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Additional Response

AMA submission to the Royal Commission into Aged Care Quality and Safety – Final Recommendations by the Counsel Assisting

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Introduction

The AMA thanks the Royal Commission into Aged Care Quality and Safety (Royal Commission) for the opportunity to comment on the final recommendations by the Counsel Assisting. However, the AMA believes that a longer consultation period to consider all the recommendations in-depth would have been more beneficial to the Royal Commission and all aged care stakeholders.

The AMA has previously provided several comprehensive submissions to the Royal Commission, as well as multiple witness statements by the AMA President at the time:

- AMA Submission to the Royal Commission into Aged Care Quality and Safety dated 30
- September 2019[1],
- AMA submission to the Royal Commission into Aged Care Quality and Safety in response to the Consultation Paper 1 - Aged Care Program Redesign: Services for the Future dated 29 January 2020[2],
- Two witness statements of Dr Anthony Bartone, both dated 18 February 2019[3,4],
- Supplementary witness statement of Dr Anthony Bartone dated 27 November 2019[5],

[1] Australian Medical Association (2019) AMA Submission to the Royal Commission into Aged Care Quality and Safety
[2] Australian Medical Association (2019) AMA submission to the Royal Commission into Aged Care Quality and Safety in response to the Consultation Paper 1 - Aged Care Program Redesign: Services for the Future
[3] Royal Commission into Aged Care Quality and Safety (2019) Statement of Dr Anthony Bartone
[4] Royal Commission into Aged Care Quality and Safety (2019) Additional Statement Dr Anthony Bartone
[5] Royal Commission into Aged Care Quality and Safety (2019) Supplementary Witness Statement Dr Tony Bartone

- AMA submission to the Royal Commission into Aged Care Quality and Safety on the impact of COVID-19 on aged care services[6] and
- AMA submission to the Royal Commission into Aged Care Quality and Safety – Required training for doctors working in aged care.

As noted in the previous AMA submissions, the work of the Royal Commission is seen by AMA members as an opportunity for real reform of the aged care sector, that will bring improvements and innovations so greatly needed. It is an opportunity to create an environment and a system that promotes good care for the most vulnerable members of our society into the future.

The majority of recommendations by the Counsel Assisting are welcomed by AMA members, as indicated in the Form for responding to Counsel Assisting's final submissions. The AMA welcomes the focus on improved governance of the aged care sector, improved regulation and transparency.

However, there are several aspects of the Counsel Assisting's submissions that the AMA members do not support that we will address in this Additional Response.

Overall, AMA members believe that the proposed new primary care model (Recommendation 62) fails to address the most significant driver of the lack of access to General Practitioners (GPs) for aged care residents, being the chronic underfunding of these services.

Better access to health care

In our first submission to the Royal Commission, the AMA put forward our long-standing view that GPs are the primary medical specialists for the care of older people and that GPs should be the forefront of health care, guiding and facilitating older people in accessing health, community, specialist and aged care services.

The AMA therefore welcomed Recommendation 11.2. by the Counsel Assisting to "bring the older people's GP to the centre of their planning for ageing and aged care". However, in the AMA view the further recommendations in the Counsel Assisting's final submission do not follow this recommendation and fail to achieve this goal.

Moreover, the AMA believes that subsequent recommendations by the Counsel Assisting pertaining to access to health care and GP care, if implemented, will lead to further exodus of GPs from aged care and additional fragmentation of care for older people receiving aged care services.

[6] Australian Medical Association (2020) AMA submission to the Royal Commission into Aged Care Quality and Safety on the impact of COVID-19 on aged care services

A new primary care model to improve access

In our first submission to the Royal Commission, the AMA warned that devising new models of care should not be a substitute for improving inadequate MBS rebates. We called for the funding models to recognise the important leadership role GP-led teams can play in providing advice on how to improve overall health outcomes beyond direct clinical needs for older people receiving aged care services. Unfortunately, recommendation 62 by the Counsel Assisting fails to meet this standard, in the view of AMA members.

Establishing a new voluntary primary care model for people receiving aged care is not supported by the AMA. AMA members see this new model as leading to further fragmentation of care, and one that goes against the evidence that continuity of care leads to improved health outcomes for older people[7]. The Counsel Assisting's proposition would essentially create a two-tiered system where continuity of care would be broken for the sake of convenience of the aged care providers and a smaller number of GP practices, to the detriment of the older person.

The AMA would like to see a model that would motivate GPs to continue to care for their patients once they enter aged care. That way the goal of increasing the number of GPs participating in a system would be achieved, along with creating a system that works for both patients and their GPs. If a patient loses their usual GP once they enter aged care, there is a risk that years and in often decades of their clinical and personal history will be lost, must be retold, or have significant gaps. The relationships that GPs make with their patients is an invaluable tool to being able to provide the best treatment options to the patient that fits in with their life, goals, values, and preferences.

Furthermore, younger doctors, AMA members who are training to be GPs are concerned regarding the possibility for practices to exploit trainees under the proposed model changes. Payment for patient enrolment to the practice risks that trainees may indeed be requested to do majority of the work for residential aged care facilities (RACFs) and patients yet receive little to no remuneration for the enrolment of patients. This risk is extendable to any doctor employed or contracted under the model of capitated enrolment.

Older people entering aged care, as the Royal Commission has widely explored and demonstrated, often express the feeling of loss of choice and control over their lives. Maintaining a relationship with their GP is one way of maintaining independence. This new proposition potentially strips them of that option. Patients should not be expected or forced to change GPs based on an unproven model of accreditation.

In the AMA view, for GPs to practice in aged care, there are certain pre-conditions that need to be met, including ensuring adequate support from the aged care providers. The AMA has written extensively on it in our first submission to the Royal Commission[8].

[7] Barker, I Steventon, A, and Deeny, S (2017) Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data BMJ. 356:j84

[8] Australian Medical Association (2019) AMA Submission to the Royal Commission into Aged Care Quality and Safety, page 9-10

Accreditation of specialised GP practices by the Australian Government

Any system that requires additional accreditation to work in Aged Care, on top of the accreditation by the Royal Australian College of General Practitioners (RACGP) for GP practices, will be strongly opposed by the AMA. An additional layer of accreditation is likely to increase the financial costs and risks for participating practices. This could lead to a further drop in the number of GPs working in aged care, exactly the opposite outcome of what the reform should aim to achieve.

The AMA is also fervently against the proposal for accreditation of practices that practice solely in aged care (niche practices).

In the view of AMA members, the proposed changes to permit some General Practices to specialise in only Aged Care, risks further fragmentation of General Practice. Although these risks would be less apparent in regional or rural towns, the risk is higher in metropolitan Australia for significant fragmentation of General Practice by sole accreditation for Aged Care provision of services. Specialised aged care GP practices may diminish the range of skills GPs have.

Enrolment and capitation payment

The AMA is in principle in favour of enrolment and supports voluntary enrolment. However, the AMA 's concern around the model proposed by the Counsel Assisting is that patients would only enrol with those accredited practices.

Furthermore, the AMA maintains that medical practitioners have the right **to decline to enter** into a therapeutic relationship as well as the right to decline to continue a therapeutic relationship (so long as an alternative health care provider is available and the situation is not an emergency)[9]. This AMA position is in opposition to the recommendation by the Counsel Assisting that requires practitioners to accept any person who wishes to enrol with it (Recommendation 62, v.). Therapeutic relationships can be compromised due to a conflict of interest, the doctor-patient relationship may breakdown and become ineffective or abusive. Maintaining the right to choose whether or not to enter into a therapeutic relationship protects both the doctor and the patient.

The AMA Code of Ethics[10] stipulates that doctors have a right to decline to enter into a therapeutic relationship where an alternative health care provider is available and the situation is not an emergency one. While it is understandable that the Counsel Assisting wishes to avoid practices accepting only patients with less complex care needs, there are a range of reasons why a doctor may decline to see a new patient such as a lack of available appointments, the patient's care needs fall outside the doctor's scope of practice or clinical capacity or belief that taking on a new patient may compromise the care they can provide to existing patients.

In addition, the Code of Ethics stipulates that doctors have a right to decline to continue a therapeutic relationship where it becomes ineffective or compromised, where an alternative health care provider is available and the situation is not an emergency one. There may be a variety

[9] Australian Medical Association (2016) AMA Code of Ethics
[10] Australian Medical Association (2016) AMA Code of Ethics

of reasons for discontinuing an existing therapeutic relationship such as where it becomes ineffective due to a communication breakdown, where the patient is aggressive or disruptive towards the doctor or others including staff and other patients, the patient's care needs are outside the doctor's scope of practice or clinical capacity, there is a breach of personal boundaries or where there is a conflict of interest (such as where the patient is a family member).

When deciding whether to enter into, or discontinue, a therapeutic relationship, doctors will weigh up their ability to properly care for the individual patient along with their duty to others including the ability to provide appropriate care to other patients and to protect the health and safety of patients and staff.

Then AMA President Dr Bartone in his witness statement[11] before the Royal Commission argued in favour of an enrolment process in which the patient/RACF resident would nominate a doctor or a practice as being their regular practice or their regular doctor, with appropriate funding to cover the care of the patient/RACF resident throughout the nomination period.

The AMA is principally against health care being funded solely through capitation payments but acknowledges that capitation payments may form part of a blended funding model. In our 2019-20 Pre-Budget Submission the AMA called on the Government to provide a quarterly 'care coordination' payment to GPs to support a more pro-active and team-based approach to care. In the AMA view, such a payment would supplement existing Medicare funding arrangements as part of a blended funding model and would operate in a similar way to the Department of Veterans' Affairs Coordinated Veterans' Care program.

The AMA calls on the Royal Commission to consider this model, rather than devising a whole new model of GP care that will not work in the long term for older patients receiving aged care services.

Restricted prescription of antipsychotics

The AMA does not support amending the Medicare Benefits Schedule (MBS) so that an initial prescription of antipsychotics can only be done by Geriatricians and/or Psychiatrists, as recommended by the Counsel Assisting.

While the AMA supports the calls for greater involvement of geriatricians and psychiatrists in aged care, we fear that with this recommendation the specialist services, which are limited in aged care, will be overburdened.

In our first submission, we called on the Royal Commission to investigate the small numbers of specialist geriatricians and psychogeriatricians who provide services in aged care, seeking to address this issue so that they can better support GPs. However, this recommendation by the Counsel Assisting goes to the extreme, where the role of GPs in caring for their patients in aged care is being diminished.

[11] Royal Commission into Aged Care Quality and Safety (2019) Transcript of Proceedings, page P-7271

It is the AMA position that restrictive practices should always be used as a last resort – where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained. We maintain that the older person's GP, along with the aged care provider, the older person's family and substitute decision maker should be involved in any decision to use a restraint.

The AMA maintains that doctors must be able to maintain clinical independence in order to make the best treatment recommendations for patients, based on current evidence, preserving their own clinical judgments regarding treatment recommendations.

In the AMA view, there are a number of conditions that will need to be met, in order to reduce the use of antipsychotics in aged care, including staffing ratios, greater number of registered nurses (RNs) in aged care, access to dementia management and behavioural training for nursing and personal care staff attendants, and ensuring a dementia-friendly environment.

Rather than introducing a 'blanket restriction' on GPs regarding prescribing antipsychotics, the AMA calls on the Royal Commission to consider alternative solutions to reducing prescribing, such as regular audits on prescribing/de-prescribing rates in aged care. The AMA envisages such audits to address all other strategies applied by the aged care providers to reduce the distress in the older person before prescribing of antipsychotics is required, reasons why those strategies failed, how long the older person was kept on antipsychotic medication and why.

Features of the new better access to health care model supported by the AMA

The AMA members support specific aspects of the model proposed by the Counsel Assisting, like the adoption by the aged care sector of digital technology and My Health Record, greater engagement with non-GP specialists, the development of aged care plans by GPs, regular medication management reviews and utilisation of telehealth.

The AMA is also supportive of payments being indexed and has called for this previously and would also support extending the incentive to home attendances for people on Level 3 and 4 packages. AMA members call on the Royal Commission to consider a short-term increase of the practice incentive payment, with the cap on the number of services increased to 10.8 services per week (recommendation 67: Changes to the General Practitioner Aged Care Access Incentive Payment).

Minimum staff time standard for residential care

The AMA supports mandating minimum staffing ratios in aged care, which has been our ongoing position. We have called for minimum staffing ratios to be introduced in all our submissions to the Royal Commission thus far. However, in the AMA view, the solution proposed by the Counsel Assisting will fail to achieve the level of care that is required for our oldest and most vulnerable.

The AMA is surprised that the Counsel Assisting in their recommendations for minimum staff time per resident opted for the lower end of what would be a 3-star model, as outlined in the Royal Commission in the Commission's Research Paper 1: How Australian residential aged care staffing levels compare with international and national benchmarks[12].

In the AMA view, meeting the needs of residents and providing residents with high quality care should be at the core of setting minimum staff to resident ratios, rather than delivering care in accordance with the "provider's model of care", as suggested by the Counsel Assisting.

The AMA also warns that the recommendation 47.5 of "at least one registered nurse (RN) on site per residential aged care facility on site at all times" is simply too low and does not correlate to further recommendations about staff mix. In many RACFs one RN will not be enough to provide for all residents and all their care needs. Furthermore, the AMA does not see any justifiable reason why mandating RN presence 24/7 in aged care facilities must wait until 2024 to be implemented. In the AMA view this should be done as soon as possible, preferably in 2021.

For the AMA, availability of RNs in RACFs is a critical issue for improving quality of care. As we have explained in our previous submissions to the Royal Commission, RNs are the only aged care provider employees that can provide frontline, timely clinical care within their scope of practice. Doctors rely on RNs to carry out their clinical directions when they leave the RACF or the patient's home. Doctors need to communicate with RNs because RNs have clinical backgrounds and can assist to determine the best clinical care for older people.

Therefore, in the AMA view, 36 minutes per day proposed by the Counsel Assisting is not enough time to dedicate to each resident if the aim is to ensure residents' improved health outcomes and in particular if the overall aim is the reablement of residents. The AMA calls on the Royal Commission to recommend increasing staff hours per resident, particularly RNs and aligning their recommendation with the 5-star model outlined in the cited research paper. This is critical to achieving quality care and patient safety in RACFs.

A Single comprehensive assessment process

The AMA supports a single comprehensive assessment process for all older people entering aged care. However, AMA members have expressed some concerns around the proposed model. Firstly, that the assessment function should remain with the state/local governments and their health care services. Any new solution proposed by the Royal Commission should replicate or be closer to current ACAT, rather than current RAS. Secondly, it is the AMA strong view that health care professionals must be involved in the assessments. Any process of assessment must include access to independent medical opinion.

The AMA has serious concerns about the rollout of this program and expects the Royal Commission to be very specific in its recommendations regarding the assessment model. The AMA is principally against a privatised model that is separate from the state/territory health systems, taking it out of public hospitals, when we know that most older people in aged care end

[12] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

up in public hospitals when they need acute care. The AMA is concerned that if a privatised model is recommended by the Royal Commission, the services will go to private entities that are registered as both providers of health and aged care, who as health care providers would be eligible for provision of assessment services. They could potentially abuse this function by channelling those assessed to their affiliated aged care providers. The AMA warns of the importance of the independent assessment process and will strongly oppose any reform that takes the assessment processes outside of the public hospital systems.

Secondly, we are concerned that the proposed single assessment model, as recommended by the Counsel Assisting, lacks any regard for the knowledge and information available to an older person usual GP, that should be utilised in the assessment process. This is in spite of the Recommendation 11.2 that calls for bringing older people's general practitioners to the centre of planning for aged care.

New proposed assessment model fails to engage with the older person's usual GP. GPs often refer their patients to aged care assessments and should be kept informed of outcomes of these assessments. GPs are familiar with their older patient's situation, their medical histories, important medical conditions that can affect their physical function, and any disabilities that their patients may have. That information should be utilised by the assessors, which is currently not the case. The aim of any comprehensive reform, such as what the Royal Commission is aiming to be, should indeed be to bring the GPs at the centre of planning of their patients' aged care, but that cannot be achieved unless they are involved in all stages of the process.

Finally, the AMA has concerns around Recommendation 12.1 (b) that allows 'care finders' to refer older people to aged care before an assessment is conducted "if this is necessary in the opinion of the care finder". The AMA is concerned that care finders will be allowed to refer older people to aged care services directly, when this is not something that health professionals can do currently and under the Counsel Assisting's recommendations. In the AMA view, no referral to aged care should happen without the involvement of independent health professionals, the patient's usual GP, general physician or geriatrician (if the patient is in hospital for example).

The AMA calls for a streamlined process to improve urgent access to respite care for older people who have been referred to My Aged Care but not yet assessed, for those who have been assessed but are awaiting a home care package, or those who have not yet entered the aged care system. Access to respite care should be streamlined by allowing GPs to approve respite care for older people in much the same way a doctor determines that a hospital admission is necessary. GPs are best informed about their patient's circumstances and requirements and are able to spot any deterioration in their health and are therefore best placed to refer their older patients to respite care. If the aim of the reform is to closer integrate and health and aged care, and place GPs at the centre of planning, then GPs should be able to refer their patients to respite care directly.

Therefore, care finders should work with GPs and other relevant health professionals, rather than make independent decisions regarding referring older people to aged care services. Referrals for transfer should not be made by people who potentially may have no knowledge of medical care or medical needs of an older person when they are at an acute point.

Conclusion

The AMA has consistently called for a comprehensive reform of the aged care sector in a way that will enable wholistic care of older people, avoiding fragmentation and enabling continuity of care. Yet, with the model of care proposed by the Counsel Assisting, there is concern that it will lead to further fragmentation of care, rather than aiming to bring health care and aged care closer together.

In the AMA view, aged care and health care are two parts of the same system that should be geared towards optimising health and wellbeing of our older people. GPs should be placed at the centre of the healthcare of older Australians, yet they have been marginalised and sidelined from the Aged Care system in which their patients reside.

Unfortunately, the recommendations by the Counsel Assisting outlined in their final submission will not resolve any of these issues but rather lead to further fragmentation of care, in the view of AMA members. They also have the potential of further deterring GPs from working in aged care.

Finally, the AMA is concerned that the recommendations by the Counsel Assisting around staffing ratios and single assessment processes, unless revisited and further elaborated, may have an opposite impact of what the Royal Commission is aiming to achieve.

The AMA urges the Royal Commission to consider this AMA submission and the arguments against some of the Counsel Assisting's recommendations. The AMA remains open to working with the Royal Commission on devising models of care that will be to the ultimate benefit of our older people.

