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THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

AGED CARE AND OTHER LEGISLATION AMENDMENT (ROYAL COMMISSION RESPONSE NO. 2) BILL 2021

SUPPLEMENTARY EXPLANATORY MEMORANDUM

Amendments to be moved on behalf of the Government

(Circulated by the authority of the Minister for Health and Aged Care,
the Hon Greg Hunt MP)

AMENDMENTS TO AGED CARE AND OTHER LEGISLATIONAMENDMENT (ROYAL COMMISSION RESPONSE NO. 2) BILL 2021

OUTLINE

The Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021 (Bill) makes amendments to deliver the second stage of aged care reforms in response to the Royal Commission into Aged Care Quality and Safety's *Final Report: Care, Dignity and Respect* (final report).

Amendments to Schedule 1

Schedule 1 of the Bill amends the *Aged Care Act 1997* (Aged Care Act) and the *Aged Care (Transitional Provisions) Act 1997* (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.

The government amendments to Schedule 1 have the effect of changing where the new concept of the *adjusted basic subsidy amount* is inserted into the Aged Care Act and the Transitional Act.

The adjusted basic subsidy amount affects both the calculations of *residential care subsidy* and *resident fees*. In the current Bill, Schedule 1 applied the *adjusted basic subsidy amount* in relation to the calculation of the maximum daily amount of resident fees. After introduction of the Bill, it was discovered that this may have the unintended effect in certain circumstances of calculating the incorrect amount of residential care subsidy to be paid to providers providing care to residents with high assets and/or high incomes.

The government amendments insert the *adjusted basic subsidy amount* concept in relation to steps in the calculation of residential care subsidy. This avoids any unintended impacts on residential care subsidy amounts while preserving intended resident fee calculation outcomes.

Amendments to Schedule 5

The amendments to Schedule 5 of the Bill strengthen the new provider governance arrangements by aligning the 'carve out' arrangements for both new approved provider governing body membership responsibilities.

Schedule 5 introduces two new responsibilities that relate to the membership of an approved provider's governing body. These responsibilities require:

- the governing body to have a majority of independent non-executive members, and
- at least one member to have experience in the provision of clinical care.

The Government acknowledges that some approved providers have a governing body that is formed by a sole director, or a small number of members. To address this, Schedule 5 provides that the above governing body membership requirements do not apply to a provider in certain circumstances.

Currently, the circumstances differ for the two new governance requirements. An approved provider that has a governing body of fewer than five members, and provides care to fewer

than 40 care recipients across their services, is not required to have a majority of governing body members who are independent non-executive members. In contrast, the Bill currently provides that an approved provider with a governing body with fewer than five members is not required to ensure that at least one member of their governing body has experience in the provision of clinical care.

The amendments to Schedule 5 of the Bill align these two 'carve out' arrangements. This will mean that the responsibility of approved providers to ensure that at least one member of their governing body has experience in the provision of clinical care will only cease to apply where the governing body has fewer than five members *and* the approved provider provides care to fewer than 40 care recipients across their services.

The amendments address feedback from the sector that not specifying the number of care recipients in relation to the requirement of clinical care experience on the governing body could provide an incentive for approved providers to reduce the size of their governing body to avoid the requirement, contrary to the intention of the Bill.

These arrangements are based on the recommendations of the Royal Commission into Aged Care Quality and Safety (Royal Commission). The Royal Commission Final Report highlighted the importance of approved providers having good governance arrangements in place for the delivery of high quality care.

The 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 to contribute to the collective capability and effective functioning of the governing body. 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.

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.

While it is acknowledged that some approved providers have smaller governing bodies, and it would therefore be difficult to meet this responsibility, if a provider is of a certain size (i.e. delivers care to 40 or more consumers), it should ensure there is independence and objectivity in executive decision making, and that the governing body has the relevant experience and expertise to easily be able to interpret reports about the delivery of care and see signs of potential problems with care delivery.

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 both circumstances exist, these approved 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 expertise in the provision of clinical care, when executive decision making impacts or interacts with the delivery of care. It may also include placing higher weight on the reports of their quality care advisory body.

Section 63-1E of the Bill provides that an approved provider may apply to the Aged Care Quality and Safety Commissioner (Commissioner) for 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 the provider. Such a determination may also be sought for the requirement that an approved provider must ensure that a majority of the members of the governing body of the provider are independent non-executive members.

