component is the casemix classification portion of the subsidy. Each resident is allocated a class based on their characteristics. This component will be different for different residents in a facility. The classification system is a branching model that enables the factors that drive care cost to be addressed interactively rather than operate in isolation. For example, two residents have cognitive impairment but one is mobile and the other is not. In the current ACFI system, cognition and mobility are each considered separately. In the AN-ACC, they are considered in combination.

The adjustment payment component under the AN-ACC model

This payment recognises the additional, but time-limited, resource requirements when someone initially enters care. The time-limited additional costs cover the following activities:

- time spent getting to know the resident and their family
- individualised care planning
- behaviour management

- health care assessments
- facilitating health care arising from assessment e.g. pain management, and
- developing an advanced care directive in partnership with the resident and their family.

This one-off payment relates only to an initial admission into residential aged care. The adjustment payment is not payable if a resident transfers between homes.

Resident classification for the variable payment

Under the AN-ACC model residents will be externally assessed using the new AN-ACC assessment tool, and placed into one of thirteen AN-ACC classes (see RUCS Report 2 for further information on the 13 classes).

The AN-ACC assessment tool has been designed to capture the core resident attributes that drive care costs in residential aged care. It is designed to be robust, concise and able to be undertaken by an external expert clinician who is not familiar with the resident.

The assessment would be undertaken within 4 weeks of entry into care. Given the high degree of professional judgement required to make clinical judgements in a relatively short period of time, assessors will need to have expert clinical skills in aged care assessment, sophisticated professional and organisational capabilities and be provided with comprehensive training and ongoing clinical and operational support to ensure consistency in assessment.

External assessors will need to be credentialed registered nurses, occupational therapists or physiotherapists who have experience in aged care and have completed approved assessment training.

The AN-ACC assessment tool is suitable for both the initial assessment and reassessment of a resident as needed.

Pricing and the National Weighted Activity Units

Under the AN-ACC, the total funding for each facility would be calculated based on the relative costs of providing care (both individual care and shared care) expressed in terms of the National Weighted Activity Unit or NWAU. The NWAU is the 'currency' used to express the price weights for each classification category (both fixed and variable). It represents cost relativities between classes and allows a single price to be set across all care activities.

For example if, for the individual resident flexible care payment, Class A has an NWAU of 0.25 and Class B an NWAU of 0.5, then Class B is twice as costly as A and will receive twice the funding.

Government will determine the price for an NWAU of 1. This price is expressed in terms of \$ per resident per day. So, in the above example, if the Australian

Government set the NWAU of 1 at a price of \$1 per day then Class A would receive \$0.25c per day and Class B \$0.50c per day. If it set the NWAU of 1 at a price of \$2 per day then Class A would receive \$0.50c per day and Class B \$1 per day.

The total weighted care day per resident comprises three components:

1. The total base care tariff (fixed component) NWAU: This is the standard daily bed day tariff determined for each different type of facility related to fixed (shared) care costs. This tariff is paid for every resident bed day in the funding period.
2. The total variable component NWAU: This is the variable component based on the AN-ACC class for each resident in care. This accounts for the variable care costs for residents with different individual care needs. An AN-ACC NWAU is assigned for each resident bed day based on the resident AN-ACC class. The total AN-ACC NWAU for the facility is the sum of NWAU across all residents for their total days of stay within the funding period.
3. The total entry adjustment period NWAU: This is an additional payment set at a standard rate per new resident admitted for the first time during the funding period.

Annual costing study to inform price

Under the AN-ACC funding model, the Government would make an annual determination about the price of an NWAU of 1.00. This price is standard across the fixed, variable and one-off adjustment payment. All prices in the funding model are then set relative to this annually determined price.

In the national hospital funding model, this price is termed the National Efficient Price and an annual costing study is undertaken which is used to inform the setting of the price in the following year. Under the proposed model a similar approach would be taken to help inform the setting of the price for an NWAU of 1.00, with the Independent Hospital Pricing Authority being tasked with undertaking or commissioning a national residential aged care costing study to help inform the price the following year.

Integration of respite and permanent residential aged care funding models

AHSRI demonstrated that the mobility of residents explains much of the difference in individual costs of care, and this is the first branch of the classification tree.