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	Individual details - Please complete for personal response		
Individual detail	Are you a person receiving aged care services or a family member of a person receiving aged care services? (select response)		
Individual detail	Do you identify as being of Aboriginal and/or Torres Strait Islander origin? (select response)		
Individual detail	Do you identify as a person from a culturally and linguistically diverse background? (select response)		
Individual detail	Do you identify as a person with a disability? (select response)		
	Organisation details - Please complete for organisational response		
Organisation Detail	What is the name of the organisation?	Australian Medical Association	
Organisation Detail	What is the nature of the organisation? (select response)	Peak body	
Organisation Detail	What is the organisation's role in Aged Care? [Free text available in comments, if needed]	AMA is the peak professional body for doctors in Australia promoting and protecting professional interests of doctors and the healthcare needs of pa	
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Response Details			
Recommendation 1	**Principles of the new aged care system** **A new act**		
1.1.	The *Aged Care Act 1997* (Cth) should be replaced with a new Act to come into force by no later than 1 July 2023. The objects of the new Act should be to:	Support	
1.1.	(a) provide a system of aged care based on a universal right to high quality, safe and timely support and care to: i. assist older people to live an active, self-determined and meaningful life, and ii. ensure older people receive high quality care in a safe and caring environment for dignified living in old age	Support	
1.1.	(b) protect and advance the rights of older people receiving aged care to be free from mistreatment and neglect, and harm from poor quality or unsafe care, and to continue to enjoy rights of social participation accessible to members of society generally	Support	
1.1.	(c) enable people entitled to aged care to exercise choice and control in the planning and delivery of their care	Support	
1.1.	(d) ensure equity of access to aged care		
1.1.	(e) provide advocacy and complaint mechanisms for people receiving aged care	Support	
1.1.	(f) provide for regular and independent review of the aged care system	Support	
1.1.	(g) promote innovation in aged care based on research	Support	
1.1.	(h) promote positive community attitudes to enhance social and economic participation by people receiving aged care.	Support	
1.2.	The new Act should state that the above objects are to be achieved by establishing:		
1.2.	(a) the Australian Aged Care Commission	Support	
1.2.	(b) the Australian Aged Care Pricing Authority	Support in principle	The AMA is in favour of having one authority determining the prices for hospital and aged care, an Independent Hospital and Aged Care Pricing Authority, as explained under point 5.1.
1.2.	(c) the office of the Inspector-General of Aged Care	Support	
1.2.	and by the other provisions of the Act.	Support	
1.3.	The new Act should:		

1.3.	(a) define aged care as: i. support and care for people to maintain their independence as they age, including support and care to ameliorate age-related deterioration in their social, mental and physical capacities to function independently ii. supports including respite for informal carers of people who need aged care	Support	
1.3.	(b) provide that the paramount consideration in the administration of the Act should be ensuring the safety, health and wellbeing of people receiving aged care	Support	
1.3.	(c) specify the following principles that should also guide the administration of the Act: i. Older people should have certainty that they will receive timely high quality support and care in accordance with assessed need ii. Informal carers of older people should have certainty that they will receive timely and high quality supports in accordance with assessed need iii. Older people should be supported to exercise choice about their own lives and make decisions to the fullest extent possible, including being able to take risks and be involved in the planning and delivery of their care iv. Older people should be treated as individuals and be provided with support and care in a way that promotes their dignity and respects them as equal citizens v. Older people are entitled to pursue (and to be supported in pursuing) physical, social, emotional and intellectual development and to be active and engaged members of the community, regardless of their age or level of physical or cognitive capability vi. The relationships that older people have with significant people in their lives should be acknowledged, respected and fostered vii. To the fullest extent possible, older people should receive support and care in the location they choose or, where that is not possible, in the setting most appropriate to their circumstances and preferences viii. Older people are entitled to receive support and care that acknowledges the aged care setting is their home and enables them to live in security, safety and comfort with their privacy respected ix. Older people should have equal access to support and care irrespective of their location or personal circumstances or preferences x. Care should be provided in a healthy environment which protects older people from risks to their health xi. Care and supports should, as far as possible, emphasise restoration and rehabilitation, with the aim of maintaining or improving older people's physical and cognitive capabilities and supporting their self-determination xii. Aboriginal and Torres Strait Islander people are entitled to received support and care that is culturally safe and recognises the importance of their personal connection to community and Country xiii. The system should support the availability and accessibility of aged care for all older Australians, including special or vulnerable groups xiv. The aged care system should be transparent and provide public access to meaningful and readily understandable	Support	
1.4.	The new Act should specify a list of rights of people seeking and receiving aged care, and should declare that the purposes of the Act include the purpose of securing those rights and that the rights may be taken into account in interpreting the Act and any instrument made under the Act. The list of such rights should be:	Support	
1.4.	(a) for people seeking aged care: i. the right to equitable access to care services ii. the right to exercise choice between available services	Support	
1.4.	(b) for people receiving aged care i. the right to freedom from degrading or inhumane treatment, or any form of abuse ii. the right to liberty, freedom of movement, and freedom from restraint iii. the right of autonomy, the right to the presumption of legal capacity, and in particular the right to make decisions about their care and the quality of their lives and the right to social participation iv. the right to fair, equitable and non-discriminatory treatment in receiving care	Support in principle	The AMA supports in principle this recommendation and would call for item iv. to be amended as follows: "iv. the right to fair, equitable and non-discriminatory treatment in receiving care, including medical care".
1.4.	(c) for people receiving end-of-life care, the right to fair, equitable and non-discriminatory access to palliative and end-of-life care.	Support in principle	The AMA supports in principle this recommendation. The AMA sees palliative care as a broader term than end of life care and the two should not be used interchangeably. The AMA suggest replacing end-of-life care with palliative care after 'for people receiving'. Palliative care should be about enhancing quality of life for older people for as long as possible, while also positively influencing the course of illness. The AMA Position Statement on Palliative Care in the Aged Care Setting outlines the AMA position on palliative care provision for older people receiving aged care services. The AMA considers access to palliative care to be the basic human right to health. A palliative approach should provide the older person with: (a) autonomy, dignity, comfort and respect; (b) an honest, open discussion about conditions and treatment options; (c) choice in available evidence-based treatment options; (d) effective management of pain and other distressing symptoms; (e) quality of life, as defined by the patient, in the circumstances; (f) their cultural or spiritual wishes honoured; and (g) access to the people they wish to be present.
1.5.	Unless indicated otherwise, the new Act should incorporate provisions giving effect to amendments to the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth) (as well as to delegated legislation made under those Acts) the subject of other recommendations.	Support	

Recommendation 2	**Integrated long-term support and care for older people**		
2.1.	The Australian Government should coordinate the development of an integrated system for the long-term support and care of older people providing for their needs for welfare support, community services directed at enhancing social participation, affordable and appropriate housing, high quality health care, and aged care, through a new National Cabinet Reform Committee on Ageing and Older Australians, to be established between the Australian and State and Territory Governments, and composed of the highest-ranking ministers whose primary responsibility is the care, health and wellbeing of older people.	Support in principle	The AMA supports in principle this recommendation. However, we would also like to see the new National Cabinet Reform Committee on Ageing and Older Australians engaging with clinicians and professionals directly involved in provision of both aged care and medical care for older people. The National Cabinet Reform Committee should be advised by the Aged Care Advisory Council.
2.2.	Work on a strategy to develop the integrated system for the long-term support and care of older people should begin immediately. That work should involve consultation with older people. The strategy should be agreed between the Australian and State and Territory Governments by 31 December 2022. The strategy should include measurable goals, regular reporting on progress to the National Federation Reform Council, and two-yearly public progress reports.	Support in principle	The AMA calls for the health professionals to be consulted in the process of development of the Strategy.
2.3.	The strategy should provide for implementation of an integrated system for the long-term support and care of older people within a 10-year period.	Support	
	Design of the new aged care system		
Recommendation 3	**Australian Aged Care Commission**		
3.1.	By 1 July 2023, the Australian Aged Care Commission should be established under the new Act as a corporate Commonwealth entity within the meaning of the *Public Governance, Performance and Accountability Act 2013* (Cth), with its own legal personality, and able to sue and be sued. The Commission should be independent of Ministerial direction, and there should be a requirement that any expectations or advice provided by the responsible Minister to the Commission should be made public. The Commission should have:	Support	The AMA supports this recommendation. It is the AMA position that the aged care system should be led by an overarching, independent body, such as an Aged Care Commission. The AMA Resourcing Aged Care Position Statement 2018 outlines the AMA position on the appropriate governance of the aged care system and its resourcing: https://ama.com.au/position-statement/aged-care-resourcing-2018.
3.1.	(a) a governing board appointed by the Governor-General, in which the authority and functions of the Commission should be vested under the new Act, comprising: i. at least three non-executive members, who are to constitute the majority of the board and one of whom is to be appointed as chair of the board, and who are to be chosen for their integrity, eminence and public standing, each of whom must be independent of any current involvement in the aged care sector, and who together are representative of the community and should have a range of backgrounds and skills including experience and proven capacity in: aged care, clinical services, human services, legal services, and corporate governance; and in one or more of the financial, accounting or general business areas ii. the Secretary of the Department administered by the responsible Minister, who shall be an *ex officio* member of the board iii. the presiding commissioner of the Commission, who shall be the chief executive officer of the Commission and may participate in the deliberations of the board of the Commission except where the presiding commissioner has a material personal interest in the subject matter under deliberation	Support	
3.1.	(b) no fewer than five assistant commissioners to be appointed by the board on the basis of their integrity, standing, skills, and expertise, one of whom must be a person of Aboriginal or Torres Strait Islander background, one of whom will be responsible for complaints, and another of whom will have workforce development and training as a dedicated portfolio	Support in principle	The AMA supports in principle this recommendation. In the AMA view, and as outlined in our Resourcing Aged Care Position Statement 2018, the governance structure of the Aged Care Commission must include a medical practitioner in an advisory role who aims to improve clinical care and clinical governance in aged care, such as through education and training.
3.1.	(c) staff employed or engaged by the Commission (whether under the provisions of the *Public Service Act 1999* (Cth) or otherwise), who should be subject to the direction and supervision of the commissioners	Support	
3.1.	(d) a distributed network of offices including regional offices to deliver or manage the delivery of assessment and care finding services, administer the aged care program, and provide general assistance to the public, and a head office outside Canberra	Support	
3.1.	(e) system management functions, including support and funding of local assessment and care finding teams and personnel, provision of information on services and providers (including through My Aged Care), system data management, ensuring the coverage of service availability for all aged care services to which people are assessed as eligible, commissioning and funding of providers to provide sufficient aged care services in all locations, providing assistance to providers to build capacity where appropriate, and managing the orderly exit of consistently poor-performing providers	Support	

3.1.	(f) the following functions: i. approval of service providers as providers eligible to receive subsidies for providing aged care ii. financial risk monitoring of providers, and prudential regulation of providers iii. approval of the scope of subsidised services approved providers may provide, and accreditation of the outlets ('services') through which they provide them iv. payment of subsidies to approved providers of aged care v. quality and safety regulation of approved providers and their services vi. ensuring that appropriate aged care services are widely available for Aboriginal and Torres Strait Islander people vii. workforce planning and development, including setting and refining requirements for minimum staffing levels and minimum qualifications for staff providing care, and (through a workforce planning division within or operated by the Commission) ongoing development of workforce capacity through requirements for training and professional development viii. consulting with the Australian Commission on Safety and Quality in Health and Aged Care (which is to be responsible under the new Act for review and setting of quality and safety standards and quality indicators) on reviews and revisions of the standards and indicators for the provision of safe and high quality aged care ix. management of complaints about providers, staff, assessors and care finders	Support	The AMA supports this recommendation. The AMA Resourcing Aged Care Position Statement 2018 outlines AMA position on the role of the Aged Care Commission: a) Oversee the aged care regulatory bodies and make recommendations to the Government on how to improve the aged care system based on their work. b) Works with the aged care industry to ensure an adequate supply of appropriate, well trained staff to meet the demand of holistic care to a diverse ageing population. c) Centralise information-sharing between all aged care regulatory bodies, hospitals, state, territory and federal governments, Primary Health Networks, advocacy services, and aged care services to identify where the system is not operating efficiently, or where the current model is failing to address health issues, which can lead to higher costs. d) Regularly assess the resources allocated for the health of older people by federal, territory, and state governments, in consultation with older people and their representatives, as well as with health care professionals, carers, and other providers of aged care. e) Make recommendations to the Federal Government and the aged care sector to ensure the level of investment in the sector enables an appropriate level and quality of services and infrastructure to meet the needs of an ageing population. This includes: i. Funding needed to meet the demand and appropriate mix of aged care services, including RACFs and home care packages, and ii. Upgrading facilities to the standard the community expects, while also complying with the standards required for the provision of contemporary medical care.
3.1.	(g) the primary responsibility for system governance, including the responsibility of continuously monitoring the performance of the system, formulating new policy and reform proposals for improvement of the performance of the system, limited authority to make legislative instruments about the details of arrangements for the administration of funding and service delivery, and the responsibility for recommending other amendments of legislation and delegated legislation to the responsible Minister	Support	As per our comment under 3.1. above.
3.1.	(h) an obligation to report regularly to the Inspector-General of Aged Care and to the responsible Minister on the performance of its functions	Support	
3.1.	(i) an obligation to lay before the Parliament and to publish an annual report on all important aspects of the operation of the new Act, including: i. the extent of unmet demand for aged care, including unmet demand for particular services or in particular places ii. the adequacy of the Commonwealth subsidies provided to meet the care needs of people needing or receiving aged care iii. the extent to which providers are complying with their responsibilities under the Act iv. the amounts paid by people receiving residential care in connection with their care, including amounts paid for accommodation and daily living needs v. the amounts paid for accommodation in the form of lump sum deposits and in the form of daily payments vi. the duration of waiting periods for assessment, and between assessment and commencement of provision of particular services, including respite and residential care vii. the extent of building, upgrading and refurbishment of aged care facilities, and viii. such other aspects of the operation of the Act as the Commission considers relevant to ensure an accurate understanding of the operation of the Act.	Support	
Recommendation 4	**Aged Care Advisory Council**		
4.1.	By 1 December 2021, the responsible Minister should appoint an Aged Care Advisory Council, to be constituted by such people of eminence, expertise and knowledge of aged care services as the Minister sees fit, drawn from all relevant aspects of the aged care system, including people receiving aged care, representatives of the aged care workforce, approved providers, health and allied health professionals, specialists in training and education, and independent experts.	Support in principle	The AMA supports in principle this recommendation. The AMA calls on the Royal Commission to either define the membership or to propose a terms of reference for this group. The AMA believes that there is a need to ensure that genuine voice aged care recipients is present on this group, which is currently not the case with relevant Government advisory bodies. The AMA also believes that researchers and academia representatives should be included. In the AMA view, current Government reform advisory forums have over-representation of aged care providers, while consumer organisations involved have low membership of people in residential aged care for example. Any new forum that is established needs to ensure that genuine consumers, those receiving care, are included.
4.1.	The Advisory Council should be established with its own secretariat, funded by the Australian Government, for the purpose of providing advice on aged care policy, service arrangements and any aspect of the performance of the aged care system, to the Australian Aged Care Commission and the Minister. It should convene itself regularly, and should have authority to provide advice to the Commission and the Minister on its own initiative. In addition, the Commission and the Minister should have authority to convene it on reasonable notice, and may refer particular issues to it for advice.	Support in principle	As outlined under recommendation 2, the Advisory Council should be advising the National Cabinet Reform Committee for Ageing and Aged Care.
Recommendation 5	**Australian Aged Care Pricing Authority**		

5.1.	The Australian Government should establish an Aged Care Pricing Authority and confer on it all necessary functions for determining prices (inclusive of subsidies and user contributions) for specified aged care services so as to meet the reasonable and efficient costs of delivering those services. Its functions should include the function of identifying and recommending to the Australian Aged Care Commission the aged care services for which price cap determinations or other forms of economic regulation may be appropriate.	Support in principle	The AMA supports in principle this recommendation. We support an independent body determining the prices in aged care, but the AMA would argue that, instead setting up a whole new agency, this role should be merged with the Independent Hospital Pricing Authority. The AMA argues that the goal of the reform should be to bring aged care closer to health care, and this to a certain extent can be achieved by having one agency defining the pricing for both. Aged care and health care affect each other, and this will continue to be the case into the future, with people living longer, growing ageing population and greater need for aged care services. Apart from minimising the cost to the Government that would be incurred by creating a whole new agency, having one agency involved in both aspects of care would be beneficial from the aspect of having one agency with an overview and projections for all relevant expenditure. The AMA understands the intention for the Aged Care Pricing Authority to have a broader remit than IHPA, however the AMA envisages that through additional resourcing the two organisations could be merged and IHPA given a broader remit. In the AMA view, the Independent Hospital Pricing Authority is a highly functional organisation with experienced staff who specialise in the development of hospital classification systems and hospital funding and we see a possibility here for synergies and efficiencies.
Recommendation 6	**Inspector-General of Aged Care**		
6.1.	The Australian Government should establish an independent office of the Inspector-General of Aged Care to monitor and report on the administration and governance of the aged care system, including:	Support	
6.1.	(a) the implementation of the reforms recommended by the Royal Commission	Support	
6.1.	(b) the performance by the Australian Aged Care Commission and the Australian Aged Care Pricing Commission of their functions	Support in principle	The AMA supports this recommendation in principle, with above caveat of combining the Aged Care Pricing Commission with the Independent Hospital Pricing Authority, as outlined in point 5.1.
6.1.	(c) the extent to which the aged care system attains the objects of the new Act.	Support	
6.2.	An Inspector-General should be appointed forthwith under interim administrative arrangements, and should in due course be established formally under the new Act.	Support	
Recommendation 7	**Enhanced individual advocacy**		
7.1.	By 1 July 2022, the Australian Government should, through the implementation unit referred to in Recommendation 123, complete a consultation with the contracted provider of services under the National Aged Care Advocacy program in order to determine the extent of unmet demand for prompt advocacy services by people seeking or receiving aged care services. In light of the conclusions reached by the implementation unit after that consultation, the Australian Government should increase the funding of the National Aged Care Advocacy program to a level that provides for increased coverage of the program so as to meet currently unmet demand for prompt advocacy services.	Support	
Recommendation 8	**Program design** **A new aged care program**		
8.1.	By 1 July 2024, the Australian Government should implement a new aged care program that combines the existing Commonwealth Home Support Programme, Home Care Packages Program, and the Residential Aged Care Program, including Respite Care and Short-Term Restorative Care. The new program should aim to retain the benefits of each of the component programs, while delivering a more comprehensive continuum of care for older people. The core features of the program should be:	Support	
8.1.	(a) a common set of eligibility criteria, identifying a need (whether of a social, psychological or physical character) to prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects of such deterioration, and to enhance the person's ability to function independently as well as possible, for as long as possible	Support	
8.1.	(b) an entitlement to all forms of support and care which the individual is assessed as needing	Support	
8.1.	(c) a single assessment process, using the same assessment framework and arrangements for assessors	Support in principle	The AMA supports in principle this recommendation. However, AMA has some concerns around the single assessment framework and arrangements for assessors. It is the AMA strong position that the new model should be based on the current ACAT rather than RAS, otherwise this new model will risk the patient safety and quality of care received. The new model must preserve and maintain functioning systems which are lead by doctors. Medical expertise is needed in aged care assessments and the new framework should recognise it. Current ACAT services provide baseline clinical data for subsequent clinical monitoring and evaluation of patient outcomes. This feature should be preserved in the new model. The AMA would also like to see the new model capture the information available to older person's usual GP, who under the current system are cut off from contributing to their patients' assessments past the referral to My Aged Care. Finally, the new framework needs to ensure independence of assessors from the aged care providers. In the AMA view, the assessment services must be linked to local hospital networks, as per the current ACAT model.
8.1.	(d) certainty of funding based on assessed need	Support	
8.1.	(e) genuine choice accorded to each individual over how their aged care needs are to be met (including choice of provider and level of engagement in managing care, and appropriate and adapted supports to enable people from diverse backgrounds and experiences to exercise choice)	Support	
8.1.	(f) access to one or multiple categories of the aged care program simultaneously, based on need	Support	
8.1.	(g) portability of entitlement between providers and across State or Territory borders.	Support	
Recommendation 9	**Meeting preferences to age in place**		
9.1.	The Australian Government should clear the home care package waiting list, otherwise known as the National Prioritisation System, by:	Support	

9.1.	(a) immediately increasing the home care packages available and allocating a package to all people on the waiting list that do not have a package or do not have a package at the level they have been approved for (as set out in their letter from the Aged Care Assessment Team/Service). The package allocated should be at the level the person was approved for (Level 1, 2, 3 or 4). This must be completed by 31 December 2021	Support	
9.1.	(b) keeping the waiting list clear by allocating a home care package at the approved level to any new entrants to the waiting list within one month of the date of their assessment. This must occur between 1 January 2022 and 1 July 2024	Support	
9.1.	(c) publicly reporting, each quarter, the status of the waiting list, showing progress in clearing the waiting list as set out in paragraphs a. and b. above, at a national, State or Territory, and regional level. This report should include reasons for delay in clearing the waiting list and actions being taken to address the delay. This must occur every quarter from 31 March 2021 to 1 July 2024.	Support	
Recommendation 10	**Care finders to support navigation of aged care**		
10.1.	From 1 July 2023, the Australian Aged Care Commission should engage, support and fund 'care finders' to provide assistance on a local, face-to-face basis, to people seeking or receiving aged care services. The care finders should be Commonwealth, State or Territory or local government employees who have suitable skills and experience in meeting the needs of people for aged care, health care, social work or other human services, or otherwise demonstrate aptitude for a highly trusted role in assisting older people who have such needs.	Support	The AMA supports this recommendation. In the AMA view, the current system fails to ensure that care for an older person at an acute point, or when they require a high level of care, is optimised before decision is made on the type of care or level of care required. In that sense, a navigator who can follow the person needing care, from the point of application to the end of their journey, would be most beneficial in the AMA's view. We support the 'care finders' being government employees, as in the AMA view they should be independent of aged care service providers so they can act in the best interest of the older person without potential conflicts of interest. Care finders should also have thorough knowledge of the aged care, disability, and health systems and in addition to coordinating services with aged care providers, they should also regularly communicate with the older person's usual GP and coordinate with the GP to optimise care for the older person while they are in the process of obtaining aged care services. Care finders should support the older person throughout the whole aged care journey, beyond obtaining aged care services to ensure continuity of care . Primary Health Networks could perform the role of aged care system navigation and calls on the Royal Commission to ensure Primary Health Network involvement.
10.2.	Pending establishment of the Commission, the implementation unit referred to in Recommendation 123 should commence engagement of care finders.	Support	
Recommendation 11	**Improved public awareness of aged care**		
11.1.	By 1 July 2022, the Australian Government in cooperation with other levels of government, and working with health professionals, aged care providers and Primary Health Networks, should fund and support education and information strategies to:	Support	
11.1.	(a) improve public awareness of resources to assist people to plan for ageing and potential aged care needs	Support	
11.1.	(b) improve knowledge about aged care among those responsible professionals with whom older people have frequent contact	Support	
11.1.	(c) encourage discussion about and consideration of aged care needs.	Support	
11.2.	These strategies should be implemented by 1 July 2022 and should:		
11.2.	(a) support a continuum of planning for ageing, including consideration of health care preferences, finances, housing and social engagement		
11.2.	(b) bring older people's general practitioners to the centre of their planning for ageing and aged care	Support	The AMA fully supports this recommendation. This has been the cornerstone of AMA policy that the AMA has advocated for many years. In the AMA view, health and aged care should be considered two parts of the same system that should be designed to optimise health and wellbeing of older people. The AMA argues that general practitioners (GPs) form a centrepiece of aged care service design, as they are involved in all stages of aged care, from entry point to the system to the end of life care. GPs perform an important role in system navigation for many older people, from connecting them to My Aged Care to advocating for their needs once they are receiving aged care services. In order for GPs to perform this important role, the AMA maintains that they should be appropriately supported and adequately funded. AMA members often report that their older patients who find themselves at an acute point in their lives and are mostly unaware of where to go for help or how to access aged care services. Often their main link and source of information will be their GP. In addition to being able to link them to My Aged Care, GPs enable continuity of care, which is linked with improved health outcomes for older patients. GPs are familiar with their older patient's situation, their medical histories, important medical conditions that can affect their physical function, and any disabilities that their patients may have. The AMA therefore argues that in the context of the model of delivery of services at entry point, GPs should be better supported. This would be beneficial further down the track in terms of care coordination for older people entering aged care. The AMA is however concerned, that further recommendations fail to put GP at the centre of planning for ageing and aged care.
11.2.	(c) be evaluated and revised annually by the Australian Aged Care Commission.	Support	
Recommendation 12	**A single comprehensive assessment process**		