When deciding whether to make a determination that these responsibilities do not apply, the Commissioner may take into account certain matters listed in section 63-1E(4), including the arrangements the approved provider has made, or proposes to make to assist the governing body of the provider to seek advice from a person with experience in the provision of clinical care, the membership of the governing body of the provider, as well as other matters such as the number of aged care services the provider has, the number of care recipients who are provided with care through those services, and the location of services.

As an 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 of time.

Amendments to Schedule 8

Schedule 8 of the Bill expands 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 under the Aged Care Act (Aged Care Act functions).

The government amendments to Schedule 8 enable the Pricing Authority to delegate its new Aged Care Act functions to its Chief Executive Officer (CEO), an acting or permanent Senior Executive Service (SES) officer of the Pricing Authority, or an acting or permanent SES officer who is also an officer or employee of an APS agency or Commonwealth authority and who is assisting the Pricing Authority in relation to those functions. Provision for this inadvertently was not previously made in Schedule 8. The government amendments respond to feedback from the Independent Hospital Pricing Authority requesting this matter be corrected.

New Schedule 9

The amendments in new Schedule 9 of the Bill revise 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 themselves lacks the capacity, consent must be given by the 'restrictive practices substitute decision-maker'. Restrictive practices substitute decision-maker 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 commencement of the strengthened arrangements 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 Commonwealth 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. This issue 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 2014* to make further provision for informed consent to the use of restrictive practices to be given 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.

Financial Impact Statement
Nil.

Consultation
The amendments to Schedule 5 address feedback from the Council on the Ageing (COTA). The Aged Care Quality and Safety Commission has been consulted about those amendments. The amendments to Schedule 8 respond to feedback from the Independent Hospital Pricing Authority.

In relation to Schedule 9, the limitations in State and Territory consent laws were raised by aged care providers and medical practitioners who are unable to gain consent to the use of restrictive practices in order to meet the requirements of the *Quality of Care Principles 2014*. Correspondence about the legal limitations in various jurisdictions has also been received from aged care peak bodies. The Department of Health has consulted each jurisdiction on their consent and guardianship laws, and intends to consult further on the specific amendments to the *Quality of Care Principles 2014*.

Statement of Compatibility with Human Rights

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

Amendments to the Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021

These amendments are 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 amendments

The Aged Care and Other Legislation Amendment (Royal Commission Response No. 2) Bill 2021 (Bill) makes amendments to deliver the second stage of aged care reforms in response to the Royal Commission into Aged Care Quality and Safety's *Final Report: Care, Dignity and Respect* (final report).

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Currently the circumstances differ for the two new governance requirements. An approved provider that has a governing body of fewer than five members, and provides care to fewer than 40 care recipients across their services, is not required to have a majority of governing body members who are independent non-executive members. In contrast, the Bill currently provides that an approved provider with a governing body with fewer than five members is not required to ensure that at least one member of their governing body has experience in the provision of clinical care.

The amendments to Schedule 5 of the Bill align these two 'carve out' arrangements. This will mean that the responsibility of approved providers to ensure that at least one member of their governing body has experience in the provision of clinical care will only cease to apply where the governing body has fewer than five members and the approved provider provides care to fewer than 40 care recipients across their services.

The amendments address feedback from the sector that not specifying the number of care recipients in relation to the requirement of clinical care experience on the governing body could provide an incentive for approved providers to reduce the size of their governing body to avoid the requirement, contrary to the intention of the Bill.

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The government amendments to Schedule 8 enable the Pricing Authority to delegate its new Aged Care Act functions to its Chief Executive Officer (CEO), an acting or permanent Senior Executive Service (SES) officer of the Pricing Authority, or an acting or permanent SES officer who is also an officer or employee of an APS agency or Commonwealth authority and who is assisting the Pricing Authority in relation to those functions. Provision for this inadvertently was not previously made in Schedule 8. The government amendments respond to feedback from the Independent Hospital Pricing Authority requesting this matter be corrected.

New Schedule 9 - Amendments relating to restrictive practices

The amendments to be included in new Schedule 9 of the Bill revise 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 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 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

The amendments to Schedules 1, 5 and 8 do not engage any human rights. The amendments in Schedule 9 engage the following rights:

- the right not to be subjected to cruel, inhuman or degrading treatment under article 7 of the *International Covenant on Civil and Political Rights* (ICCPR), and article 15 of the *Convention on the Rights of Persons with Disabilities* (CRPD);
- the right to security of the person and freedom from arbitrary detention under article 9 of the ICCPR and article 14 of the CPRD;
- the right to health under article 12(1) of the International Covenant on Economic Social and Cultural Rights (ICESCR), and article 25 of the CRPD.