Under AN-ACC, mobility is measured by the De Morton Mobility Index (DEMMI) – modified. To provide a better gauge of respite care need, this assessment can be administered by ACATs at the time of eligibility assessment for respite care. The outcome of this assessment would classify individuals into three classes of mobile, mobile with assistance and immobile for respite purposes, with respite subsidy linked to the class.

This will effectively align respite with permanent residential aged care funding and ensure that both are indexed/priced using the same model, preventing the

divergence in funding that is currently occurring. Another benefit is that by removing the funding disparity the barriers to providers offering more respite should also be addressed.

Appendix 2: Calculating annual regulating costs and savings

- 41 per cent of residential aged care facilities are for-profit
- 55 per cent of residential aged care facilities are not-for-profit
- 4 per cent of residential aged care facilities are government owned

- Number of facilities: 2722
- Number of aged care residents to be assessed for the AN-ACC: 300,000
- Number of aged care residents (in 2019-2020): 244,363
- Number of operational places at 30 June 2020: 217,145
- Number of new entrants categorised as Class 1 (palliative care): 3,500
- Number of providers requiring AN-ACC Temporary Transition Program: 65

- One hour wages for an accountant = \$103.95 per hour (includes loading)
- One hour wages for a nurse = \$96.4 per hour (includes loading)
- One hour wages for managerial/administration work = \$73.05 per hour (includes loading)

Option 2

Regulatory Savings

Data collected from 80 providers by aged care accountancy firm StewartBrown shows that in 2018-19 providers spent an average of \$842 per bed on staff working in specialist ACFI roles and external ACFI consultants.

When extrapolated to account for the number of occupied beds per organisational type (charitable; community based; private incorporated body; publicly listed company; religious; and religious/charitable) and the provider size (single; 2 to 6; 7 to 19; and 20+) in the 2018-19 financial year, this would equate to approximately \$200 million per year across all providers.

Regulatory Costs

Providers need to provide financial data to the Department at the facility level to enable the annual costing studies:

- Number of facilities x 5 hours of an accountant's time / 55 per cent not-for-profit
- Number of facilities x 5 hours of an accountant's time / 41 per cent for-profit

Having external assessors come to do AN-ACC assessments and reassessments:

- Number of residential aged care residents to be assessed for the AN-ACC x 15 minutes of a nurse's time / 55 per cent not-for-profit
- Number of residential aged care residents to be assessed for the AN-ACC x 15 minutes of a nurse's time / 41 per cent for-profit

Participation in periodic studies to update the classification tool (every three years):

- Number of facilities in study (30) x 150 hours of nurse time / 55 per cent not-for-profit
- Number of facilities in study (30) x 150 hours of nurse time / 41 per cent for-profit

Administration work for new entrants categorised as Class 1 (Palliative):

- Number of new entrants categorised as Class 1 x 5 minutes of managerial/administrator time / 55 per cent not-for-profit
- Number of new entrants categorised as Class 1 x 5 minutes of managerial/administrator time / 41 per cent for-profit

AN-ACC Temporary Transition Program:

- Number of affected providers x 2 hours of managerial/administrator time x 2 years (2022-23 and 2023-24) / 55 per cent not-for-profit
- Number of affected providers x 2 hours of managerial/administrator time x 2 years (2022-23 and 2023-24) / 41 per cent for-profit

Option 3

Regulatory Savings

Providers no longer need to have to verify that they are providing one of the approved allied health treatments to claim 12.4 a or b in the CHC domain

- Number of aged care residents x 1 hour of a nurse's time / 55 per cent not-for-profit
- Number of aged care residents x 1 hour of a nurse's time / 41 per cent for-profit

Providers no longer need to fill out a number of redundant ACFI items:

- Number of aged care residents x 5 minutes of a nurse's time / 55 per cent not-for-profit
- Number of aged care residents x 5 minutes of a nurse's time / 41 per cent for-profit

Regulatory Costs

Providers to provide evidence that the allied health therapies provided to residents are evidence based, relevant to each residents needs and actually provided:

- Number of aged care residents x 15 minutes of a nurse's time / 55 per cent not-for-profit
- Number of aged care residents x 15 minutes of a nurse's time / 41 per cent for-profit.