12.1.	By 1 July 2023, the Australian Government should replace the Aged Care Assessment Program and the Regional Assessment Services with a single assessment process. That assessment process should:	Support in principle	AMA supports this recommendation under certain caveats. Firstly, in the AMA view, the assessment function should remain with the state/local governments and their health care services. The new solution should replicate or be closer to current ACAT, rather than current RAS. Secondly, health care professionals must be involved in the assessments. Any process of assessment must include access to independent medical opinion. The AMA has serious concerns about the rollout of this program, and expects the Royal Commission to be very specific in its recommendations regarding this model. The AMA is principally against a privatised model that is separate from the state/territory health systems, taking it out of public hospitals, when we know that most older people in aged care end up in public hospitals when they need acute care. The AMA is concerned that if a privatised model is recommended by the Commission, the services will go to private entities that are registered as both providers of health and aged care, who as health care providers would be eligible for provision of assessment services. They could potentially abuse this function by channelling those assessed to their affiliated aged care providers. The AMA warns of the importance of the independent assessment process and will strongly oppose any reform that takes the assessment processes outside of the public health systems.
12.1.	(a) be independent from approved providers, so that a person's level of funding should be determined independently of the approved provider, but that determination may involve consultation with providers or prospective providers, provided final assessment decisions affecting eligibility for funding are made by independent assessors	Support in principle	The AMA in principle supports this recommendation, but refers to our comments under 12.1. Our concerns are around 'independence' from providers of aged care services, and existence of entities who provide both aged care and health care, yet are seen as separate legal entities under the legislation. Secondly, we are concerned with the lack of regard for the knowledge and information available to an older person usual GP, in spite of Recommendation 11.2 that calls for bringing older people's general practitioners to the centre of planning for aged care. GPs often refer their patients to aged care assessments, and should be kept informed of outcomes of these assessments. GPs are familiar with their older patient's situation, their medical histories, important medical conditions that can affect their physical function, and any disabilities that their patients may have. That information should be utilised by the assessors, which is currently not the case. The aim of any comprehensive reform, such as the Royal Commission is aiming to be, should indeed be to bring the GPs at the centre of planning of their patients' aged care, but that can't be achieved unless they are involved in all stages of the process.
12.1.	(b) occur, wherever possible, before funded services commence, although funded services may be offered on an interim basis pending assessment where this is necessary in the opinion of a care finder	Support in principle	AMA doesn't support care finders referring older people to aged care services without the involvement of independent health professionals, patient's usual GP, general physician or geriatrician (if the patient is in hospital for example). The AMA would like this recommendation brought closer toward achieving recommendation 11.2. The AMA calls for a streamlined process to improve urgent access to respite care for older people who have been referred to My Aged Care but not yet assessed, for those who have been assessed but are awaiting a home care package, or those who have not yet entered the aged care system. Access to respite care should be streamlined by allowing GPs to approve respite care for older people in much the same way a doctor determines that a hospital admission is necessary. GPs are best informed about their patient's circumstances and requirements and are able to spot any deterioration in their health and are therefore best placed to refer their older patients to respite care. If the aim of the reform is to closer integrate and health and aged care, and place GPs at the centre of planning, then GPs should be able to refer their patients to respite care directly. Therefore, care finders should work with GPs and other relevant health professionals, rather than make independent decisions regarding referring older people to aged care services. Referrals for transfer should not be made by people who potentially may have no knowledge of medical care or medical needs of an older person when they are at an acute point.
12.1.	(c) be efficient and scalable according to the complexity of needs and vulnerability of the older person	Support in principle	As explained under point 12.1 (b) above, scalability to address the complexity of need for care of an older person will not be the adequate solution for optimising their care. Any decision on care for an older person must take into account the opinions of independent medical professionals, GPs, general physicians and geriatricians.
12.1.	(d) be forward-looking and promote older people's autonomy and self-determination	Support	
12.1.	(e) include assessment of the need for care management and the intensity and complexity of that need	Support	
12.1.	(f) include an assessment of any informal carer's needs	Support	
12.1.	(g) use multidisciplinary teams for more complex needs.	Support	
12.2.	People should be provided with details of their assessed need and funding level at the conclusion of the assessment process.	Support	
12.3.	Reasonable requests for reassessment of need can be made by a person receiving care (or their informal carer, close family or other representative), their care finder, or their approved provider.	Support	
Recommendation 13	**Respite supports category**		

13.1.	From 1 July 2022, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should implement a respite supports category within the aged care program that:	Support	The AMA has in the past called for a streamlined process to improve urgent access to respite care for older people who have been referred to My Aged Care but not yet assessed, for those who have been assessed but are awaiting a home care package, or those who have not yet entered the aged care system. Access to respite care could be streamlined by allowing GPs to approve respite care for older people in much the same way a doctor determines that a hospital admission is necessary. GPs are best informed about their patient's circumstances and requirements and are able to spot any deterioration in their health and are therefore best placed to refer their older patients to respite care. If the aim of the reform is to closer integrate and health and aged care, and place GPs at the centre of planning, then GPs should be able to refer their patients to respite care directly.
13.1.	(a) supports the carers of older people earlier and more often to maintain their wellbeing and supports the caring relationship	Support	In the AMA view, the new system should provide an option for the older person's/carers usual GP to streamline access to respite care.
13.1.	(b) provides a greater range of high quality respite support in people's homes, in cottages and in purpose-built facilities	Support	
13.1.	(c) provides people with up to 63 days of respite per calendar year	Support	
13.1.	(d) is grant funded with a capital component.		
13.2.	The respite supports category should continue within the new aged care program from 1 July 2024.	Support	
Recommendation 14	**Approved provider's responsibility for care management**		
14.1.	From 1 July 2022, unless an assessment team has assessed the person as eligible for home care (or, from 1 July 2024, care at home) without the need for any care management, the person's approved provider must assign a care manager to the person.	Support in principle	The AMA supports in principle this recommendation. In the AMA view, the new system should avoid replicating the current situation where a large percentage of funding for HCP for example goes towards funding of 'care management' where very little or no management is provided (see for example this report: http://www.agedcarematters.net.au/wp-content/uploads/2019/03/OlderPeopleLivingWellwithIn-HomeSupport.pdf showing that some providers charged over 50 per cent for care management and administration fees). Also, it should be within the remit of the Inspector-General Aged Care to monitor the implementation of care coordination by individual providers with adequate indicators set up for that monitoring to occur.
14.2.	In the case of home care (or, from 1 July 2024, care at home), if the person has more than one approved provider, the person's lead provider must assign a care manager to the person.	Support in principle	The AMA would like to see the care management service being coordinated with the 'care finder'. That way a certain degree of independence by the older person from their lead provider would be achieved. With care finder/navigator being independent of aged care service providers, they can act in the best interest of the older person without potential conflicts of interest. In addition to coordinating services with aged care providers, the navigator can also communicate with the older person's usual GP when clinical care is required.
14.3.	Care management should be scaled to match the complexity of the older person's needs and should be provided in a manner that respects any wishes of the person to be involved in the management of their care.	Support in principle	The AMA supports in principle this recommendation. As explained above, for old, frail, vulnerable people, who often have no family to support them, the best way to respect their wishes and ensure that their best interest is preserved, is to involve an independent care navigator into the planning of their care management.
14.4.	The care manager should:		
14.4.	(a) have relevant qualifications and experience as a registered nurse or allied health professional	Support	
14.4.	(b) consult with the person and, if applicable, their carer, to develop a comprehensive support and care plan, including activities to promote various aspects of health and wellbeing and to enhance their ability to live or participate in the community and address their strengths, capability, aspirations and goals	Support in principle	Consultations should involve other care professionals involved in their care, such as the older person's GP. This activity must be linked with the recommendation 62.2 below that requires the GP to prepare an 'Aged Care Plan' (in collaboration with a geriatrician and the aged care provider and others) for each person enrolled in their care.
14.4.	(c) implement, monitor and review the support and care plan, and adjust as appropriate	Support in principle	This should be done in consultation with the persons usual GP, and having consideration for the GP developed Aged Care Plan.
14.4.	(d) for home care (or, from 1 July 2024, care at home), meet the requirements for care management set out in the care recipient's care plan and (if applicable) personalised budget	Support	
14.4.	(e) for residential care: i. identify when the older person accessing aged care services requires additional care beyond the usual services provided by the approved provider ii. take reasonable steps to ensure that the older person in aged care accesses appropriate health care at an appropriate time iii. take reasonable steps to ensure that any health care plan is implemented on an ongoing basis and updated as required iv. liaise with general practitioners, other primary health care providers, including allied health care providers, specialists and multidisciplinary outreach services; and take reasonable steps to ensure that staff of the provider are available to support visiting health practitioners v. liaise with the person's family and staff of the aged care provider.	Support	This recommendation should be linked to recommendation 62.2 below.
Recommendation 15	**Social supports category**		
15.1.	From 1 July 2022, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should implement a social supports category within the aged care program that:	Support	The AMA supports this recommendation. For people receiving care at home, having access to external social supports such as currently provided by CHSP programme, should be enabled under the new model. In the AMA view, for this recommendation to achieve its intended outcome, involvement of the care finder/navigator that is independent of aged care providers will be crucial.
15.1.	(a) provides supports that reduce and prevent social isolation and loneliness among older people	Support	
15.1.	(b) can be co-ordinated to the greatest practicable extent in each location with services and activities provided by local government, community organisations and business designed to enhance the wellbeing of older people	Support	
15.1.	(c) includes the social support, delivered meals and transport service types from the Commonwealth Home Support Programme	Support	
15.1.	(d) is grant funded.		
15.2.	The social supports category should continue within the new aged care program from 1 July 2024.	Support	

Recommendation 16	**Assistive technology and home modifications category**		
16.1.	From 1 July 2022, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should implement an assistive technology and home modifications category within the aged care program that:	Support	AMA supports this recommendation. AMA Innovation in Aged Care position statement outlines what the AMA sees as the optimal approach to innovation and technologies that would enable adequate provision of aged care services. Older people must be adequately supported to develop and maintain their technology literacy. Technologies must be accessible and easy to use. This is integral for a successful technology based aged care system.
16.1.	(a) provides goods (including aids and appliances) and services that promote a level of independence in daily living tasks and reduces risks to living safely at home	Support	
16.1.	(b) includes the assistive technology, home modifications and hoarding and squalor service types from the Commonwealth Home Support Programme	Support in principle	The AMA supports in principle this recommendation, but warns that the current CHSP model does not attract enough funding for this purpose and would need to be upscaled significantly to meet the individualised needs of older people.
16.1.	(c) is grant funded.		The AMA does not have a position on the most appropriate type of funding for assistive technologies. In the AMA view, investment is required to ensure that the aged care sector is kept up to date with broader technological developments. Investment in innovation is needed to ensure that mainstream developments are accessible to all those accessing aged care services, not just those who can afford them.
16.2.	The assistive technology and home modifications category should continue within the new aged care program from 1 July 2024.	Support	
Recommendation 17	**Residential care category**		
17.1.	From 1 July 2024, the Australian Government and the Australian Aged Care Commission should implement a category within the new aged care program for residential care that:	Support	
17.1.	(a) provides older people with: i. goods and services to meet daily living needs ii. accommodation iii. care and support to preserve and, where possible, restore capacity for meaningful and dignified living in a safe and caring environment	Support	
17.1.	(b) ensures care is available for people who can no longer live at home due to their frailty, vulnerability or behavioural and psychological symptoms of dementia, or other similar reasons	Support	
17.1.	c. provides integrated and high quality and safe care based on assessed needs, which allows for personalised care, regular engagement, and a coordinated and integrated range of supports across the following domains: i. Care management ii. Social supports, including support for psychological, cultural and (if applicable) spiritual wellbeing iii. Personal, clinical, enabling, therapeutic care and support – including nursing care and allied health care iv. Palliative and end-of-life care.	Support	The AMA supports this recommendation. The AMA Palliative Care in the Aged Care Setting Position Statements calls for palliative care to be provided in all aged care settings, including residential aged care, home care and respite care and, as much as possible, enable people to be cared for and die at the place of their choice.
Recommendation 18	**Residential aged care to include allied health**		
18.1.	To ensure residential aged care includes a level of allied health care appropriate to each person's needs, the Australian Government and the Australian Aged Care Commission should, by no later than 1 July 2024:	Support	The AMA supports this recommendation, and calls on the Royal Commission to ensure that there is coordination between older person's usual GP and allied health when determining level of need for each individual person.
18.1.	(a) require approved providers to engage at least one of each of the following allied health professionals: an oral health practitioner; a mental health practitioner; a podiatrist; a physiotherapist; an occupational therapist; a pharmacist; a speech pathologist; a dietitian; an exercise physiologist; a music or art therapist	Support	The AMA supports this recommendation, and calls on the Royal Commission to ensure that there is coordination between older person's usual GP and allied health when tailoring these services to the needs of the older person.
18.1.	(b) require providers to enter into arrangements with each of the following professional groups to provide services as required to care recipients: optometrists; audiologists	Support	
18.1.	(c) provide funding to approved providers for the engagement of allied health professionals through a blended funding model, including: i. a capped base payment per resident designed to cover about half of the costs of establishing ongoing engagement of allied health professionals ii. an activity-based payment for each item of direct care provided with the Australian Aged Care Pricing Authority determining the quantum of funding for the base payment and the level of activity-based payments, including by taking into account the extra costs of providing services in regional, rural and remote areas		The AMA does not have a position on the funding models for allied health professionals.
18.1.	(d) ensure strict monitoring of the level of allied health services that are actually delivered, including collection and review of data on the number of full-time equivalent allied health professionals delivering services, the number of current allied health assessments, the volume of service provision, and expenditure on allied health services.	Support	
Recommendation 19	**Designing for diversity**		
19.1.	The Australian Government (or, from 1 July 2023, the Australian Aged Care Commission) should:		
19.1.	(a) by 1 July 2022, implement: i. training requirements as a condition of approval or continued approval of providers that all staff engaged by providers who are involved in direct contact with people seeking or receiving services in the aged care system undertake regular training about cultural safety and trauma-informed service delivery ii. similar training requirements for people engaged to provide care finder and assessment services iii. as a condition of approval or continued approval of any aged care providers who publicly represent their ability to provide specialised services for groups of people of diverse experience or background, a requirement to verify to the satisfaction of the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) that the provider has proper grounds for making that representation	Support	

19.1.	(b) by 1 July 2022: i. formulate a standard dataset and data collection mechanism for collecting, monitoring, analysing and using data about the diverse characteristics and life experiences of older people seeking or receiving aged care, including, as considered appropriate, people whose circumstances are not currently included in the 'special needs' provision, such as those living with mental illness, dementia or disability, and ii. commence collection and analysis of those data for the purpose of identifying variations in and improving equity of access and utilisation of aged care by people of diverse backgrounds and experiences	Support	
19.1.	(c) complete, by 1 July 2024, a national audit evaluating regional and local variation in levels of services for people from diverse backgrounds and life experiences, and, in light of the outcomes of the national audit, thereafter undertake commissioning arrangements to address deficits in meeting the needs of people from diverse backgrounds on a regional and local basis as required	Support	
19.1.	(d) report to the Inspector-General and the public on the extent to which the needs of diverse older people are being met by the aged care system by 31 December 2024.	Support	
Recommendation 20	**Planning based on need, not rationed**		
20.1.	By 1 July 2024, the Australian Government should develop and implement a new planning regime, to replace the Aged Care Provision Ratio, which:	Support	
20.1.	(a) supports a funding allocation that is sufficient to meet people's entitlements for their assessed need	Support	
20.1.	(b) provides for demand-driven access to aged care based on assessed need	Support	
20.1.	(c) funds cost-effective enabling care in the interests of people who need such care	Support	
20.1.	(d) collects data to monitor outputs and outcomes	Support	
20.1.	(e) aligns planning boundaries for Aged Care Planning Regions with boundaries based on Primary Health Network regions so that aged care planning is aligned with primary health care and hospital planning.	Support	The AMA fully supports this recommendation and calls on urgent action on this. The experience of COVID-19 and establishment of Victorian Aged Care Response Centre have proven the benefits of having established aged care regions covering relevant LHNs and PHNs. The AMA calls for this structure to be formalised, with formalised governance groups that include LHNs, PHNs, ideally Public Health Units and relevant aged care governance structures.
	Quality and safety		
Recommendation 21	**Embedding high quality aged care**		
21.1.	The *Aged Care Act 1997* (Cth) should be amended to provide that the Australian Commission on Safety and Quality in Health and Aged Care, in setting and amending safety and quality standards for aged care (under the functions referred to in Recommendation 23), give effect to the following characteristics of high quality aged care:	Support	
21.1.	(a) diligent and skilful care	Support	
21.1.	(b) safe and insightful care	Support	
21.1.	(c) caring relationships	Support	
21.1.	(d) empowering care	Support	
21.1.	(e) timely care.	Support	
Recommendation 22	**A general duty to provide high quality and safe care**		
22.1.	The new Act should include a general, positive and non-delegable statutory duty on any approved provider to ensure that the personal care or nursing care they provide is of high quality and safe so far as is reasonable having regard to:	Support	
22.1.	(a) any reasonably foreseeable risks to any person to whom the provider provides, or is engaged to provide, that care	Support	
22.1.	(b) the wishes of any person for whom the provider provides, or is engaged to provide, that care, and	Support	
22.1.	(c) any other relevant circumstances.	Support	
22.2.	Any entity which facilitates the provision of aged care services funded in whole or in part under the new Act should have a duty to ensure that any worker whom it makes available to perform personal care work has the experience, qualifications, skills and training to perform the particular personal care work the person is being asked to perform.	Support in principle	The AMA supports in principle this recommendation. However, in the AMA view, the duty of ensuring experience, qualifications and training, should not fall on the aged care providers alone. This should also be part of the registration scheme for aged care workers. The AMA supports establishing a National Scheme that will entail a registration process requiring PCWs to demonstrate a sufficient level of qualifications to work in aged care.
Recommendation 23	**Aged care standard setting by the re-named Australian Commission on Safety and Quality in Health and Aged Care**		
23.1.	Section 9 of the *National Health Reform Act 2011* (Cth) should be amended urgently to:	Support	
23.1.	(a) rename the Australian Commission on Safety and Quality in Health Care as the 'Australian Commission on Safety and Quality in Health and Aged Care', and	Support	
23.1.	(b) confer upon that body the functions of formulating standards, guidelines and indicators relating to aged care safety and quality.	Support	
23.2.	Amendments to section 10 of the *National Health Reform Act 2011* (Cth) should also be made to provide for an appropriate consultation process for the Commission's aged care functions.	Support	
Recommendation 24	**Urgent review of the Aged Care Quality Standards**		
24.1.	By 15 July 2021, the responsible Minister should refer to the Australian Commission on Safety and Quality in Health and Aged Care the following matters for urgent ad hoc review and, if the Commission considers appropriate, amendment of the Aged Care Quality Standards:	Support	The AMA supports this recommendation. In our submission to the Royal Commission, the AMA warned that while the new Aged Care Quality Standards that came into effect 1 July 2019 consist of important principles of respect, dignity, and engagement with older people, they are high level, subjective and potentially vague. In the AMA view, Standards simply altered the administrative duties of aged care providers but did not improve the actual care the older person receives. The additional administration requirements are perceived by AMA members as 'tick box' exercises that detract from the time aged care staff have to actually care for the older person. In our submission, the AMA recommended more specific Aged Care Quality Standards, including a Medical Access Standard to be developed for RACFs that would help facilitate access to doctor services and high-quality clinical care.