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

The amendments in Schedule 9 of the Bill engage the right not to be subjected to cruel, inhuman or degrading treatment outlined in article 7 of the ICCPR and article 15 of the CRPD. 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 than under 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 considered 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 the use of restrictive practices. This is because, without clear arrangements as to who is able to consent, there is a heightened risk that restrictive practices will be used without consent being given by 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 a determination as to whether restrictive practices should be administered.

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 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.

The amendments that would form new Schedule 9 of the Bill also promote 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.

Right to health

The amendments that would form new Schedule 9 of the Bill also promote the right to health under Article 12(1) of the ICESCR and Article 25 of the CRPD. These articles refer to the right of individuals to the highest attainable standard of physical and mental health. The amendments promote 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 the use of restrictive practices 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 in current consent arrangements and provide alterative arrangements so that restrictive practices are able to be used in necessary circumstances, in accordance with the *Quality of Care Principles 2014*. 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.

Conclusion

The amendments proposed in new Schedule 9 of the Bill are compatible with human rights because they promote the protection of human rights.

The Hon Greg Hunt MP, Minister for Health and Aged Care

AMENDMENTS TO AGED CARE AND OTHER LEGISLATIONAMENDMENT (ROYAL COMMISSION RESPONSE NO. 2) BILL 2021

NOTES ON CLAUSES

Amendment 1
Amendment 1 inserts new item 11 at the end of the table at clause 2 of the Aged Care Legislation Amendment (Royal Commission Response No. 2) Bill 2021 (Bill). New item 11 provides that the amendments to be made by new Schedule 9 of the Bill (restrictive practices) are to commence the day after the Act receives Royal Assent.

Schedule 1 – Residential aged care funding

Amendment (2)
Amendment (2) inserts after item 37 in Schedule 1 of the Bill new items 37A, 37B, 37C and 37D, which amend section 44-21 of the Aged Care Act to introduce the concept of the *adjusted basic subsidy amount* in relation to calculation of the *care subsidy reduction* as an amount used in the overall calculation of the *residential care subsidy amount*.

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 37A – Subsection 44-21(2) (Care subsidy reduction calculator, step 4, paragraphs (a) and (b))
Item 37A repeals step 4, paragraphs (a) and (b) of subsection 44-21(2) and substitutes new paragraphs (a) and (b) so that step 4 operates by reference to the sum of the following two amounts:

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

The effect of this amendment is that the care subsidy reduction calculation uses the adjusted basic subsidy amount rather than the basic subsidy amount as previously, to ensure the new Australian National Aged Care Classification (AN-ACC) funding model operates as intended.

Item 37B – Subsection 44-21(2) (Care subsidy reduction calculator, step 5, paragraphs (a) and (b))
Item 37B repeals step 5, paragraphs (a) and (b) of subsection 44-21(2) and substitutes new paragraphs (a) and (b) so that step 5 operates by reference to the sum of the following two amounts:

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

The effect of this amendment is that the care subsidy reduction calculation uses the adjusted basic subsidy amount rather than the basic subsidy amount as previously, to ensure the new AN-ACC funding model operates as intended.

Item 37C – 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 subsection 44-21, the care subsidy reduction is the sum of the adjusted basic subsidy amount (defined in subsection (6A)) and any primary supplement amounts outlined in subdivision 44-C for the care recipient for that day.

This amendment is to ensure consistency with related amendments to subsection 44-21(2) through items 37B and 37C above.

Item 37D – After subsection 44-21(6)
This item inserts a new subsection 44-21(6A), which defines the *adjusted basic subsidy amount* for a care recipient for a day as 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 used in relation to calculation of the amount of care subsidy reduction (see subsections 44-21(2) and (3) as amended by items 37A, 37B and 37C), and indirectly to calculate the maximum daily amount of resident fees (see section 52C-3).

Amendment (3)
Amendment (3) is a consequential amendment of Amendment (2) and omits items 40 and 41 of the Bill, as these are no longer required due to new items 37A and 37B.

Amendment (4)
Amendment (4) omits item 71 of the Bill, and inserts new items 71, 71A and 71B, which amend sections 44-21 and 44-23 of the Aged Care Act with the effect of introducing (via the definition of the *subsidy related amount*) the new concept of the *adjusted basic subsidy amount* in relation to calculation of *the daily income tested reduction* as an amount used in the overall calculation of the *residential care subsidy amount*.

The effect of these technical amendments is to ensure the new AN-ACC funding model operates as intended.

Section 44-21 deals with the daily 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. Section 44-23 of the Transitional Act deals with determination of the amount of income tested reduction where the care recipient or their representative has not provided sufficient information about the care recipient's total assessable income (see section 44-24).

Item 71 – Subsection 44-21(3) (Income tested reduction calculator, step 4, paragraph (c))
Item 71 repeals step 4, paragraph (c) in subsection 44-21(3) 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 item 71A).

Item 71A – At the end of section 44-21
This item inserts new subsections 44-21(4) and (5) at the end of section 44-21 of the Transitional Act to outline how the *subsidy related amount* and the *adjusted basic subsidy amount* for a care recipient are to be determined.

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 under amended sections 44-21 and 44-23, and are indirectly used to calculate the maximum daily amount of resident fees under section 58-2 of the Transitional Act.

Item 71B – Paragraph 44-23(4)(b)
Section 44-23 of the Transitional Act deals with determination of the amount of income tested reduction where the care recipient or their representative has not provided sufficient information about the care recipient's total assessable income (see section 44-24).

This item amends paragraph 44-23(4)(b) of the Transitional Act 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 related amendments to subsection 44-21(3).

This amendment is to ensure consistency with related amendments in items 71 and 71A above.

Amendment (5)
Amendment (5) omits items 80 and 81 of the Bill, as these are no longer required due to the insertion of new items 71, 71A and 71B.

Amendments (6) and (7)
Amendment (6) and Amendment (7) are consequential amendments to item 90 of the Bill, which is an application provision dealing with other amendments relating to residential care subsidy under the Aged Care Act and the Transitional Act, by including references to section 44-21 of the Aged Care Act as amended (see Items 37A, 37B, 37C and 37D) and to section 44-21 and paragraph 44-23(4)(b) of the Transitional Act as amended (see items 71, 71A and 71B).

Amendment (8)
Amendment (8) inserts, after item 97 of the Bill, new items 97A and 97B, which are savings provisions providing for the operation of the care subsidy reduction under the Aged Care Act (see section 44-21 of that Act, as amended by items 37A, 37B, 37C and 37D) and for the daily income tested reduction under the Transitional Act (see sections 44-21 and 44-23 of that Act, as amended by items 71, 71A and 71B) in relation to the commencement day.

Item 97A – Saving—care subsidy reduction under the Aged Care Act
This item provides that provisions relating to the care subsidy reduction under section 44-21 of the Aged Care Act as in force immediately before the commencement day, continue to apply, on and after that day, in relation to a payment period that starts before that day.

Item 97B – Saving—daily income tested reduction under the Transitional Act
This item provides that provisions relating to the daily income tested reduction under section 44-21 and 44-23(4)(b) of the Transitional Act as in force immediately before the

commencement day, continue to apply, on and after that day, in relation to a payment period that starts before that day.

Amendment (9)
Amendment (9) omits Items 99 and 100 of the Bill, which are no longer required due to the insertion of new Items 37A, 37B, 37C and 37D, and inserts new Items 99 and 100, which are application provisions providing for the operation of the maximum daily amount of resident fees to reserve a place (see section 52C-5 of the Aged Care Act as amended by Item 42 of the Bill) in relation to the commencement day.

Item 99 – Application—maximum daily amount of resident fees on or after the commencement day under the Aged Care Act
This item is an application provision and provides that section 52C-5 of the Aged Care Act, as amended by the amending Part, applies in relation to a day that is on or after the commencement day. This is a consequential amendment to omitting Items 41 and 42 through Amendment (3).

Item 100 – Saving—maximum daily amount of resident fees for a day that is before the commencement day under the Aged Care Act
This item is a saving provision and provides that notwithstanding amendments to section 52C-5 of the Aged Care Act by the amending Part, that section as in force immediately before the commencement day, applies in relation to a day that is before the commencement day. This is a consequential amendment to omitting Items 41 and 42 through Amendment (3).