24.1.	(a) requiring best practice oral care, medication management, pressure injury prevention, wound management, continence care, falls prevention, and infection control, and providing sufficient detail on what these requirements involve and how they are achieved	Support	The AMA supports this recommendation, but would also advocate for a Medical Access Aged Care Quality Standard. The AMA believes aged care provider support to facilitate access to doctor services should be standardised. This would in turn ensure there are adequate minimum protocols, equipment, and facilities to incentivise medical practitioners to visit RACFs, and guide aged care providers to ensure older people receive the appropriate medical treatment they need.
24.1.	(b) imposing appropriate requirements to meet resident nutritional needs and ensure meals are desirable to eat, having regard to a person's preferences and religious and cultural considerations	Support	The AMA supports this recommendation. In our submission to the Royal Commission, we recommended the development and implementation of national nutrition standards for aged care facilities, ensuring menus are varied and food is appealing and palatable. The AMA also calls for the requirements to also include hydration.
24.1.	(c) sufficiently reflecting the needs of people living with dementia and providing high quality dementia care	Support	
24.1.	(d) implementing a new governance standard	Support	
24.1.	(e) requiring residential aged care providers to demonstrate their capacity to provide high quality palliative care, including staff capacity (number, skill and type), processes and clinical governance, for recognising deterioration and dying.	Support	The AMA supports this recommendation. The AMA Palliative Care in the Aged Care Setting Position Statements calls for palliative care to be provided in all aged care settings, including residential aged care, home care and respite care. In the AMA view, everyone involved in palliative care in the aged care setting should be adequately trained for the provision of that care, including GPs, nursing staff, allied health professionals and personal care attendants. Adequate funding to provide quality palliative care must be built in to any RACF funding model by defining the skills and staff requirements and recognising that palliative management is a basic RACF service. Appropriate clinical governance in all settings should ensure that older people receive adequate medical care throughout their entire healthcare journey. The AMA has called for Improved government accountability mechanisms for aged care provider governing bodies and their members to be established to ensure appropriate clinical care for older people in their RACFs and their safety.
24.2.	The Australian Commission on Safety and Quality in Health and Aged Care should complete its review by 31 December 2022.	Support	
Recommendation 25	**Priority issues for periodic review of the Aged Care Quality Standards**		
25.1.	By 1 July 2022, the responsible Minister should refer the following matters for the Australian Commission on Safety and Quality in Health and Aged Care to consider as part of the first comprehensive review of the Aged Care Quality Standards:	Support	
25.1.	(a) imposing appropriate requirements relating to the professional development and training for staff	Support	The AMA supports this recommendation. In our submission to the Royal Commission we warned that, while the new Aged Care Quality Standards require providers to employ a workforce that is "skilled and qualified to provide safe, respectful and quality care services" and require staff to be able to "describe the training, support, professional development and supervision for them to be able to carry out their role", the Standards do not specify the type of training that staff are required to undertake. We also called for improved regulation of aged care workers, warning that other professions that have the responsibility to care for people have mandatory minimum qualifications and are regulated.
25.1.	(b) including sufficient reference to and delineation between staff practice roles and responsibilities	Support	The AMA supports this recommendation. In our submission to the Worker Regulation Scheme Consultation, the AMA called for clear lines of responsibility in provision of aged care to be defined. We warned that in any potential worker regulation scheme the responsibility of the aged care providers for the wellbeing of recipients of aged care services must not be relegated. We also called for the worker registration scheme to ensure that any conflation of roles between nursing staff and personal care workers is avoided.
25.1.	(c) requiring providers to assist people receiving care to make and update advance care plans if they wish to, and ensuring that those plans are followed	Support	The AMA supports this recommendation. As outlined in our Medical Care for Older People and Palliative Care in the Aged Care Setting position statements, it is the AMA's position that it should be mandatory for people accessing aged care services to have and Advance Care Directive (ACD) in place. The process of developing an ACD does not have to be in detail if the person does not wish it to be, however keeping a record that this has been considered is beneficial to their care when they are unable to make their own decisions. In our submission to the Royal Commission, the AMA called for advance care planning to form an integral part of person-centred care in aged care. In the AMA view, implementing and respecting ACDs should form an integral part of any clinical governance in aged care. A clinical care plan developed by the doctor in charge of the patient's care normally sets out specific treatment directions at the end of life, such as decisions regarding resuscitation and the provision of palliative care, which should be followed by health professionals in a medical facility or RACF. When the patient has an existing ACD, this should inform the development of the clinical care plan.
25.1.	(d) reflecting the Aged Care Diversity Framework and underlying Action Plans, including considering making them mandatory.	Support	
Recommendation 26	**Aged Care Quality Standards**		
26.1.	The renamed Australian Commission on Safety and Quality in Health and Aged Care should complete a comprehensive review of the Aged Care Quality Standards within three years of taking on the standard-setting function and every 5 years after that. It should also be empowered to undertake ad hoc reviews and make corresponding amendments either of its own motion or where issues are referred to it for consideration by the Australian Aged Care Commission or the responsible Minister.	Support	
Recommendation 27	**Establishment of a dementia support pathway**		
27.1.	By 1 January 2023, the Australian Government should establish a comprehensive, clear and accessible post-diagnosis support pathway for people living with dementia and their carers and families. This should involve:	Support	
27.1.	(a) providing information and advice on dementia and support services, including the aged care system	Support	
27.1.	(b) facilitating access to peer support networks	Support	
27.1.	(c) providing education courses, counselling and support services for both people living with dementia and their family and carers	Support	
27.1.	(d) providing assistance with planning for continued living and access to care, including regular and planned respite for carers.	Support	

27.2.	The Australian Government should provide information and material to general practitioners and geriatricians on the pathway and encourage them to refer people to the pathway at the point of diagnosis.	Support in principle	The AMA supports this recommendation. The AMA also calls on the Commission to recommend and involve the AMA and RACGP in development the information material and their distribution.
Recommendation 28	**Specialist dementia care services**		
28.1.	By 1 July 2023, the Australian Government should review and publicly report on:	Support	The AMA supports the review of the SDCU program. We have in the past warned that the SDCU program does not represent a holistic solution to the many issues surrounding dementia – rather it attempts to deal with one specific issue within the context of the wider problems with Australia's aged care system. In the AMA view, it is important to ensure that Residential Aged Care Facilities (RACFs) do not rely heavily on this program as a substitute for improving dementia management in usual RACF settings. The AMA calls for the review to look into examining and defining a maximum time limit that a patient can reside in a SDCU, as patients' health can either improve, worsen, or stay the same, at different rates. In the AMA view, the length of stay should be determined in coordination with the patient's treating doctor.
28.1.	(a) whether the number of Specialist Dementia Care Units established or planned to be established is sufficient to meet need within the areas and populations they are designed to cover	Support	
28.1.	(b) the capacity of those Units to meet the needs of people exhibiting extreme changed behaviour and whether any further resources are required	Support	
28.1.	(c) the suitability of the Units for shorter stay respite for people living with moderate to extreme changed behaviour.	Support	
28.2.	The outcome of the review should be implemented by the Australian Government as a matter of urgency.		
28.3.	The Australian Government should immediately ensure that the specialist dementia service it funds provides treatment to people with a mental health condition if they meet other eligibility criteria (including, for instance, a diagnosis of dementia).	Support	
Recommendation 29	**Regulation of restraints**		
29.1.	By 1 July 2021, the Australian Government should introduce new requirements regulating the use of chemical and physical restraints in residential aged care to replace Part 4A of the *Quality of Care Principles 2014* (Cth).	Support in principle	The AMA supports in principle this recommendation. However, in the AMA view, for the use of restrictive practices in residential aged care to be properly controlled and managed, there are a number of pre-conditions that will have to be met, pertaining primarily to improving workforce capability, capacity, and connectedness through: • Minimum mandatory staff to resident ratios in residential aged care facilities (RACFs), • Mandatory minimum qualifications for personal care attendants, • Maintaining continuity of care through a regular GP, • Increased access to medication management reviews, • Recognising health and aged care systems as one system, including interoperability between clinical information systems, My Aged Care and the My Health Record. It is the AMA position that chemical and physical restraints in aged care should only be used as a last resort – where any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained. The decision should always be made on a case-by-case basis and needs to find a balance between the need to ensure the older person's safety, and those around them, while respecting their right to dignity and self-determination, including via previously expressed or known values or wishes (if they have lost decision-making capacity) .
29.2.	The new requirements should comprehensively regulate the use of chemical and physical restraints in residential aged care and should be informed by:	Support in principle	
29.2.	(a) the report of the review conducted pursuant to section 15H of the *Quality of Care Principles 2014* (Cth)	Support in principle	
29.2.	(b) the report of the Parliamentary Joint Committee on Human Rights on the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 (Cth), and	Support in principle	
29.2.	(c) the operation of the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth).	Support in principle	
29.3.	A person receiving aged care who is the subject of a restraint should be readily able to seek an independent review of the lawfulness of the conduct.	Support	
29.4.	Any breach by an approved provider of the new requirements should expose the provider to a civil penalty.	Support	
29.5.	The Australian Commission on Safety and Quality in Health and Aged Care should review the operation of the new requirements as part of its first comprehensive review of the Aged Care Quality Standards.	Support	
Recommendation 30	**Quality indicators**		
30.1.	By 15 July 2021, the responsible Minister should refer to the Australian Commission on Safety and Quality in Health and Aged Care responsibility for the introduction, implementation and amendment of aged care quality indicators, including:	Support in principle	AMA is in principle supportive of strong quality indicators to improve aged care provision. However, any new process needs to take into consideration the current ongoing process of development of three new quality indicators headed by the Department of Health, in a consultative process managed by PwC. AMA is engaged in this process.
30.1.	(a) ongoing research into the use and evidence basis for quality indicators	Support	
30.1.	(b) publication of guidance on use of indicator data to identify risks and to undertake evidence-based risk management.	Support	
30.2.	By 1 July 2023, the Australian Commission on Safety and Quality in Health and Aged Care should:		
30.2.	(a) expand the suite of quality indicators for care in residential aged care	Support	
30.2.	(b) develop quality indicators for care at home, and	Support	
30.2.	(c) implement a comprehensive quality of life assessment tool for people receiving aged care in residential care and at home.	Support	
30.3.	In the interim, in addition to the existing commitment to implement quality indicators in the new domains of falls and fractures and medication management, the Australian Government should expand the National Mandatory Indicator Program, as set out in the 2019 PwC Consultation Paper 'Development of Residential Aged Care Quality Indicators', to use more comprehensive indicators for the existing domains of pressure injuries, physical restraint and unplanned weight loss.	Support	
Recommendation 31	**Using quality indicators for continuous improvement**		

31.1.	By 1 July 2022, the Australian Government should implement reporting and benchmarking of provider performance against quality indicators. To achieve this:	Support	
31.1.	(a) the Australian Commission for Safety and Quality in Health and Aged Care should develop a methodology to enable providers to be benchmarked against similar providers	Support	
31.1.	(b) the Australian Government should track sector and provider performance and set progressive improvement targets to raise performance against quality indicators over time	Support	The AMA is supportive of this recommendation. In our submission to the Royal Commission, we warned that at the moment there is no visibility of quality performance on an individual provider level, nor how the data collected is used by individual providers to improve or maintain their levels of performance.
31.1.	(c) the Australian Government should publicly report on sector and provider performance against benchmarks.	Support	The AMA supports this recommendation. Having public information about individual provider performance against benchmarks would help recipients of aged care services make informed decisions about their choice of services. However, the AMA warns of the need for safeguards to put in place. Specifically, we warn that publishing Quality Indicator data on the individual provider level may drive perverse outcomes for older people. Providers may reject older people with dementia or advanced disease who are at higher risk of skin breakdown or weight loss out of fear that published data may reflect badly on them.
31.2.	From 1 July 2023 onwards, the Australian Aged Care Commission should assume responsibility for the functions and powers in subparagraphs 31.1. (b) and (c).	Support	
Recommendation 32	**Aboriginal and Torres Strait Islander People** **Aboriginal and Torres Strait Islander service arrangements within the new aged care system**		
32.1.	The Australian Government should ensure that the new aged care system makes specific and adequate provision for the changing and diverse needs of Aboriginal and Torres Strait Islander people and that:	Support	
32.1.	(a) Aboriginal and Torres Strait Islander people receive culturally respectful and safe, high quality, trauma-informed, needs-based and flexible aged care services regardless of where they live	Support	
32.1.	(b) priority is given to existing and new Aboriginal and Torres Strait Islander organisations, including health, disability and social service providers, to cooperate and become providers of integrated aged care services	Support	
32.1.	(c) regional service delivery models that promote integrated care are deployed wherever possible	Support	
32.1.	(d) there is a focus on providing services within, or close to, Aboriginal and Torres Strait Islander populations while maximising opportunities for people to remain on, and maintain connection with, their Country and communities	Support	
32.1.	(e) aged care is available and providers are engaged at the local aged care planning region level on the basis of objectively established need that is determined in consultation with Aboriginal and Torres Strait Islander populations and communities, and recognising that aged care needs and service delivery preferences may vary between locations and population centres	Support	
32.1.	(f) older Aboriginal and Torres Strait Islander people are given access to interpreters on at least the same basis as members of culturally and linguistically diverse communities when seeking or obtaining aged care including health care services.	Support	
Recommendation 33	**An Aged Care Commissioner within the Australian Aged Care Commission with oversight of Aboriginal and Torres Strait Islander aged care**		
33.1.	By 1 July 2023, there should be within the Australian Aged Care Commission a statutory role that involves the ongoing fostering, promotion and development of culturally safe, tailored and flexible aged care services for Aboriginal and Torres Strait Islander people across the country. The person appointed to this role shall be an Aboriginal or Torres Strait Islander person.	Support	
33.2.	In advance of the formal establishment of the Commission, a person should be appointed by 31 December 2021 under interim administrative arrangements to perform relevant functions and exercise relevant powers.	Support	
Recommendation 34	**Cultural safety**		
34.1.	By 1 July 2022, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should:	Support	
34.1.	(a) require all of its employees who are involved in the aged care system, and any care finders who are not its employees, to undertake regular training about cultural safety and trauma-informed service delivery	Support	
34.1.	(b) require all aged care providers which promote their services to Aboriginal and Torres Strait Islander people to: i. train their staff in culturally safe and trauma-informed care, and ii. demonstrate to the Australian Aged Care Commission that they have reached an advanced stage of implementation of the Aboriginal and Torres Strait Islander Action Plan under the Diversity Framework	Support	
34.2.	From 1 July 2023, the Australian Aged Care Commission should:	Support	
34.2.	(a) ensure care finders serving Aboriginal and Torres Strait Islander communities are local Aboriginal and Torres Strait Islander people who are culturally trained and familiar with existing Aboriginal and Torres Strait Islander service providers who are trusted by the local population	Support	
34.2.	(b) wherever possible, ensure aged care assessments of Aboriginal and Torres Strait Islander people are conducted by assessors who are, wherever possible, Aboriginal or Torres Strait Islander people, or others who have undertaken training in cultural safety and trauma-informed approaches	Support	
34.2.	(c) work with State and Territory Governments to establish culturally appropriate advance care directive processes, guidance material and training for aged care providers that account for the diversity of cultural practices and traditions within each State and Territory.	Support	
Recommendation 35	**Prioritising Aboriginal and Torres Strait Islander organisations as aged care providers**		

35.1.	The Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should assist Aboriginal and Torres Strait Islander organisations to expand into aged care service delivery, whether on their own or in partnership with other organisations, including Aboriginal Community Controlled Organisations and existing Aboriginal and Torres Strait Islander providers.	Support	
35.2.	In fostering additional providers, the Australian Government and the Commission should provide a degree of flexibility in the approval and regulation of Aboriginal and Torres Strait Islander aged care providers to ensure:	Support	
35.2.	(a) existing Aboriginal and Torres Strait providers are not disadvantaged and should continue to provide high quality and safe aged care while being assisted to meet the new provider requirements	Support	
35.2.	(b) other organisations that wish to move into aged care to enhance services to Aboriginal and Torres Strait Islander people across Australia are given special consideration.	Support	
35.3.	Flexible mechanisms should include additional time to meet new requirements, alternative means of demonstrating the necessary capability or requirement, and, in some very limited cases, exemptions. Assistance should include financial assistance for capacity building.	Support	
Recommendation 36	**Employment and training for Aboriginal and Torres Strait Islander aged care**		
36.1.	By 1 December 2022, the Australian Government should:	Support	
36.1.	(a) develop a comprehensive national Aboriginal and Torres Strait Islander Aged Care Workforce Plan in consultation with the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care, including: i. the refinement of existing Aboriginal and Torres Strait Islander training and employment programs ii. targets for the training and employment of Aboriginal and Torres Strait Islander people across the full range of aged care roles	Support	The AMA is supportive of this recommendation. The AMA would like to see the future workforce plan enable the self-empowerment of prospective ATSI workers, enabling them to influence the modelling of work training as well as care provided, as recommended by the Future of Australia's Aged Care Sector Workforce Report (2017).
36.1.	(b) provide the funds necessary to implement the Plan and meet the training and employment targets	Support	
36.1.	(c) work with the State and Territory Governments to implement the Plan, including making vocational educational training facilities, teachers and courses available in urban, rural, regional and remote Australia.	Support	
36.2.	In the interim, the Australian Government should ensure, in consultation with the National Advisory Group for Aboriginal and Torres Strait Islander Aged Care, that the existing employment programs and initiatives for Aboriginal and Torres Strait Islanders are aligned to the needs of the aged care sector.	Support	
Recommendation 37	**Funding cycle**		
37.1.	The Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should block fund providers under the Aboriginal and Torres Strait Islander Aged Care Service Arrangements (see Recommendation 32) on a three to seven year rolling assessment basis.	Support	
37.2.	The Australian Aged Care Pricing Authority should:	Support in principle	The AMA supports in principle this recommendation, with the caveat that the AMA supports a unified Hospital and Aged Care Pricing Authority.
37.2.	(a) set the funding of the Aboriginal and Torres Strait Islander aged care service arrangements following advice from the Aged Care Custodian	Support	
37.2.	(b) annually assess and adjust the block funding on the basis of the actual costs incurred while providing culturally safe and high quality aged care services to Aboriginal and Torres Strait Islander people in the preceding year.	Support	
Recommendation 38	**Program streams**		
38.1.	Under the Aboriginal and Torres Strait Islander Aged Care Service Arrangements, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should:	Support	
38.1.	(a) provide flexible grant funding streams that are able to be pooled for: i. home and community care ii. residential and respite care (including transition)	Support	
38.1.	(b) establish funding streams under the Aboriginal and Torres Strait Islander aged care service arrangements that allow Aboriginal and Torres Strait Islander aged care service arrangement providers to apply for funding for: i. capital development and expenditure ii. provider development	Support	
38.1.	(c) make funds available, on application, for any residential aged care provider that has Aboriginal and Torres Strait Islander residents who require assistance to retain connection to their Country, including meeting the costs of: i. travel to and from Country, as well as the costs of any people needed to provide clinical or other assistance to the resident to make the trip ii. a family member travelling to and from the older person at a distant residential facility iii. establishing, maintaining and using infrastructure that facilitates connection between the residential facility and communities on Country, such as videoconferencing technology.	Support	
	Aged care workforce		
Recommendation 39	**Aged care workforce planning**		
39.1.	The Australian Government should establish an Aged Care Workforce Planning Division within the Australian Department of Health by 1 January 2022. When the Australian Aged Care Commission is established, the Division should be transferred to the Commission, answering to an Assistant Commissioner. It should be responsible for developing workforce strategies for the aged care sector through:	Support	
39.1.	(a) long-term workforce modelling on the supply and demand of health professionals, including allied health professionals, and care workers	Support	

39.1.	(b) consultation with the providers of education and training for health professionals and personal care workers, in partnership with the State and Territory Governments, Universities, Registered Training Organisations, National Boards, professional associations, and specialist colleges	Support	
39.1.	(c) ensuring an appropriate distribution of health professionals (including allied health professionals) and care workers to meet the needs of population across the aged care sector, particularly in regional, rural and remote Australia	Support	
39.1.	(d) aged care workforce planning, including through modelling, and shaping the role of immigration and changes to visa arrangements as a workforce strategy to address aged care workforce needs.	Support in principle	The AMA supports in principle this recommendation. The AMA warns however that any changes to visa arrangements need to take into consideration the current situation regarding migrant workers in aged care and the continuous shift towards utilisation of workers on temporary visas to fill the workforce demand (see for example this research paper https://www.arts.unsw.edu.au/sites/default/files/documents/Migrant%20Workers%20in%20Frontline%20Care.pdf). In the AMA view this situation is untenable if the aim is to completely reform the system as there will be more requirements on aged care staff under the new registration scheme.
39.2.	By 1 July 2022, the Aged Care Workforce Planning Division should prepare an interim workforce strategy and planning framework for the next 3 years (2022–25).	Support	
39.3.	By 1 July 2025, the Aged Care Workforce Planning Division within the Australian Aged Care Commission should prepare a 10 year workforce strategy and plan, following the interim 3 year Workforce Strategy (2025–35).	Support	
39.4.	The Aged Care Workforce Planning Division should be supported by an Aged Care Workforce Fund that can be used to support training, clinical placements, scholarships and other initiatives to respond in a targeted manner to the workforce challenges that the Division identifies.	Support	
Recommendation 40	**Aged Care Workforce Council**		
40.1.	By 1 July 2021, the Australian Government should strengthen the capacity of the Aged Care Workforce Council by:	Support in principle	The AMA does not have a specific policy on the terms of reference for the Aged Care Workforce Council, however is generally supportive of work towards improving the aged care workforce structure and function.
40.1.	(a) having an Australian Government representative become a member and assume the role of chair	Support in principle	
40.1.	(b) reviewing membership of the Council to ensure it is comprised of individuals, including worker representatives who represent the diversity of the aged care workforce with an appropriate mix of skills and experience to lead and drive change across the sector	Support in principle	
40.1.	(c) providing the necessary funding and resources to enable the Council to implement workforce recommendations of this Royal Commission and to build on its work implementing the Aged Care Workforce Strategy Taskforce's strategic actions.	Support in principle	
40.2.	By 30 June 2022, the Aged Care Workforce Council should:	Support in principle	
40.2.	(a) re-profile all aged care occupational groups, jobs and job grades to ensure they reflect the skills, capabilities, knowledge and competencies as well as the structure required in the new aged care system	Support in principle	
40.2.	(b) revise the competency and accreditation requirements for all job grades in the aged care sector to ensure education and training builds the required skills and knowledge	Support in principle	
40.2.	(c) standardise job titles, job designs, job grades and job definitions for the aged care sector, and	Support in principle	
40.2.	(d) lead the Australian Government and the aged care sector to a consensus to support applications to the Fair Work Commission to improve wages based on work value and or equal remuneration. This may include re-defining job classifications and job grades in relevant awards.	Support in principle	
40.3.	The Aged Care Workforce Council should work collaboratively with the proposed Aged Care Workforce Planning Division so that its work complements aged care workforce design and planning.	Support in principle	
40.4.	From 1 July 2022, the Aged Care Workforce Council, in conjunction with the National Careers Institute, peak industrial partners, Universities Australia and VET providers, and informed by its work on redefining the Aged Care Workforce structure, should develop and document a clear set of career pathways for the aged care sector. These career pathways should:	Support in principle	
40.4.	(a) highlight opportunities for nurses to advance in clinical and managerial roles in the aged care sector	Support in principle	
40.4.	(b) facilitate personal care workers having opportunities to move laterally across aged care, disability care, community care and primary health care and vertically in aged care by advancing into nursing, specialist care roles and supervisory or managerial roles	Support in principle	
40.4.	(c) develop and document career opportunities in the aged care sector for non-direct care workers, including kitchen hands, cooks, cleaners, gardeners, drivers, security and people performing administrative roles.	Support in principle	
40.5.	By 1 July 2022, the Human Services Skills Organisation should develop detailed multimedia careers information for prospective aged care workers including information about work experience opportunities and pre-employment programs with approved aged care providers and nominated Registered Training Organisations.	Support in principle	
Recommendation 41	**Increases in award wages**		
41.1.	Employee organisations entitled to represent the industrial interests of aged care employees covered by the *Aged Care Award 2010* , the *Social, Community, Home Care and Disability Services Industry Award 2010* and the *Nurses Award 2010* should collaborate with the Australian Government and employers and apply to vary wage rates in those awards to:		The AMA does not have a position on specific award wages for aged care workers.
41.1.	(a) reflect the work value of aged care employees in accordance with section 158 of the *Fair Work Act 2009* (Cth), and/or		
41.1.	(b) seek to ensure equal remuneration for men and women workers for work of equal or comparable value in accordance with section 302 of the *Fair Work Act 2009* (Cth).	Support	
Recommendation 42	**Improved remuneration for aged care workers**		

42.1.	In setting prices for aged care, the Aged Care Pricing Authority should take into account the need to attract sufficient staff with the appropriate skills to the sector, noting that relative remuneration levels are an important driver of employment choice.	Support	The AMA is supportive improved remuneration for aged care workers in general.
Recommendation 43	**Review of certificate-based courses for aged care**		
43.1.	By 1 January 2022, the Human Services Skills Organisation should	Support	The AMA supports this recommendation. In the AMA view, qualification requirements for personal care workers, that should form an integral part of courses that qualify them for provision of care in aged care should include the basic health care skills, such as basic care skills (nutrition and hydration), oral health, mental health, dementia, palliative care and end-of-life care, and medication management, as well as: • Strategies to prevent deterioration in health, such as exercise programs, adequate nutrition and hydration • Strategies to reduce distress in dementia patients • Intervention and management of elder abuse • Engaging with Culturally and Linguistically Diverse (CALD) and Aboriginal and Torres Strait Islander (ATSI) older people • Palliative care skills • Mental health skills • Strategies to address other common health issues that older people face • Basic life support.
43.1.	(a) review the need for specialist aged care Certificate III and IV courses, and	Support	
43.1.	(b) commence an annual cycle of review of the content of the Certificate III and IV courses and consider if any additional units of competency should be included.	Support	
Recommendation 44	**Dementia and palliative care training for workers**		
44.1.	The Australian Government should implement, by 1 July 2022, as a condition of approval or continued approval of aged care providers that all staff engaged by providers who are involved in direct contact with people seeking or receiving services in the aged care system undertake regular approved training about dementia care and palliative care.	Support	The AMA supports this recommendation. The AMA has been calling for providers to ensure that their staff are adequately trained to perform their duties. We have also previously warned that the new Aged Care Quality Standards fail to ensure that this is the case. Being able to provide dementia and palliative care should be the core duty of aged care providers, and as such they should ensure their staff have adequate skills and knowledge, including strategies to reduce distress in dementia patients and palliative care skills, including but not limited to the following: Recognising signs of deterioration in older people and increasing palliative care needs that require further specialist assessment, including by Specialist Palliative Care services; How to talk to the patient and their family members about the diagnosis and the need for palliative care; Managing conflicts and stressful situations with people who are receiving palliative care, their family members and carers; Bereavement care; Resilience mechanisms for coping with death and dying of patients; Providing social and spiritual support for dying older people; Cultural, religious and spiritual aspects of palliative care.
Recommendation 45	**Review of health professions' undergraduate curricula**		
45.1.	By 1 January 2023, the relevant national boards, professional associations, and accreditation bodies for nursing, medicine, audiology, optometry, dietetics, dental practice, psychology, social work, occupational therapy, osteopathy, podiatry, physiotherapy and speech therapy should review existing course accreditation standards to ensure professional entry qualifications for these professions are appropriately addressing age-related conditions and illnesses, including dementia, to ensure that graduates have the education and knowledge to meet the care needs of older people.	Support	The AMA supports this recommendation. In our first submission to the Royal Commission we said that education and training for doctors in caring for older people should be increased and that this must start at medical school.
Recommendation 46	**Funding for teaching aged care programs**		
46.1.	By 1 July 2023, the Australian Government should fund teaching aged care programs for delivery to students in both residential aged care and home care settings. The teaching aged care programs should have designated catchment areas and should:	Support	
46.1.	(a) operate on a 'hub and spokes' model	Support	
46.1.	(b) collaborate with educational institutions and research entities	Support	
46.1.	(c) facilitate clinical placements for university and vocational education and training sector students	Support	The AMA supports this recommendation. The AMA sees aged care homes as fertile ground for teaching of doctors, that offers an experience that is different to that in large teaching hospitals. The AMA said that provision of accredited medical training places in residential aged care would add to the overall breadth and depth of medical training and improve the quality of care for older people.
46.1.	(d) train future aged care workers in local aged care services.	Support	The AMA supports this recommendation and would point the Commissioners to an example of good practice by the University of Canberra's Health Precinct and their learning model, that enables work-integrated learning opportunities for students, including paid employment in aged care: https://www.canberra.edu.au/on-campus/campus-development/precincts-and-projects/health-precinct/moran-aged-care-early-learning-centre-and-health-cluster.
Recommendation 47	**Minimum staff time standard for residential care**		

47.1.	The Australian Government should require approved providers of residential aged care facilities to meet a minimum staff time quality and safety standard. This requirement should take the form of a quality and safety standard for residential aged care. The minimum staff time standard should allow approved providers to select the appropriate skills mix for delivering high quality care in accordance with their model of care.	Do not support	The AMA supports staffing ratios in aged care, which has been our ongoing position. We have called for minimum staffing ratios to be introduced in all our submissions to the Royal Commission thus far. However, the AMA cannot support this recommendation. In the AMA view, setting the minimum staff to resident ratios should be about meeting the needs of the residents and providing residents with the high quality of care, rather than providers selecting the skills mix to match their model of care. In the AMA view, the definition " appropriate skills mix for delivering high quality care in accordance with their model of care" is too broad and will not result in appropriate standards for achieving high quality care. The outcome may be the same as what we have with the current Aged Care Quality Standards which are too high level and to vague and have resulted in poor health outcomes for aged care recipients. As per our further comments under this section, the AMA calls on the Royal Commission to increase staff time per resident per day, taking into consideration the models that have been investigated by the Royal Commission in the Commission's Research Paper 1: How Australian residential aged care staffing levels compare with international and national benchmarks (https://agedcare.royalcommission.gov.au/sites/default/files/2019-12/research-paper-1.pdf). The AMA calls on the Commission to propose the solution that will bring the sector closer to 5 star rating.
47.2.	From 1 July 2022, the minimum staff time standard should require approved providers to engage registered nurses, enrolled nurses, and personal care workers for at least 215 minutes per resident per day for the average resident, with at least 36 minutes of that staff time provided by a registered nurse.	Do not support	While the AMA supports staffing ratios and minimum staff time per resident, the AMA cannot support this recommendation. In the AMA view 36 minutes of care by a registered nurse per resident per day is not sufficient to meet the increasingly complex needs of residents in residential aged care. Registered Nurses (RNs) are the only aged care provider employees that can provide frontline, timely clinical care within their scope of practice. Doctors rely on RNs to carry out their clinical directions when they leave the RACF or the patient's home. Doctors need to communicate with RNs because RNs have clinical backgrounds and can assist to determine the best clinical care for older people. Older people who require aged care need RNs to safely administer medicines and help prevent medical issues such as bed sores and fractures. 36 minutes per day is not enough time to dedicate to each resident if the aim is to ensure residents' improved health outcomes and in particular if the overall aim is the reablement of residents. Furthermore, the AMA does not see the justification for this recommendation to be delayed to second half of 2022.
47.3.	In addition, from 1 July 2022, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility for the morning and afternoon shifts (16 hours per day).	Do not support	The AMA cannot support this recommendation. It is the AMA ongoing position that registered nurses must be available on site in residential aged care 24 hours a day to ensure older peoples' medical needs are adequately met, including the appropriate administration of medicines. Mandated RN availability 24 hours in RACFs should start as soon as possible, and the AMA does not see the need for this recommendation to be delayed until 1 July 2022. The AMA's comments at 47.5 also apply to comments for recommendation 47.3.
47.4.	From 1 July 2024, the minimum staff time standard should increase to require approved providers to engage registered nurses, enrolled nurses, and personal care workers for the average resident for at least:	Do not support	As per our comment above under 47.3, the AMA does not see the reason for a delay until 2024 for increased staffing hours and registered nurse availability 24/7. The AMA calls on the Royal Commission to recommend implementation of RN availability 24/7 as soon as possible, preferably in 2021.
47.4.	(a) 215 minutes per resident per day for the average resident, with at least 44 minutes of that staff time provided by a registered nurse, or	Do not support	The AMA cannot support this recommendation. In the AMA view the proposed combination of time will not sufficiently address the increasing needs of aged care residents who are entering aged care older and more frail. With the reform of the aged care sector proposed by the Royal Commission, we can expect that older people will stay at their homes for as long as possible, meaning that they will be entering residential aged care in the latest stages of their lives when their needs can no longer be met by home and community care. Therefore ensuring sufficient numbers and continuous presence of medically trained staff will be crucial.
47.4.	(b) 264 minutes per resident per day for the average resident, with at least 36 minutes of that staff time provided by a registered nurse.	Do not support	As per our comments under 47.2 and 47.4, the AMA cannot support this recommendation.
47.5.	In addition, from 1 July 2024, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility at all times.	Do not support	AMA supports registered nurse availability 24/7. However, in some RACFs one registered nurse will not be sufficient to care for all residents. The number of RNs at the RACF at all times should be determined by the number of residents and their care needs. The AMA would also warn against potential unwanted consequences of this recommendation. Specifically, there need to be safeguards in place to ensure that those providers who currently employ nurses in night shifts do not see this as a permission to discontinue their employment until July 2024 when this becomes a mandatory requirement. Therefore the AMA calls on the Royal Commission to recommend the 24/7 availability of RNs as soon as possible, as per our comment under 47.4.
47.6.	The minimum staff time standard should be linked to the case mix adjusted activity based funding model for residential aged care facilities. This means that approved providers with a higher than average proportion of high needs residents would be required to engage additional staff, and vice versa.	Support in principle	The AMA supports in principle this recommendation, as it allows for staffing numbers to be adjusted to the needs of the residents. The AMA is however concerned around how this recommendation interacts with above recommendations 47.2 and 47.4, that talk about 'average' residents and recommend staffing hours based on the 'average' resident. Further clarification will be required by the Royal Commission as to what constitutes an 'average resident' and a 'high needs resident'.
47.7.	Approved providers should be able to apply to the Australian Aged Care Commission for an exemption from the quality and safety standard relating to staff skills mix, but not the standard relating to numbers of staff. Any exemption should be granted for a limited time, and details of the exemption should be published on My Aged Care. The grounds for granting an exemption should include:	Do not support	The AMA does not support this recommendation in principle as it will potentially open the possibility for aged care providers to employ lower numbers of nursing staff, in particular registered nurses. The AMA does however see where this recommendation can be justifiable, as outlined below.
47.7.	(a) specific purpose residential aged care facilities, such as specialist homeless facilities, where the profile of the residents is such that it may be appropriate to substitute a registered nurse with another qualified health professional	Do not support	The AMA does not see situations where there will be no need for a registered nurse in a specialist homeless facility, even with the employment of other health professionals.
47.7.	(b) residential aged care facilities that are co-located with a health service, such as Multi-Purpose Services, where registered and enrolled nurses are present at the co-located health service	Support in principle	

47.7.	(c) regional, rural and remote residential aged care facilities, where the approved provider can demonstrate it has been unable to recruit sufficient numbers of staff with the requisite skills, and	Do not support	The AMA calls for adequate programmes to be put in place by the Government that would attract more medically qualified staff to regional and rural areas of Australia. In our first submission to the Royal Commission, the AMA called on the Royal Commission to ensure that the Government commits to significant funding increases to bridge the gap between city and country. It should focus on measures that will make a long-term difference, and commit to policies that: • rebuild health infrastructure – particularly public hospitals; • support the recruitment and retention of the medical and aged care workforce; • provide more opportunities to train medical students and doctors in rural areas; • provide incentives for aged care staff, particularly nursing staff, to live and work in rural and remote areas; • support rural medical and aged care practices to ensure they are able to meet the complex health needs of people in rural and remote communities.
47.7.	(d) innovative residential aged care facilities where an alternative skills mix is being trialled and it would be appropriate to substitute a registered nurse with another qualified health professional. There should be a requirement for any such trial to be comprehensively evaluated and publicly reported.	Support in principle	The AMA supports in principle this recommendation, but we call on the Royal Commission to define what constitutes a 'trial', who approves the trial, how long the trial period would be, how many trials one aged care facility can undertake, who will perform the evaluation and that the evaluation must include indicators for health outcomes of the residents.
47.8.	The Australian Commission on Safety and Quality in Health and Aged Care should review and update this standard as appropriate. At a minimum, this should occur in line with significant revisions of the case mix classification for residential aged care facilities, or at least every five years.	Support	
Recommendation 48	**National personal care worker registration scheme**		
48.1.	By 1 July 2022, the Australian Health Practitioner Regulation Agency should establish a National Board and a registration scheme for personal care workers, with the following key features:	Do not support	The AMA supports a National Worker Registration Scheme, however does not support personal care workers being registered with AHPRA for reasons that range from aged care practice and policy to practicalities of AHPRA systems and processes. Firstly, currently all professions that are on the AHPRA register list require tertiary education and qualifications, which Certificate III recommended as the mandatory minimum qualification is not. Secondly, registration with AHPRA requires mandatory indemnity insurance which can be costly for personal care workers. Thirdly, indemnity insurance covers duty of care, and it is the AMA view that personal care workers should do work under supervision and should not make isolated decisions about personal care of older people. Other AMA objections to this recommendation can be seen in our submission to the aged care worker regulation scheme consultation: https://ama.com.au/articles/ama-submission-aged-care-worker-regulation-scheme-consultation.
48.1.	(a) a mandatory minimum qualification	Support	
48.1.	(b) ongoing training and continuing professional development requirements	Support	
48.1.	(c) minimum levels of English language proficiency	Support	
48.1.	(d) criminal history screening requirements	Support	
48.1.	(e) a code of conduct and power for the registering body to investigate complaints into breaches of the Code of Conduct.	Support	
48.2.	For existing aged care workers who do not meet the mandatory minimum qualification requirements, there should be transitional arrangements that allow them to apply to the National Board for registration based on their experience and prior learning.	Support	
Recommendation 49	**Mandatory minimum qualification for personal care workers**		
49.1.	A Certificate III should be the mandatory minimum qualification required for personal care workers performing paid work in aged care. The proposed Personal Care Worker National Board should establish an accreditation authority to:	Support	The AMA supports this recommendation. The AMA has been calling for the introduction of minimum mandatory qualifications for personal care workers, noting that other professions that have the responsibility to care for people have mandatory minimum qualifications requirements and are regulated. The AMA has provided a comprehensive submission to the Aged Care Worker Regulation Scheme where full details of AMA position on worker registration and qualification can be seen: https://ama.com.au/articles/ama-submission-aged-care-worker-regulation-scheme-consultation.
49.1.	(a) develop and review accreditation standards for the mandatory minimum qualification	Support	
49.1.	(b) assess programs of study and education providers against the standards, and	Support	
49.1.	(c) provide advice to the National Board on accreditation functions.	Support in principle	This (and 49.2) should occur however the AMA does not support it occurring under AHPRA.
49.2.	The National Board should approve the accredited program of study, and review the need for personal care workers in home care to have specialised skills or competencies.	Support in principle	
	Informal carers		
Recommendation 50	**Informal carers and assisting them to receive support**		
50.1.	The Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should improve services and support for informal carers by:	Support	
50.1.	(a) linking My Aged Care and the Carer Gateway by 1 July 2022, to enable the sharing of information to enable respite available through My Aged Care and support services available on the Carer Gateway to be identified jointly and to be provided in a co-ordinated manner	Support	
50.1.	(b) on and from 1 July 2022: i. enabling direct referral and information sharing for informal carers between My Aged Care, care finders, assessment services and the Carer Gateway ii. providing accurate and up-to-date information on My Aged Care about the range of supports locally available to informal carers, including training, education, counselling, income support, and access to the Carers Hub network (once established)	Support	

50.1.	(c) on and from 1 July 2023: i. requiring My Aged Care, care finders and assessment services to identify informal carers when assessing a person for aged care ii. enabling care finders to refer informal carers to assessment services for assessment for and access to formal respite care iii. supporting and funding a community-based Carers Hub network.	Support	
Recommendation 51	**Volunteers and Aged Care Volunteer Visitors Scheme**		
51.1.	From 1 July 2021, the Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should promote volunteers and volunteering in aged care to support older people to live a meaningful and dignified life and supplement the support and care provided to them through the aged care system, whether in their own home or in a residential care home, by:	Support	
51.1.	(a) increasing the funding to the Volunteer Grants under the Families and Communities Program – Volunteer Grants Activity in 2021–22 to support organisations and community groups to recruit, train and support volunteers who provide assistance to older people	Support	
51.1.	(b) requiring, as a condition of approval and continuing approval of all approved providers, that all aged care services, which use volunteers to deliver in-house co-ordinated and supervised volunteer programs, must: i. assign the role of volunteer coordination to a designated staff member ii. provide induction training to volunteers and regular ongoing training, to volunteers in caring for and supporting older people, complaints management and the reporting of abuse and neglect iii. retain evidence of provision of such training	Support	
51.1.	(c) providing additional funding, and expanding the Community Visitor Scheme and changing its name to the Aged Care Volunteer Visitors Scheme, to provide extended support for older people receiving aged care who are at risk of social isolation.	Support	
Recommendation 52	**Provider governance** **Legislative amendments to improve provider governance**		
52.1.	By 1 January 2022, the *Aged Care Act 1997* (Cth) should be amended to require that:		
52.1.	(a) the governing body of an approved provider providing personal care services must have a majority of independent non-executive members (unless the provider has applied to the Aged Care Quality and Safety Commissioner for an exemption and the exemption has been granted)	Support in principle	The AMA supports in principle this recommendation. While the AMA does not have a position on how the care governance arrangements should be established, the AMA has in the past called for governance bodies' members to include those with relevant clinical care experience, including doctors and nurses. It is the AMA view that GPs for example can provide advice on how to improve overall health outcomes of residents, they can advise on policy procedures, clinical governance and an appropriately resourced care environment.
52.1.	(b) the constitution of an approved provider must not authorise a member of the governing body to act other than in the best interests of the provider		
52.1.	(c) an applicant for approval to provide aged care services must notify the Aged Care Quality and Safety Commissioner of its key personnel, and an approved provider must notify the Commissioner of any change to key personnel within ten business days of the change		
52.1.	(d) a 'fit and proper person' test (replacing the 'disqualified individual' test) applies to key personnel		
52.1.	(e) an approved provider must provide an annual report to the Secretary of the Australian Department of Health containing information to be made publicly available through My Aged Care.		
52.2.	By 1 January 2022, the *Freedom of Information Act 1982* (Cth) should be amended to remove from Schedule 3 of that Act references to provisions in the *Aged Care Act 1997* (Cth) and the *Aged Care Quality and Safety Commission Act 2018* (Cth), thereby ensuring that the exemption in section 38 of the Freedom of Information Act does not apply to 'protected information' under aged care legislation merely on the grounds that it is information that relates to the affairs of:		
52.2.	(a) an approved provider		
52.2.	(b) an applicant for a grant under Chapter 5 of the Aged Care Act		
52.2.	(c) a service provider of a Commonwealth-funded aged care service, or		
52.2.	(d) an applicant for approval under section 63B of the Aged Care Quality and Safety Commission Act.		
52.3.	The new Act should contain provisions reflecting both the amendments to the Aged Care Act and the system governance arrangements provided for in that new Act. Under the new Act, the system governor and quality regulator will be the Australian Aged Care Commission. The government functions in subparagraphs 52.1. (a), (c) and (e) above will be undertaken by the Australian Aged Care Commission.		
Recommendation 53	**New governance standard**		
53.1.	Any governance standard for aged care providers developed by the Australian Commission on Safety and Quality in Health and Aged Care should require every approved provider to:	Support	
53.1.	(a) have members of the governing body who possess between them the mix of skills, experience and knowledge of governance responsibilities, including care governance, required to provide governance over the structures, systems and processes for ensuring the safety and high quality of the care delivered by the provider	Support	See our comment under 52.1 (a).
53.1.	(b) have a care governance committee, chaired by a non-executive member with appropriate experience in care provision, to monitor and ensure accountability for the quality of care provided, including clinical care, personal care and services, and supports for daily living	Support	