Schedule 5 – Governance of approved providers

Amendment (10)
Amendment (10) omits proposed subsections 63-1D(3) and (4) from item 16 of Schedule 5 of the Bill (page 71, lines 8 to 24) and substitutes new subsections 63-1D(3) and (4) into item 16.

Currently, proposed subsections 63-1D(3) and (4), omitted by Amendment 10, set out different circumstances where the responsibilities under new paragraphs 63-1D(2)(a) and (b) do not apply to an approved provider. Amendment 10 aligns the circumstances where the two new governing body membership responsibilities under new subsection 63-1D(2) not apply to approved providers.

New subsection 63-1D(3) provides that the responsibilities under new subsection 63-1D(2) do not apply 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.

New subsection 63-1D(4) 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 made under new section 63-1E that one or both of the 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.

Schedule 8 – Independent Health and Aged Care Pricing Authority

Amendments (11) and (12)
Amendments (11) and (12) amend item 49 in Schedule 8 of the Bill, which, taken with item 48, amends section 161 of the *National Health Reform Act 2011* (National Health Reform Act), which deals with delegation by the Pricing Authority.

Subsection 161(1), as amended by item 48, provides that the Pricing Authority may, subject to subsections 161(3) and (4), by writing, delegate one or more of its functions and powers to:

- a member of the Pricing Authority; or
- the Pricing Authority CEO; or
- a person who is a member of the staff of the Pricing Authority and an SES employee or acting SES employee.

Amendment (11) will amend item 49 so that new subsection 161(2) provides that, subject to the limitations in subsection 161(4), the Pricing Authority may in writing delegate a function of the Pricing Authority 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 that function.

Amendment (12) will amend item 49 so that new subsection 161(3) provides that the Pricing Authority must not delegate an Aged Care Act function to a member of the Pricing Authority.

Previously, item 49 only enabled the Pricing Authority to delegate an Aged Care Act function to an officer or employee mentioned in paragraph 174(a) or (b) of the National Health Reform Act 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 an Aged Care Act function.

The overall effect of Amendments (11) and (12) will be that the Pricing Authority may, in addition, delegate its Aged Care Act functions to the following persons:

- the Pricing Authority CEO; or
- a person who is a member of the staff of the Pricing Authority and an SES employee or acting SES employee.

No other changes have been made to item 49, including to the types of functions or powers that may not be delegated by the Pricing Authority (new subsection 161(4)) or that in performing a delegated function or exercising a delegated power, the delegate must comply with any written directions of the Pricing Authority (new subsection 161(5)). This reflects previous subsection 161(2).

Amendment (13)
Amendment (13) amends item 124, which amends section 96-2 of the Aged Care Act. Section 96-2 deals with the delegation of powers and functions of the Secretary under the Aged Care Act.

Item 124 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 Aged Care Act functions.

Amendment (13) amends new subsection 96-2(3A) to be inserted by item 124, which enables the Pricing Authority to, in writing, sub-delegate powers or functions delegated to it by the Secretary under subsection 96-2(3).

Previously, subsection 96-2(3A) only enabled the Pricing Authority to sub-delegate a function or power delegated to it under subsection 96-2(3) to an officer or employee mentioned in paragraph 174(a) or (b) of the National Health Reform Act 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 that function.

Amendment (13) will amend subsection 96-2(3A) so that the Pricing Authority may sub-delegate a function to a person covered by subsection 161(1) or 161(2) of the National Health Reform Act, other than a member of the Pricing Authority.

This will mean that the persons to whom the Pricing Authority may sub-delegate the power or function delegated to it under subsection 96-2(3) 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 that function.

Item 124 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.

Schedule 9 – Restrictive practices

Amendment (14)
Amendment (14) inserts new Schedule 9 at the end of the Bill. Schedule 9 relates to restrictive practices and includes four new items that amend the Aged Care Act.

Item 1 to new Schedule 9 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 by the interaction with current State and Territory consent and guardianship laws, Item 1 to new Schedule 9 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 an 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 should 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 in primary legislation as part of the current project to introduce 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. The new Act will replace the existing aged care legislative framework and is intended to commence from 1 July 2023, subject to parliamentary processes. 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 to new Schedule 9 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 to new Schedule 9 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 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 either 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 when they are adhering 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 (such as 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 of Schedule 9 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).