53.1.	(c) allocate resources and implement mechanisms to support regular feedback from and engagement with people receiving aged care, their representatives, and staff to obtain their views on the quality and safety of the services that are delivered and the way in which they are delivered or could be improved	Support	
53.1.	(d) have a system for receiving and dealing with complaints, including regular reports to the governing body about complaints and containing, among other things, an analysis of the patterns of and underlying reasons for complaints	Support	
53.1.	(e) have effective risk management practices covering care risks as well as financial and other enterprise risks, and give particular consideration to ensuring continuity of care in the event of default by contractors or subcontractors	Support	
53.1.	(f) have a nominated member of the governing body: i. attest annually on behalf of the members of the governing body that they have satisfied themselves that the provider has in place the structures, systems and processes to deliver safe and high quality care, and ii. if such an attestation cannot be given, explain the inability to do so and how it will be remedied.	Support in principle	The AMA supports improved reporting and accountability mechanisms for aged care providers.
Recommendation 54	**Program of assistance to improve governance arrangements**		
54.1.	The Australian Government should establish an ongoing program commencing in the 2021–22 financial year to provide assistance to approved providers to improve their governance arrangements, including their care governance arrangements.	Support	
Recommendation 55	**Research, Innovation and Technology** **Dedicated Research Council**		
55.1.	By 1 July 2022, the Australian Government should establish and fund a dedicated Aged Care Research Council to:	Support in principle	The AMA broadly supports the recommendation to establish a dedicated Aged Care Research Council to steer the direction of additional research into health and service delivery issues that affect the ageing population. It would be better if this proposed research council is fully independent. The AMA has continuously called on the Government to ensure the funding of research programs that focus on aged care issues, in particular: the care of older people with co and multi-morbidities; prevention, management and cure for dementia as the leading cause of death in Australia; the prevalence and management of elder abuse in Australia. The AMA believes that the research should be multidisciplinary, because of the complex inter-relationships between genetic, psycho-social, environmental and economic factors causing dysfunction from disease, disuse and the effects of biological ageing.
55.1.	(a) set the strategy and agenda for research and development into aged care and ageing related health conditions	Support	In AMA's view, improved quality and safety of aged care will not be realised from greater research investment in isolation. Understanding best-practice aged care is just the first step. Equally important is translating this knowledge into practice and benchmarking the performance of each aged care service so their performance can be measured and compared to the performance of their peers and they can identify how to modify their current practices to improve residents' outcomes over time.
55.1.	(b) administer an aged care and ageing related health conditions research fund with an annual budget, funded by a special appropriation, of 1.8% of the total government expenditure on aged care	Support in principle	The proposed elevation of research into ageing-related health conditions on the National Medical and Research Council should not divert precious little research funding from other health priorities. The call for an additional 1.8 per cent of total government expenditure on aged care to be dedicated to research on aged care, must be sourced from a new federal government budget allocation that is over and above the existing level of federal government funding.
55.1.	(c) conduct peer review of projects to determine funding allocations	Support	
55.1.	(d) prioritise research that involves co-design with older people, their families and the aged care workforce	Support	The AMA supports research being co-designed with older people, their families and aged care workforce. However, the AMA warns that this research must ensure equal representation of special needs groups, including but not limited to CALD, ATSI, LGBTI older people (see for example National Ageing Research Institute CALD Dementia Research Action Plan https://www.nari.net.au/policy/culturally-and-linguistically-diverse-cald-dementia-research-action-plan).
55.1.	(e) facilitate networks between research bodies, academics, industry and government for research, technology pilots and innovation projects, and assist with the translation of research into practice to improve aged care in Australia	Support	
55.1.	(f) work with the Australian Research Council, the National Health and Medical Research Council, and health and research networks to facilitate the sharing and application of research outcomes with policy makers, research bodies, health care bodies, approved providers and the community	Support	
55.1.	(g) ensure that research into ageing-related health conditions is high on the national research agenda including for the Australian Research Council and the National Health and Medical Research Council.	Support	
Recommendation 56	**Data governance and an aged care national minimum dataset**		
56.1.	The Australian Government should establish the framework to enable the Australian Aged Care Commission to effectively take leadership of and responsibility for aged care data on and from 1 July 2023. This will require the Australian Government to:	Support	
56.1.	(a) establish a 'management group' to develop an outcomes framework for an aged care national minimum dataset	Support	
56.1.	(b) develop data sharing agreements, in accordance with any relevant legislation, and under agreements with the States and Territories, to support timely access to and linkage of data for the aged care national dataset and quality indicators	Support	
56.1.	(c) ensure that legislative hurdles to the Australian Institute of Health and Welfare obtaining aged care national minimum dataset elements are removed and the collection is timely and mandatory	Support	
56.1.	(d) ensure the Australian Institute of Health and Welfare Authority is funded to curate and regularly publish an aged care national minimum dataset through an unconditional annual appropriation from the Federal Budget adequate to perform the curation and publication of the dataset and publish aged care data for public education through the GEN website.	Support	
56.2.	The Australian Aged Care Commission's aged care data functions will involve:	Support	

56.2.	(a) chairing the 'management group' to develop an outcomes framework for an aged care national minimum dataset, including ensuring that relevant stakeholders are consulted	Support	
56.2.	(b) overseeing the development of a common language and standardisation of aged care data, including consideration of interoperability with the health care sector	Support	
56.2.	(c) facilitating the development of software for use by approved providers, to be accredited by the Australian Institute of Health and Welfare for collection of aged care national minimum dataset elements and quality indicator data and incorporating compliance with the Aged Care Quality Standards	Support in principle	The AMA supports in principle this recommendation. The AMA has previously called for appropriate data collection. The AMA's position is that My Health Record provides significant opportunities for future research of needs of older people, particularly when it becomes interoperable with My Aged Care, as was planned by the Australian Digital Health Agency. The AMA calls for the regulation to ensure that privacy and security measures are put in place, with development and use of any software that will be used for data collection and data exchange.
56.2.	(d) facilitating the development of software and ICT systems to enable automatic reporting by approved providers on mandatory reporting obligations, quality indicators, prudential arrangements and other responsibilities	Support	
56.2.	(e) establishing arrangements consistent with the 'collect once, use many times' principle, including: i. ICT interoperability arrangements between the Australian Aged Care Commission and the Australian Commission on Safety and Quality in Health and Aged Care to enable the sharing of data relevant to the functions of both organisations ii. ensuring administrative data relevant to approved providers, such as assessment data, is made available to providers, and iii. ensuring a mechanism exists for approved providers to effectively and securely transfer information about a consumer when the consumer changes service providers.	Support	
56.3.	The *Australian Institute of Health and Welfare Act 1987 (Cth)* , and other legislation as required, should be amended as necessary to achieve the objectives of this recommendation. This should include ensuring the Institute has the powers and responsibilities necessary to undertake the curation and publication of the aged care national minimum dataset.	Support	
56.4.	The Australian Institute of Health and Welfare should accredit software used by approved providers and, where relevant, data custodians assessed as compatible with the dataset specifications of the aged care national minimum dataset.	Support	
Recommendation 57	**Accommodation** **Improving the design of aged care accommodation**		
57.1.	The Australian Government should guide the design of more appropriate residential aged care accommodation for older people by:	Support in principle	The AMA supports the development of national aged care design principles and guidelines that are evidence based.
57.1.	(a) developing and publishing by 1 July 2022 a comprehensive set of national aged care design principles and guidelines on accessible and dementia-friendly design for residential aged care, which should be: i. capable of application to 'small home' models of accommodation as well as to enablement and respite accommodation settings ii. amended from time to time as necessary to reflect contemporary best practice	Support in principle	
57.1.	(b) implementing by no later than 1 July 2023 a program to promote adoption of the National Aged Care Design Principles and Guidelines in design and construction of residential aged care buildings, which program should include: i. industry education, including sharing of best practice models ii. financial incentives, whether by increased accommodation supplements or capital grants or other measures or a combination of such measures, for residential aged care buildings that comply with the Guidelines	Support in principle	
57.1.	(c) advancing to the National Federation Reform Council by 1 July 2025 a proposal for amendments to Class 9c of the National Construction Code to require the adoption of accessible and dementia-friendly design standards for any new residential aged care buildings, or those proposed to be substantially refurbished, according to specifications informed by the National Aged Care Design Principles and Guidelines.	Support in principle	
Recommendation 58	**Capital grants for 'small home' models of accommodation**		
58.1.	The Australian Government should expand, with effect from 1 January 2022, the Rural, Regional and Other Special Needs Building Fund to provide additional capital grants for building or upgrading residential aged care facilities to provide small scale congregate living.	Support in principle	The AMA supports increased access to aged care services in rural and regional areas and for special needs groups.
58.2.	A majority of the people who receive, or who will receive, aged care at the premises to which any such grant relates should, within the meaning of section 7 of the *Grant Principles 2014* (Cth), be one or more of the following:	Support in principle	
58.2.	(a) supported residents, concessional residents or assisted residents	Support in principle	
58.2.	(b) people with special needs	Support in principle	
58.2.	(c) low-means care recipients	Support in principle	
58.2.	(d) people who live in a location where there is a demonstrated need for additional residential care services	Support in principle	
58.2.	(e) people who do not live in a major city.	Support in principle	
58.3.	A capital grants program for building or upgrading residential aged care facilities to provide small scale congregate living should continue after the introduction of the new Act.	Support in principle	
Recommendation 59	**Younger people in residential aged care** **No younger people in residential aged care**		
59.1.	The Australian Government should immediately put in place the means to achieve, and to monitor and report on progress towards, the commitments announced by the Australian Prime Minister on 25 November 2019 to ensure that:	Support	
59.1.	(a) no person under the age of 65 enters residential aged care from 1 January 2022	Support	
59.1.	(b) no person under the age of 45 lives in residential aged care from 1 January 2022	Support	

59.1.	(c) no person under the age of 65 lives in residential aged care from 1 January 2025 by:	Support in principle	The AMA supports in principle this recommendation. In the AMA view, this recommendation needs to take into consideration people living with younger onset dementia (YOD), who fall under NDIS. AMA is aware of current ongoing issues at the intersections of NDIS and aged care when people living with YOD wish or need to enter residential aged care. In many cases specialised dementia care units will be the only suitable place to accommodate and support people living with YOD. If there is a firm benchmark, such as described here, it may mean that many people who need dementia supports who are under 65 will be left in the limbo and potentially without the care they need.
59.1.	(a) referring for assessment by the agency most appropriate for the assessment of the person concerned, such as the National Disability Insurance Agency (and not an Aged Care Assessment Team or Aged Care Assessment Service), any younger person who is at risk of entering residential aged care	Support	AMA supports this recommendation but warns that better coordination between NDIS and aged care systems is required to enable seamless transition between different services for people living with disability. Coordination with primary care in the process is crucial as well as other service sectors, including allied health.
59.1.	(b) developing hospital discharge protocols with State and Territory Governments to prevent discharge into residential aged care of any younger person	Support	
59.1.	(c) developing, funding and implementing with State and Territory Governments programs for short-term and long-term accommodation and care options for any younger person who is: i. living in or at risk of entering residential aged care and ii. not eligible to be a participant in the National Disability Insurance Scheme	Support	
59.1.	(d) requiring the National Disability Insurance Agency to publish an annual Specialist Disability Accommodation National Plan setting out, among other things, priority locations and proposed responses to thin markets	Support	
59.1.	(e) providing directly for, where appropriate and necessary, accommodation in the Specialist Disability Accommodation market, particularly in thin or underdeveloped markets	Support	
59.1.	(f) funding dedicated and individualised advocacy services for younger people who are living in or at risk of entering residential aged care	Support	
59.1.	(g) collecting data on an ongoing basis, and publishing up-to-date collected data each quarter, on, for each State and Territory, the number of younger people living in residential aged care and, among other things i. their age ranges ii. the average length of time in residential aged care iii. the numbers of admissions into and discharges from residential aged care, and iv. the reasons for younger people exiting from residential aged care, such as death, turning 65 years old or moving into the community	Support	
59.1.	(h) having the responsible Minister report to the Parliament every six months about progress towards achieving the announced commitments, and	Support	
59.1.	(i) ensuring that a younger person will only ever live in residential aged care if it is in the demonstrable best interests of the particular person (and is independently certified to be such by someone with suitable skills, experience, training and knowledge of the person) in limited and exceptional circumstances such as, for instance, where: i. the person will turn 65 years old within a short period of time, being no more than three months, after entering into residential aged care ii. the person's close relatives over 65 years of age live in a residential aged care facility and the person would suffer serious hardship on being separated from those relatives iii. an Aboriginal or Torres Strait Islander person between the age of 50 and 64 years old elects to live in residential aged care.	Support in principle	As per our comment above under 59.1, this recommendation is supported with the caveat. AMA urges the Commission to ensure that this recommendation takes into consideration the needs of people living with Younger Onset Dementia (YOD), for whom sometimes specialist dementia units may be the only suitable place of accommodation.
Recommendation 60	**Aged care for people with disability** **Equity for people with disability receiving aged care**		
60.1.	By 1 July 2024, every aged care recipient with a disability or disabilities, regardless of when acquired, should receive through the aged care program daily living supports and outcomes (including assistive technologies, aids and equipment) equivalent to those that would be available under the National Disability Insurance Scheme to a person with the same or substantially similar conditions.	Support	The AMA supports this recommendation. In our submission to the Royal Commission, the AMA has recommended that the Government should consider replicating the NDIS program for assistive technologies in aged care.
Recommendation 61	**Annual reporting to Parliament by the Disability Discrimination Commissioner and the Age Discrimination Commissioner**		
61.1.	By 1 July 2024, the Disability Discrimination Commissioner and the Age Discrimination Commissioner should be required, as part of the new National Disability Strategy, to report annually to the Parliament on the numbers of aged care recipients with disabilities who are 65 years old or older and their ability to access daily living supports and outcomes (including assistive technologies, aids and equipment) equivalent to those available under the National Disability Insurance Scheme.	Support	
Recommendation 62	**Better access to health care** **A new primary care model to improve access**		
62.1.	Commencing by no later than 1 January 2024, the Australian Government should implement a new voluntary primary care model for people receiving aged care.	Do not support	
62.2.	The new primary care model would have the following characteristics:		
62.2.	(a) general practices may, if they choose, apply to the Australian Government to become accredited aged care general practices	Do not support	The AMA does not support and will oppose any system of accreditation separate to, and on top of, the RACGP Standards. The AMA fears that this proposed model will lead to further exodus of GPs from aged care and achieve the opposite of what is intended. AMA members also see additional danger in having "aged care practices" only, which are not conducive to holistic, longitudinal care.

62.2.	(b) the initial accreditation criteria would be: i. accreditation with the Royal Australian College of General Practitioners ii. participation in after-hours cooperative arrangements, and iii. use of My Health Record	Do not support	
62.2.	(c) over time, as aged care general practices mature, the accreditation requirements could be strengthened	Do not support	
62.2.	(d) each accredited aged care general practice would enrol people receiving residential care or personal care at home who choose to be enrolled with that practice	Support in principle	The AMA supports in principle the enrolment concept.
62.2.	(e) each accredited aged care general practice would receive an annual capitation payment for every enrolled person, based on the person's level of assessed need	Do not support	The AMA does not support the capitation payment model. The AMA has previously called for a 'blended payment' model. In the AMA members' view, fee for service model can reward over-servicing, while capitation rewards under-servicing, and there is a balance to be struck between the two, which will not be achieved by this proposed model.
62.2.	(f) an accredited aged care general practice would agree with each enrolled person and the person's aged care provider on how care will be provided, including by any use of telehealth services and nurse practitioners	Support in principle	The AMA supports in principle this recommendation. However, the AMA sees this as achievable without needing to implement a whole new model of GP care. This is already done by many AMA members who work in aged care facilities, via a formal agreement between the GP and the facility, that outlines how the service is provided. Agreement by the patient/their carer/family member is also sought in this process. See the AMA's Medical Care for Older People position statement.
62.2.	(g) the accredited aged care general practice would be required to: i. meet the primary health care needs of each enrolled older person (including through any cooperative arrangements with other general practices to provide after-hours care if required) ii. use My Health Record in conjunction with aged care providers iii. initiate and take part in regular medication management reviews iv. prepare an 'Aged Care Plan' (in collaboration with a geriatrician and the aged care provider and others) for each enrolled person v. accept any person who wishes to enrol with it (subject to geography) to avoid practices accepting only patients with less complex care needs, and vi. report on performance against a range of performance indicators, including immunisation rates and prescribing rates	Support in principle	The AMA supports in principle some of these recommendations, including use of My Health Record, regular medication management reviews and preparation of an Aged Care Plan. The AMA does not agree that a doctor should be made to accept any person who wishes to enrol with them. The AMA Code of Ethics stipulates that doctors have a right to decline to enter into a therapeutic relationship where an alternative health care provider is available and the situation is not an emergency one. While it is understandable that the Commission wishes to avoid practices accepting only patients with less complex care needs, there are a range of reasons why a doctor may decline to see a new patient such as a lack of available appointments, the patient's care needs fall outside the doctor's scope of practice or clinical capacity or belief that taking on a new patient may compromise the care they can provide to existing patients. In addition, the Code of Ethics stipulates that doctors have a right to decline to continue a therapeutic relationship where it becomes ineffective or compromised, where an alternative health care provider is available and the situation is not an emergency one. This may include where it becomes ineffective due to a communication breakdown, where the patient is aggressive or disruptive, the patient's care needs are outside the doctor's scope of practice or clinical capacity, there is a breach of personal boundaries or where there is a conflict of interest. When deciding whether to enter into, or discontinue, a therapeutic relationship, doctors will weigh up their ability to properly care for the individual patient along with their duty to provide appropriate care to other patients and to protect the health and safety of patients and staff.
62.2.	(h) the capitation payment would be reduced by the value of benefits paid when an enrolled person sees a general practitioner in another practice.	Support in principle Do not support	As outlined under point 62.2.(e), the AMA does not support the capitation payment model.
62.3.	The Australian Government should undertake a thorough evaluation of the new primary care model in 2030 and make appropriate adjustments to the model at that time.	Do not support	As outlined under 62.1, the AMA does not support the proposed new primary care model.
	Royal Australian College of General Practitioners' accreditation requirements		
63.1.	By 31 December 2021, the Royal Australian College of General Practitioners should amend its Standards for general practices to allow for accreditation of general practices which practise exclusively in providing primary health care to aged care recipients in residential aged care facilities and in their own homes.	Do not support	The AMA does not support this recommendation. The AMA sees accreditation of practices which practice exclusively in aged care as contributing to further fragmentation of care.
	Access to specialists and other health practitioners through Multidisciplinary Outreach Services		
64.1.	By 1 January 2022, the Australian and State and Territory Governments should introduce Local Hospital Network-led multidisciplinary outreach services.	Support	The AMA supports establishment and expansion of Multidisciplinary Outreach Services. The AMA has previously called for their expansion nationally, with the establishment of appropriate funding procedures. The AMA's view is that these teams should include non-GP specialists such as geriatricians, psych geriatricians, and psychiatrists. The AMA believes that the composition of such teams should be based on individual patient needs and indicative clinical situation at the time of acute care need. The AMA also argues that these teams should be complementary to the services GPs provide in RACFs and should not be performing care without coordination with the patient's usual GP.
64.2.	These services should be funded through amendment of the National Health Reform Agreement, and all aged care recipients receiving residential care or personal care at home should have access based on clinical need.	Support	The AMA supports this recommendation. As explained under point 64.1, the AMA has previously called for appropriate funding systems and procedures to be established for the outreach services.
64.3.	The amended National Health Reform Agreement should include a recurrent and sustainable funding mechanism to stimulate outreach services. The level of funding should be based on underlying costs as determined by the Independent Hospital Pricing Authority.	Support	
64.4.	The key features of the model should include:	Support	
64.4.	(a) provision of services in a person's place of residence wherever possible	Support	
64.4.	(b) multidisciplinary teams, including nurse practitioners, allied health practitioners and pharmacists	Support	
64.4.	(c) access to a core group of relevant specialists, including geriatricians, psych geriatricians and palliative care specialists	Support	
64.4.	(d) embedded escalation to other specialists (including endocrinologists, cardiologists, infectious disease specialists and wound specialists), who are already salaried within the hospital and assigned to the model for part of their work	Support	
64.4.	(e) 24 hour a day on-call services available to: i. aged care recipients receiving residential care or personal care at home ii. the families of those people receiving aged care, and iii. staff of aged care services	Support	The AMA supports this recommendation but would also call on the Royal Commission to ensure that these services are coordinated with patients' usual GPs. In the AMA view, any non-GP specialist services must work directly with, and must not replace GP services, which should be the backbone of health care provision in aged care.
64.4.	(f) proactive care and rehabilitation	Support	

64.4.	(g) a focus where feasible on skills transfer to staff working in aged care	Support	The AMA supports this recommendation. The AMA is aware that during COVID-19 outbreaks in aged care facilities in Victoria, the outreach teams worked directly with the aged care staff and supported them in developing their skills in use of PPE for example.
64.4.	(h) a specific focus on palliative care outreach services	Support	
64.4.	(i) clinical governance arrangements involving Local Hospital Networks and relevant aged care and primary care providers.	Support	The AMA supports improvement of clinical governance arrangements, especially when there are multiple actors involved in older person's care. The AMA has previously warned that a system in which the outreach services work in coordination with the patient's usual GP will achieve its best value once proper shared clinical online systems are established, that are RACGP standards compliant. This should facilitate improved communication and exchange of information is functioning and may prevent any unwanted loss of patient's information. This is important because older people frequently move from RACFs to emergency departments and then to hospital. Outreach teams are another stakeholder that is added to an already complex communication. Having a clinical online system that facilitates these transitions and at the same time is accessible to the patient's usual GP will enable continuity of care and lead to improved health outcomes for older people.
	Increased access to Older Persons Mental Health Services		
65.1.	By 1 January 2022, the Australian and State and Territory Governments should:	Support	
65.1.	(a) fund separately under the National Health Reform Agreement outreach services delivered by State and Territory Government older persons mental health services to aged care recipients receiving residential care or personal care at home	Support	
65.1.	(b) introduce performance measures and benchmarks for these outreach services	Support	
65.1.	(c) promulgate standardised service eligibility criteria for hospital, community based, and aged care older persons mental health services that do not exclude from eligibility for such services people with dementia.	Support	
	Establish a Senior Dental Benefits Scheme		
66.1.	The Australian Government should establish a new Senior Dental Benefits Scheme, commencing no later than 1 January 2023, which will:	Support	
66.1.	(a) fund dental services to people who: i. live in residential aged care, or ii. live in the community and receive the age pension or qualify for the Commonwealth Seniors Health Card	Support	
66.1.	(b) include benefits set at a level that minimises gap payments, and includes additional subsidies for outreach services provided to people who are unable to travel, with weightings for travel in remote areas	Support	
66.1.	(c) provide benefits for services limited to treatment required to maintain a functional dentition (as defined by the World Health Organization) with a minimum of 20 teeth.	Support	
	Short-term changes to the Medicare Benefits Schedule to improve access to medical and allied health services		
67.1.	The Australian Government should:		
67.1.	(a) create new Medicare Benefits Schedule items by 1 November 2021 to allow for a benefit to be paid for a comprehensive health assessment, whether conducted by a general practitioner or a nurse practitioner, when an aged care recipient begins to receive residential aged care or personal care at home and at six month intervals thereafter, or more frequently if there is a material change in a person's circumstances or health	Support	
67.1.	(b) immediately amend the Medicare Benefits Schedule to allow benefits to be paid under the GP Mental Health Treatment items 2700 to 2717 to patients receiving these services within a residential aged care service	Support	
67.1.	(c) create new Medicare Benefits Schedule items by 1 November 2021 for: i. a mental health assessment, and subsequent development of a treatment plan, by a general practitioner or psychiatrist, within two months of a person's entry into residential aged care ii. three monthly re-assessments or reviews of a mental health assessment by a general practitioner, psychiatrist, or psychologist	Support in principle	The AMA supports in principle this recommendation. While access to mental health assessments and supports is welcomed, the AMA does not consider mandating three-monthly reassessments or reviews as warranted. These should be done on 'as required' basis and in line with the current older person's treatment plans.
67.1.	(d) create new Medicare Benefits Schedule items by 1 November 2021, with the value of the benefit aligned with recommended professional fees, for allied mental health practitioners providing services to people in residential aged care and: i. the number of services for which a benefit is payable should be based on clinical advice ii. these benefits should cease on 1 January 2023, when the aged care allied health funding arrangement is established	Support in principle	
67.1.	(e) amend the General Practitioner Aged Care Access Incentive payment to: i. increase the minimum annual number of services required by general practitioners to qualify for the payment and the amount of the corresponding payment ii. introduce incremental increases to the amount of the payment for general practitioners who deliver more the minimum annual number of services and index these amounts on the same basis as Medicare Benefits Schedule general practitioner attendance items.	Support in principle	The AMA is in principle supportive of amending the GP Aged Care Incentive payment. The minimum of 2.3 services per week to access the payment is also acceptable to the AMA, however the AMA members would like to see at least a double increase (10.8 services per week) for Tier 4.
	Enhance the Rural Health Outreach Fund to improve access to medical specialists for people receiving aged care		
68.1.	The Australian Government should:	Support	
68.1.	(a) amend the priorities of the Rural Health Outreach Fund by 1 July 2021 to include delivery of: i. geriatrician services in regional, rural and remote Australia, and ii. medical specialist services to people receiving aged care in regional, rural and remote Australia	Support	
68.1.	(b) increase, for these additional priorities, the annual funds available by $9.6 million, starting in the 2021–22 financial year, and	Support	
68.1.	(c) ensure that these additional priorities of the Fund are maintained on an ongoing basis.	Support	
	Access to specialist telehealth services		

69.1.	By 1 November 2021, the Australian Government should:	Support	
69.1.	(a) expand access to Medicare Benefits Schedule-funded specialist telehealth services to aged care recipients receiving personal care at home	Support	The AMA supports this recommendation. It is the AMA position that telehealth can improve health care access and outcomes for patients, particularly for those living with chronic conditions and for vulnerable groups. While the AMA supports telehealth for specialists, we maintain that telehealth GP access remains crucial for aged care recipients. There should be MBS items incorporating telehealth (as with referred specialist consultations), secure messaging and other remote forms of communication for GP consultations to significantly enhance access to GPs and improve the efficiency in the delivery of medical care. The AMA also supports establishment of telehealth GP items for consultations between the GP, aged care staff and relatives/carers. In the AMA view, this may reduce some barriers to accessing medical services after hours.
69.1.	(b) require aged care providers delivering residential care or personal care at home to have the necessary equipment and clinically and culturally capable staff to support telehealth services.	Support	
	Increased access to medication management reviews		
70.1.	The Australian Government should immediately improve access to quality medication management reviews for people receiving aged care by:	Support	The AMA supports this recommendation. In our submission to the Royal Commission the AMA called for medication reviews to occur annually, and then on an as-needed basis to ensure medications are appropriate for older people. The AMA acknowledged that pharmacists who work with doctors have an important role in: assisting with medication adherence; improving medication management; and providing education about medication safety.
70.1.	(a) allowing and funding pharmacists from 1 January 2022 to conduct reviews on entry to residential care and annually thereafter, or more often if there has been a significant change to the care recipient's condition or medication regimen	Support	
70.1.	(b) amending the criteria for eligibility for residential medication management reviews to include people in residential respite care and transition care	Support	
70.1.	(c) monitoring quality and consistency of medication management reviews.	Support	The AMA supports this recommendation. The AMA members also call for a framework that would allow for medication reviews to happen routinely for all recipients of aged care services (as above) that can be initiated by either the aged care provider or the pharmacist.
	Restricted prescription of antipsychotics		
71.1.	By 1 November 2021, the Australian Government should amend the Medicare Benefits Schedule so that only a psychiatrist or a geriatrician can initially prescribe antipsychotics. General practitioners should be able to prescribe repeat prescriptions of antipsychotics for up to a year for people who have received an original prescription from a psychiatrist or geriatrician.	Do not support	The AMA supports reducing the inappropriate use of antipsychotics. However, AMA members are concerned that this recommendation that restricts prescription of antipsychotics to psychiatrists and geriatricians only will overburden the specialist services, that are already providing limited services in aged care. It also potentially diminishes the training and skills of GPs. In the AMA view, there are several systemic issues that will need to be resolved, that mostly pertain to staffing of aged care facilities, their training and availability of RNs in residential aged care, to actually ensure the minimisation of use of antipsychotics . Furthermore, putting blanket restrictions on GPs re prescribing for their patients in general could further deter GPs from working in aged care. It is the AMA position that chemical restraints in aged care should only be used as last resort and only to reduce the distress of the patient. The AMA members suggest alternative solutions to reducing prescribing in aged care, such as mandating regular audits on prescribing/deprescribing rates, that would also include/address all other strategies used by the aged care providers to reduce the distress by the older person before prescribing is done, reasons why those failed, how long the patient was kept on antipsychotic medication and why.
	Improving the transition between residential aged care and hospital care		
72.1.	The Australian and State and Territory Governments should:	Support	
72.1.	(a) by 1 July 2022, implement, and commence publicly reporting upon compliance with, hospital discharge protocols that ensure that discharge to residential aged care from hospital should only occur once appropriate clinical handover and discharge summary (including medications list) has been provided to and acknowledged by the residential care service, and provided to the person being discharged	Support	The AMA supports this recommendation, but believes that this transition should acknowledge the role of older person's GP in this process. It is the AMA position that During transfer of care back from hospital to community or RACF, the patient's GP needs to be provided with clear and appropriate information to support safe and meaningful clinical handover of patient care. This includes: i) A summary of the patient's primary and secondary diagnosis/es, complications, procedures and management; ii) A summary of relevant investigations; iii) Details of any allied health and support services provided to the patient while in hospital; iv) Changes to medications, including clear documentation of reason for change; v) A list of medications to be administered following discharge, including their timeline and details of the supply given to the patient by the hospital; vi) Any allergies, reactions or alerts; vii) Details of arrangements for ongoing care, including details of any follow-up appointments and clarity about the care to be provided by various providers; viii) Details of the information provided to the patient/family; ix) Support and care arrangements for family members and carers; x) Details of follow up appointments, if any; and xi) An advance care plan or directive (when relevant).

72.1.	(b) by 1 December 2021, require staff of aged care services, when calling an ambulance for a resident, to provide the paramedics on arrival with an up-to-date summary of the resident's health status, including medications and advance care directives.	Support	It is the AMA position that moving between aged care and health care providers should be facilitated by a chain of communication that covers: i) patient's details, including contact details of their carers/representatives; ii) name and contact details of older person's GP; iii) name and contact details of the designated contact person at the aged care provider; iv) the reason for patient's transfer from aged care to health care provider and vice versa; v) the patient's clinical images, including any pre-existing diagnosis and investigations done; vi) patient's prescribed medication and any allergies to medication; vii) patient's care plan and advance care directive, if available.
	Improving data on the interaction between the health and aged care systems		
73.1.	The Australian Government and State and Territory Governments should improve the data available to monitor the interaction between the health and aged care systems and improve health and aged care planning and funding decisions. In particular:	Support in principle	The AMA supports in principle this recommendation. The AMA recognises the need to track the level of aged care services used by aged care recipients and the changes over time.
73.1.	(a) the Australian Government should implement an aged care identifier by 1 July 2022 in the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule datasets to allow regular public reporting on the number and type of medical and pharmaceutical services provided to people receiving aged care	Support in principle	The AMA supports in principle having identifiers to be able to collect, track and record data. However, as explained under the 73.1 point above, the system should ensure minimisation of duplication and creation of multiple identifiers. In the AMA view, planned interoperability between My Aged Care and My Health Record should be taken into consideration when planning this aspect of data collection and tracking.
73.1.	(b) by 1 July 2023 all National Minimum Datasets reported to the Australian Institute of Health and Welfare should include an item identifying whether a person is receiving aged care services and the type of aged care the person is receiving	Support in principle	We agree there is a need to introduce a marker to link the type and level of approved aged care service with the MBS, PBS and hospitals services used by a person who receives an aged care service. Once all residential aged care providers register for the My Health Record, the only aged care services used by an older person, that are not identifiable through the healthcare identifiers, are approved home packages. Instead of introducing a third identifier for each aged care recipient (IHI, My Aged Care plus a new ID to track the health services used by a person who is supported by a home care package), the AMA suggests consideration of: Linking the person's My aged care services ID to their IHI for the purpose of data matching and reporting; or Adding a marker to the age care service recipient's IHI. Option (b) has the disadvantage of requiring My Aged Care to track and update each older persons IHI marker when they transition from one level or type of age care service to another.
73.1.	(c) National Minimum Datasets covering all State and Territory Government-funded health services should be implemented by 1 July 2023	Support in principle	
73.1.	(d) all governments should implement a legislative framework by 1 July 2023 for health and aged care data to be directly linked, shared and analysed to understand the burden of disease of current and prospective aged care recipients and their current and future health needs	Support in principle	
73.1.	(e) the Australian Government should direct the Australian Institute of Health and Welfare to include data tabulated on the basis of aged care recipient status in any relevant health statistical publications, and make the de-identified data publicly available through the Australian Government's data portal data.gov.au.	Support in principle	
	Universal adoption by the aged care sector of digital technology and My Health Record		
74.1.	The Australian Government should require that, by 1 July 2022:	Support	
74.1.	(a) every approved provider of aged care: i. uses a digital care management system (including an electronic medication management system) meeting a standard set by the Australian Digital Health Agency and interoperable with My Health Record ii. invites each person receiving aged care from the provider to consent to his or her care records being made accessible on My Health Record iii. if the person consents, places that person's care records (including, at a minimum, the categories of information required to be communicated upon a clinical handover) on My Health Record and keeps them up to date	Support in principle	The AMA supports in principle this recommendation. The AMA warns that the success of implementing the My Health Record in residential aged care will depend on a number of factors including: The standards of conformance set by the Australian Digital Health Agency for the residential age care clinical information system (CIS); The timeliness of achieving full conformance with the standards, and the ease of My Health Record use via the CIS; The level of resourcing to train age care staff in My Health Record use; The ease of writing and uploading clinical information about a person in a residential aged care facility, into the My Health Record on the CIS in the age care facility. Also, The delivery of Recommendation 74.1(a) (iii), cannot be met by an approved provider of aged care unless they are also a healthcare provider registered under the National Law with their own HPI-I who is also registered for the My Health Record. A manager of the aged care facility could be authorised to access and upload information to the resident's My Health Record if it is part of providing health treatment to the Resident.
74.1.	(b) the Australian Digital Health Agency immediately prioritises support for aged care providers to adopt My Health Record	Support	The AMA supports this recommendation. We warn that most clinical data uploaded to the My Health Record on behalf of a residential aged care resident, will be done by a visiting medical practitioner or other healthcare provider. It is not clear if the upload will be from the healthcare providers own computer or the new CIS mandated in these Recommendations.
	Clarification of roles and responsibilities for delivery of health care to people receiving aged care		
75.1.	By 31 December 2021, the Australian and State and Territory Governments should amend the National Health Reform Agreement to include an explicit statement of the respective roles and responsibilities of approved aged care providers and State and Territory health care providers to deliver health care to people receiving aged care, similar to the Applied Principles and 'tables of supports' for the National Disability Insurance Scheme, on the basis that, among other things:	Support	
75.1.	(a) allied health care should generally be provided by aged care providers	Support in principle	The AMA supports in principle this recommendation on the basis that it clarifies who is responsible for these services. The AMA calls on the funding models and regulation to ensure that this actually occurs in practice. The AMA requests further clarification around whether external allied health professionals would still be able to provide the service (e.g. subcontracted by the aged care provider, or supplied as part of the General Practice team), or whether aged care providers would need to employ multiple different allied health professionals to meet the needs of residents. The latter may be problematic in terms of meeting the large breadth of allied health services required. Further detail is needed around how this recommendation would work with multiple benefits schemes (e.g. aged care provider funding, MBS, the proposed Dental Benefits Scheme)

75.1.	(b) specialist services, including specialist palliative care and subacute rehabilitation, should be provided by State and Territory health care providers, even if these services involve allied health practitioners	Support in principle	The AMA supports in principle this recommendation, as per our comment under 76.1.
75.1.	(c) less complex health conditions should be managed by aged care providers' staff, particularly nurses.	Support in principle	The AMA supports less complex health conditions being managed by registered nurses, not other staff members. Registered nurses are the only staff members qualified to provide medical care. Further clarification is needed around the definition of a 'less complex' health condition. Less complex health conditions can manifest into more serious conditions if not treated by the appropriate staff member (i.e. registered nurses)
75.2.	By 31 December 2021, the Australian Government should amend the *Quality of Care Principles 2014* (Cth) to clarify the role and responsibilities of approved providers to deliver health care to people receiving aged care, including but not limited to their particular role and responsibilities to deliver allied health care, mental health care, and oral and dental health care.	Support in principle	See the AMA's comment under 75.1
	Improved access to State and Territory health services by people receiving aged care		
76.1.	By 1 July 2022, the Australian and State and Territory Governments should amend the National Health Reform Agreement or any future health funding agreement to include explicit commitments by State and Territory Governments to provide:	Support in principle	The AMA supports in principle this recommendation. In the AMA view the goal of the amendment of the National Health Reform Agreement must be to ensure that the quality of care for older people is paramount. It should not be about the cost shifting between the Commonwealth and the states/territories. Aged care recipients should have equal access to health care services as all other members of the community. The AMA would call on the Royal Commission to ensure in its recommendations that there are strong protections in place to ensure Commonwealth contribution to this cost; The new improved access needs to ensure that these services are brought to the older person at the place of their residence where they are accessing aged care services (be it at their home or a residential facility), rather than the service being provided at hospital, with Commonwealth considering their contribution to hospital funding as covering for that cost.
76.1.	(a) access by people receiving aged care to State and Territory Government-funded health services, including palliative care services, on the basis of the same eligibility criteria that apply to residents of the relevant State and Territory more generally	Support in principle	
76.1.	(b) clinically appropriate subacute rehabilitation for patients who i. are aged care recipients receiving residential care or personal care at home, or ii. may need such aged care services if they do not receive rehabilitation, as well as performance targets and reporting requirements on the provision of subacute rehabilitation care to people receiving aged care.	Support in principle	
Recommendation 77	**Ongoing consideration by the Health National Cabinet Reform Committee**		
77.1.	The Health National Cabinet Reform Committee should require the Australian Health Ministers' Advisory Council to:	Support	
77.1.	(a) consider the full suite of the Royal Commission's recommendations related to the interface of the health care and aged care systems and report to the next meeting of the Committee	Support	
77.1.	(b) include a standing item in all future meetings of the Council on the aged care system and its interface with the health care system.	Support	
Recommendation 78	**Aged care in regional, rural and remote areas** **Planning for the provision of aged care in regional, rural and remote areas**		
78.1.	From 1 December 2021, the Australian Government should:	Support	
78.1.	(a) identify areas where service supply is inadequate and actively respond by supplementing services to meet entitlements and needs, and	Support	The AMA supports this recommendation. The AMA would however call on the Royal Commission to determine the benchmarks for adequate supply of services. Aged care facilities in smaller rural are often serviced only by local GPs who have little or no support. Many of these GPs are close to retirement or returning to the city. However, these areas may be deemed as "serviced" and not receive additional supports despite desperately needing supports. The AMA considers it crucial that the Royal Commission takes these issues into consideration and determine adequate benchmarks.
78.1.	(b) plan for the specific needs of different locations and develop aged care service provision based on those identified needs and by doing so ensure that older people in regional, rural and remote locations are able to access aged care in their community equitably with other older Australians.	Support	The AMA supports this recommendation and has called on the Government to develop comprehensive plans to better support provision of health and aged care in regional, rural and remote Australia. This will only be achieved with significant funding increases to bridge the gap between the city and the country and the Royal Commission should ensure that the Government commits sufficient funding for this purpose.
78.2.	From 1 December 2021, the Australian Government should make it clear when people first engage with the aged care system if they will not be able to access a certain type of aged care in their community.	Support	
78.3.	On and from 1 July 2023, the Australian Aged Care Commission will assume these functions and powers.	Support	
Recommendation 79	**The Multi-Purpose Services Program**		
79.1.	The Australian Government (and, from 1 July 2023, the Australian Aged Care Commission) should maintain and extend the Multi-Purpose Services Program in the new aged care system by, from 1 December 2021:	Support	The AMA supports this recommendation. The AMA notes that this program was last reviewed in 2019 and recommends that another review is conducted once the proposed reforms have been established.
79.1.	(a) together with State and Territory Governments, establishing new Multi-Purpose Services in accordance with community need as identified by the Australian Government or the Commission	Support	The AMA fully supports this recommendation. AMA members have called on the Government to ensure that at least one multi-purpose health service is available in every rural town that has rural hospital facility. This would prevent older people being transferred from their towns and communities and improve their overall health outcomes.
79.1.	(b) ensuring that people entering Multi-Purpose Services are subject to the same eligibility and needs assessments as all other people receiving aged care	Support	
79.1.	(c) requiring people accessing Multi-Purpose Services to make contributions to the cost of their care and accommodation on the same basis as all other people receiving aged care (with appropriate protections for people currently accessing Multi-Purpose Services)	Support	
79.1.	(d) permitting Multi-Purpose Service providers to access all aged care funding programs on the same basis as other aged care providers	Support	

79.1.	(e) developing a funding model for Multi-Purpose Services which reflects the changing number and acuity of people receiving care over time while maintaining certainty of funding over the course of a financial year	Support	
79.1.	(f) together with State and Territory Governments, establishing a cost-shared capital grants program to rebuild or refurbish older Multi-Purpose Services to ensure that the infrastructure meets contemporary aged care design standards, particularly to support the care of people living with dementia.	Support	
	Funding in the new aged care system		
Recommendation 80	**Amendments to residential aged care indexation arrangements**		
80.1.	Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for residential aged care so that all care subsidies, and the viability supplement, are increased on 1 July each year by the weighted average of:		Determining indexation arrangements for aged care is out of scope for the AMA.
80.1.	(a) 45% of the yearly (to the 30 June immediately preceding the indexation date) percentage increase to minimum wage for an Aged Care employee Level 3 under the Aged Care Award 2010 (section 14.1)		
80.1.	(b) 30% of the yearly (to the 30 June immediately preceding the indexation date) percentage increase to the minimum wage for a registered Nurse Level 2 – pay point 1 under the Nurses Award 2010 (section 14.3)		
80.1.	(c) 25% of the yearly percentage (to the 30 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.		
80.2.	The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Aged Care Pricing Authority is established and has commenced independent determination of prices for residential care.		
Recommendation 81	**Amendments to aged care in the home indexation arrangements**		
81.1.	Commencing with effect on 1 July 2021, the Australian Government should amend the indexation arrangements for home care so that subsidy rates are increased on 1 July each year by the weighted average of:		Determining indexation arrangements for aged care is out of scope for the AMA.
81.1.	(a) 60% of the yearly (to the 30 June immediately preceding the indexation date) percentage increase to minimum wage for an Aged Care employee Level 3 under the Aged Care Award 2010 (section 14.1)		
81.1.	(b) 15% of the yearly (to the 30 June immediately preceding the indexation date) percentage increase to the minimum wage for a registered Nurse Level 2 – pay point 1 under the Nurses Award 2010 (section 14.3)		
81.1.	(c) 25% of the yearly percentage (to the 30 March immediately preceding the indexation date) increase to the Australian Bureau of Statistics Consumer Price Index.		
81.2.	The increases based on these arrangements should apply to the financial year commencing 1 July 2021 and continue until such time as the Aged Care Pricing Authority is established and has commenced independent determination of prices for aged care in the home.		
Recommendation 82	**Immediate changes to the Basic Daily Fee**		
82.1.	The Australian Government should, no later than 1 July 2021, offer to provide funding to each approved provider of residential aged care adding to the base amount for the Basic Daily Fee by $10 per resident per day, for all residents. The additional funding should be only provided on the condition that the provider gives the Australian Government a written undertaking that:		Determining the level of Basic Daily Fee for aged care is out of scope for the AMA.
82.1.	(a) it will conduct an annual review of the adequacy of the goods and services it has provided to meet the basic living needs of residents, and in particular their nutritional requirements, throughout the preceding 12 months, and prepare a written report of the review		
82.1.	(b) the review report will set out in detail the provider's expenditure to meet the basic needs of residents, especially their nutritional needs, and changes in expenditure compared with the preceding financial year		
82.1.	(c) by 31 December each year, commencing in 2021, the governing body of the provider will attest that the annual review has occurred, and will give the review report and a copy of the attestation, to the Australian Aged Care Commission (or, pending its establishment, the implementation unit referred to in Recommendation 123)		
82.1.	(d) in the event of failure to comply with the above requirements, the provider will be liable to repay the additional funding to the Australian Government, and agrees that this debt may be set-off against any future funding as a means of repayment.		
82.2.	The Australian Government will commence payment of the additional funding to a provider within one month of the provider giving its written undertaking.		
82.3.	The results of any review may be taken into account in any reviews of the compliance of the provider with the Aged Care Quality Standards.		
Recommendation 83	**Amendments to the viability supplement**		
83.1.	With immediate effect, the Australian Government should continue the 30% increase in the viability supplement that commenced in March 2020, as paid in respect of each residential aged care service and person receiving home care, until the Aged Care Pricing Authority has determined new arrangements to cover the increased costs of service delivery in regional, rural and remote areas and has commence independent determination of prices.		Determining the level of viability supplement for aged care is out of scope for the AMA.
83.2.	For the avoidance of doubt, the increased indexation arrangements proposed in Recommendations 80 and 81 should apply in addition to the measure in this recommendation.		
Recommendation 84	**Immediate funding for education and training to improve the quality of care**		

84.1.	The Australian Government should establish a two-year scheme, commencing on 1 July 2021 to improve the quality of the current aged care workforce. The scheme should reimburse providers of home support, home care and residential aged care for the cost of education and training of the direct care workforce employed (either on a casual, part-time or full-time basis) at the time of its commencement or during the period of its operation. Eligible education and training should include:	Support	
84.1.	(a) Certificate III in Individual Support and Certificate IV in Ageing Support	Support in principle	The AMA supports in principle this recommendation on the basis that the Certificates are reviewed as recommended under 43.1.
84.1.	(b) continuing education and training courses (including components of training courses, such as 'skill sets' and 'micro-credentials') relevant to direct care skills, including, but not limited to, dementia care, palliative care, oral health, mental health, pressure injuries and wound management.	Support	
84.2.	Reimbursement should also include the costs of additional staffing hours required to enable an existing employee to attend the training or education. The scheme should be limited to one qualification or course per worker.	Support in principle	In the AMA view, there should be further elaboration on this requirement in the Royal Commission's final report, particularly what constitutes a course or qualification. The AMA supports in principle the funding/reimbursement to qualifications or courses, but does not see the need for the introduction of limiting the scheme to one per worker. Aged care providers may wish to support and retain the workers who are doing a good job and one way of doing that would be to provide them with access to courses and qualifications that would further develop their skills. Workers who have achieved multiple qualifications or courses should be valued by the aged care system as they are more likely to provide better quality care. Therefore, in the AMA view, there is no need for the Royal Commission to introduce this limitation. Defining a minimum number of courses per employer would be supported by AMA, but we do not see a justifiable reason for introducing the cap.
Recommendation 85	**Functions and purposes of the Aged Care Pricing Authority**		
85.1.	Before the establishment of the Aged Care Pricing Authority, preliminary work on estimating the costs of providing high quality aged care should be undertaken by the implementation unit referred to in Recommendation 123.	Support in principle	As explained under point 5.1, the AMA supports one pricing authority for both aged care and health care. In the AMA view, if well managed, a pricing authority has the potential to deliver cost and funding allocation transparency and ensure decisions of government and aged care providers are accountable. However, we warn that an independent pricing authority will not correct the issue of aged care underfunding, in particular under-indexation, unless the new authority is given the power to set these parameters independent of the Federal Government.
85.2.	Upon its establishment (by 1 July 2023) under the new Act, the Aged Care Pricing Authority should take over that work and all resources developed by the implementation unit.		
85.3.	The functions of the Aged Care Pricing Authority should include:		
85.3.	(a) providing expert advice to the Australian Aged Care Commission on optimal forms for funding arrangements for particular types of aged care services and in particular market circumstances	Support in principle	
85.3.	(b) reviewing data and conducting studies relating to the costs of providing aged care services	Support in principle	
85.3.	(c) determining prices for particular aged care services based on estimates of the amounts (whether constituted by government subsidies or user payments or both) appropriate to the provision of high quality and safe aged care services	Support in principle	
85.3.	(d) evaluating, or assisting the Australian Aged Care Commission to evaluate, the extent of competition in particular areas and markets	Support in principle	
85.3.	(e) advice on appropriate forms of economic regulation, and implementation of such regulation, where necessary.	Support in principle	
85.4.	In undertaking its functions, the Aged Care Pricing Authority should be guided by the following objects:	Support in principle	
85.4.	(a) ensuring the availability and continuity of high quality and safe aged care services for people in need of them	Support in principle	
85.4.	(b) ensuring the efficient and effective use of public funding and private user contributions in the provision of high quality and safe aged care services	Support in principle	
85.4.	(c) promoting efficient investment in the means of supply of high quality and safe aged care services in the long term interests of people in need of them	Support in principle	
85.4.	(d) promoting the development and retention of a highly motivated and appropriately skilled and numerous workforce necessary for the provision of high quality and safe aged care services in the long term interests of people in need of them.	Support in principle	
Recommendation 86	**Requirement to participate in Aged Care Pricing Authority activities**		
86.1.	By 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require participation by approved providers in cost data reviews.	Support in principle	
86.2.	By 1 July 2023, the new Act should require that as a condition of approval or continued approval, aged care providers are required to participate in any activities the Aged Care Pricing Authority requires to undertake its functions, including transmitting cost data in a format required by the Authority for the purposes of costing studies. The Aged Care Pricing Authority should take costs associated with these activities into account when determining funding levels.	Support in principle	
Recommendation 87	**Services to be funded through a combination of block and activity based funding**		
87.1.	The Aged Care Pricing Authority should advise the Australian Aged Care Commission on the combination and form of block and activity based funding that should be adopted for social supports, respite, and assistive technology and home modifications, having regard to the characteristics of these services and market conditions where they are delivered.		Determining the right combination of block and activity funding is out of scope for the AMA.
Recommendation 88	**Case mix-adjusted activity based funding in residential aged care**		
88.1.	By 1 July 2022, the Australian Government should fund approved service providers for delivering residential aged care through a case mix classification system, such as the Australian National Aged Care Classification (AN-ACC) model. The classification system should take into account the above recommendations for high quality aged care. On-going evidence-based reviews should be conducted thereafter to refine the model iteratively, for the purpose of ensuring that the model accurate classification and funding to meet assessed needs.	Support	AMA position on the new AN-ACC funding model is elaborated in our submission to the New Funding Model consultation: https://ama.com.au/submission/ama-submission-department-health-%E2%80%93-proposal-new-residential-aged-care-funding-model

88.2.	The implementation date of 1 July 2022 is needed to support Recommendations 46.2 and 46.3. However, the independent pricing capability referred to in Recommendations 5 and 85 is unlikely to be developed by that time. Therefore an estimated National Weighted Average Unit (NWAU) for interim application of a case mix-adjusted funding model such as AN-ACC should be calculated by or on behalf of the implementation unit and applied to fund approved providers of residential care prior to the commencement of independent pricing by the Aged Care Pricing Authority.	Support in principle	The AMA acknowledges that this significant reform will need to be improved over time as unknown risks emerge. For this reason, the AMA regards the Australian National – Aged Care Classification (AN-ACC) model as a positive first step to improving the funding of the aged care sector to improve the quality of care older people receive. The AMA cautions that (National Weighted Activity Units) NWAU prices must be adequate, sufficiently indexed, and adjusted for staff wages growth so quality care is not compromised by a lack of funding. The AMA urges the Department to consider the existing issues under the hospital NWAU system under the AN-ACC model context.
Recommendation 89	**Maximum funding amounts for care at home**		
89.1.	With effect from 1 July 2024, the Australian Government should ensure that the maximum Commonwealth funding amount available for a person receiving care at home is the same as the maximum Commonwealth funding amount that would be made available to provide care for them if they were assessed for care a residential aged care service.		The AMA does not have a position on the maximum Commonwealth funding that should be available for a person receiving care at home. The AMA however warns that the cost of provision of care in a residential facility factors in all relevant costs, including the capital costs, costs of utilities, as well as costs of running the facility as opposed to the person's home.
Recommendation 90	**Framework for the assessment of funding to incentivise an enablement approach to residential care**		
90.1.	From 1 July 2022, the following enablement incentives should be incorporated into the rules, principles and guidelines for assessment and funding eligibility:	Support	
90.1.	(a) where reassessment determines that a person is entitled to a higher level of funding, and the approved provider can demonstrate that they have been providing the higher level of care then it should be eligible for back-payment to the date that the reassessment was requested	Support	
90.1.	(b) in order to promote an enablement approach in care at a residential aged care home, a resident should not be required to be reassessed if their condition improves under the care of a provider.	Support	
Recommendation 91	**Reporting of staffing hours**		
91.1.	From 1 July 2022, the *Accountability Principles 2014* (Cth) should be amended to require any approved providers of residential aged care to provide reports, on a quarterly basis in standard form reports, setting out total direct care staffing hours provided each day at each facility they conduct, broken into different employment categories (including personal care workers, enrolled nurses engaged in direct care provision, registered nurses engaged in direct care provision, and allied healthcare professionals engaged in direct care provision).	Support	
Recommendation 92	**Payment on accruals basis for care at home**		
92.1.	By 1 September 2021, home care providers should commence invoicing and receipt of payments from the Australian Government out of their clients' home care packages on an accruals basis, only once services have been delivered or the liability to deliver them has been incurred.	Support	
Recommendation 93	**Standardised statements on services delivered and costs in home care**		
93.1.	The Australian Government should develop and implement a standardised statement format for home care providers to record services delivered and costs incurred on behalf of home care package holders. From 1 July 2022, providers should be required to issue completed statements in the standardised format to people receiving their care on a monthly basis.	Support	
Recommendation 94	**Fees for social supports, assistive technology and home modifications**		
94.1.	Individuals receiving social supports, assistive technology and home modifications should be required to make nominal co-payments for the services that they receive.		The AMA does not have a position on co-payments for aged care.
94.2.	The levels of these notional co-payments should be set in the new Act.		
Recommendation 95	**Fees for respite care**		
95.1.	Individuals receiving respite care should be required to contribute to the costs of the services that they receive associated with ordinary costs of living and additional services. They should not be required to contribute to the costs of the accommodation and care services that they receive.		The AMA does not have a position on co-payments for aged care.
95.2.	The level of any payment for the ordinary costs of living should be determined from time to time by the Australian Aged Care Pricing Authority.		
Recommendation 96	**Fees for care at home**		
96.1.	Individuals receiving care at home should not be required to contribute to the costs of any care services that they receive. They should, however, be required to make nominal co-payments for any domestic assistance services that they receive.		The AMA does not have a position on co-payments for aged care.
96.2.	The levels of these notional co-payments should be set in the new Act.		
Recommendation 97	**Fees for residential aged care – ordinary costs of living**		
97.1.	From 1 July 2023, the amount that providers should be paid for services that are associated with ordinary costs of living should be determined by the Aged Care Pricing Authority. Funding for this amount should be provided by:		The AMA does not have a position on the amounts that should be paid to aged care providers for ordinary cost of living.
97.1.	(a) a basic fee paid by the resident equal to 85% of the maximum amount of the basic age pension		
97.1.	(b) a means tested fee paid by the resident		
97.1.	(c) a subsidy paid by the Australian Government to make up any gap.		
97.2.	The means tested fee should have the following features:		
97.2.	(a) it should be zero for anyone in receipt of the full pension		
97.2.	(b) it should be recalibrated to achieve progressively greater contributions from people who have greater levels of assets and income without imposing hardship, or arbitrary outcomes on people in certain asset or income brackets		
97.2.	(c) non-pensioners should be required to pay the full costs of ordinary living (without any contribution by the Australian Government).		
Recommendation 98	**Repeal co-contributions for care component of funding in residential care**		
98.1.	From 1 July 2023, the means tested daily care fee for care provided in residential care facilities should be repealed.		The AMA does not have a position on co-contributions.

Recommendation 99	**Reform of means testing for accommodation charges**		
99.1.	From 1 July 2023, the maximum amount that the Australian Government will pay for a person's accommodation costs in residential aged care should be determined by the Aged Care Pricing Authority.		The AMA does not have a position on means testing for accommodation charges.
99.2.	The amount payable in respect of any individual should be determined by a means test that is calibrated to achieve progressively greater contributions from people who have greater levels of assets and income without imposing hardship, or arbitrary outcomes on people in certain asset or income brackets.		
99.3.	Where a resident is eligible under this means test for some Australian Government assistance with their accommodation costs then the fee that they can be charged is capped at the amount worked out by the means test.		
99.4.	Where a resident is not eligible for any Australian Government assistance with their accommodation costs then the fee that they can be charged should be not be price-capped, but should remain subject to a provisional upper limit (to be set by the Aged Care Pricing Authority from time to time) that may be raised upon application by the approved provider to the Authority.		
	Prudential regulation and financial oversight		
Recommendation 100	**Prudential regulation by the Australian Aged Care Commission**		
100.1.	From 1 July 2023, the Australian Aged Care Commission should be given the statutory role as the prudential regulator for aged care with responsibility for ensuring that, under all reasonable circumstances, providers of aged care have the ongoing financial capacity to deliver high quality care and meet their obligations to repay accommodation lump sums as and when the need arises.	Support in principle	The AMA does not have a position on prudential regulation. However, we do support ensuring that older people are not abandoned in the situation where an aged care provider is no longer financially capable of providing the service.
100.2.	The Commission should also be given the statutory role of developing and implementing an effective financial reporting framework for the aged care sector that complements the purposes of the prudential standards.	Support in principle	
100.3.	The Presiding Commissioner shall allocate the responsibilities associated with prudential oversight and the establishment of an effective financial reporting framework to an Assistant Commissioner.	Support in principle	
Recommendation 101	**Establishment of prudential standards**		
101.1.	From 1 July 2023, the Australian Aged Care Commission should be empowered to make and enforce standards relating to prudential matters that must be complied with by approved providers.	Support in principle	The AMA does not have a position on prudential regulation, but we expect the regulation to ensure that the aged care providers have sufficient capacity to provide care to recipients of aged care and that there is sufficient transparency of expenditure by the providers.
101.2.	In this context prudential matters are matters relating to:		
101.3.	(a) the conduct of the affairs of approved providers in such a way as to: i. ensure that providers remain in a sound financial position, or ii. ensure continuity of care in the aged care system, or	Support in principle	
101.4.	(b) the conduct of the affairs of approved providers with integrity, prudence and professional skill.	Support in principle	
Recommendation 102	**Liquidity requirements**		
102.1.	From 1 July 2023, the Australian Aged Care Commission should be empowered under statute to impose liquidity requirements on approved providers of residential aged care which hold refundable accommodation deposits, for the purpose of ensuring that such providers are able to repay refundable accommodation deposits promptly as and when required without jeopardising their financial viability.		The AMA does not have a position on liquidity requirements.
Recommendation 103	**Capital adequacy requirements**		
103.1.	From 1 July 2023, the Australian Aged Care Commission should be empowered under statute to impose capital adequacy requirements on approved providers for the purpose of ensuring that providers maintain adequate net assets above the liabilities they owe.		The AMA does not have a position on capital adequacy requirements.
Recommendation 104	**More stringent financial reporting requirements**		
104.1.	From 1 July 2023, the Australian Aged Care Commission should be empowered under statute to require approved providers to submit regular financial reports.	Support	The AMA supports more stringent financial reporting and greater transparency of expenditure by aged care providers. The AMA supports the same level of financial transparency in aged care as that required from Australia's public hospital system. As the majority of funding for aged care comes from the Government and taxpayers, the AMA believes that the public have a right to know how the funds are being spent. Full detail on AMA position on financial transparency can be viewed in our submission to the Senate Community Affairs Legislation Committee inquiry into the Aged Care Legislation Amendment (Financial Transparency) Bill 2020: https://ama.com.au/articles/ama-submission-aged-care-legislation-amendment-financial-transparency-bill-2020.
104.2.	The frequency and form of the reports should be prescribed by the Commission.	Support	
Recommendation 105	**Continuous disclosure requirements in relation to prudential reporting**		
105.1.	From 1 July 2023, approved providers should be required under statute to comply with continuous disclosure requirements, under which an approved provider that becomes aware of material information that:	Support in principle	See our comment under 104.
105.1.	(a) affects the provider's ability to pay its debts as and when they become due and payable, or	Support in principle	
105.1.	(b) affects the ability of the provider or any contractor providing services on its behalf to continue to provide aged care that is safe and of high quality to individuals to whom it is currently contracted or otherwise engaged to provide aged care must immediately disclose the information to the Commission.	Support in principle	
105.2.	The Australian Aged Care Commission should have the power to designate events, facts or circumstances that should give rise to continuous disclosure obligations.	Support in principle	
Recommendation 106	**Tools for enforcing the prudential standards and guidelines and financial reporting obligations of providers**		
106.1.	From 1 July 2023, the Australian Aged Care Commission should have the power to impose a range of regulatory responses where there has been a breach of the new prudential standards or the financial reporting requirements, including a failure to comply with the continuous disclosure requirements.	Support in principle	

106.2.	Such responses should include:	Support in principle	
106.2.	(a) the power to give directions to a provider that mirror those that can be made by the Australian Prudential Regulatory Authority pursuant to the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth)	Support in principle	
106.2.	(b) the power to impose civil and administrative penalties in respect of any breach	Support in principle	
106.2.	(c) the ability to accept enforceable undertakings	Support in principle	
106.2.	(d) the ability to impose sanctions to limit the ability of the provider to expand its services, revoke accreditation for a service, or revoke approved provider status.	Support in principle	
Recommendation 107	**Building the capability of the regulator**		
107.1.	In establishing the Australian Aged Care Commission, the Australian Government should ensure that its prudential capability in relation to the aged care sector includes the following:	Support in principle	
107.1.	(a) an effective program to recruit and retain senior forensic accountants and specialists with prudential regulatory experience, and sufficient numbers of supporting employees who have either accounting qualifications or other financial skills	Support in principle	
107.1.	(b) systems and processes to capture, collate, analyse and share regulatory intelligence from internal and external sources to build a risk profile of approved providers	Support in principle	
107.1.	(c) a system and processes to monitor indicators of risk revealed by providers' financial reporting tailored to the aged care sector and to respond to them in a timely manner	Support in principle	
107.1.	(d) an electronic forms and lodgement platform for the use of all large operators, with an optional alternate electronic filing system available for smaller operators	Support in principle	
107.1.	(e) appropriate resourcing of the above system and processes, including design expertise, Information Communications Technology requirements, technical support, and recruitment and training of sufficient numbers of appropriately skilled staff.	Support in principle	
Recommendation 108	**Requirement to report on outsourcing of care management**		
108.1.	From 1 July 2022, the *Accountability Principles 2014 (Cth*) should be amended to require that aged care providers approved to provide residential care or personal care services at home notify the Australian Aged Care Commission of any proposed sub-contracting of general management of care before the arrangement takes effect.	Support	
Recommendation 109	**Effective regulation** **Civil penalty for certain contraventions of the general duty**		
109.1.	The new Act should provide that:		
109.1.	(a) on application by the Australian Aged Care Commission to a court of competent jurisdiction, the following is a contravention of the Act attracting a civil penalty: i. a breach by an approved provider of the general duty to provide high quality and safe aged care so far as reasonable (see Recommendation 22), and ii. where the breach gives rise to harm, or the risk of harm, to a person whom the provider is providing care or engaged under a contract or understanding to provide care; and iii. where a failure to provide 'high quality' care is taken to occur if and only if the approved provider has failed to comply with one or more of the Aged Care Quality Standards	Support in principle	The AMA supports in principle this recommendation. Medical practitioners are subject to a comprehensive regulatory framework which covers many of the issues raised here. The AMA supports a similar outcome for the aged care providers as we believe that they should also be well regulated.
109.1.	(b) the contravention attracts a civil penalty, and attracts accessorial liability for directors, key personnel and any other person who: i. aids, abets, counsels or procures the approved provider to commit the contravention ii. induces the approved provider to commit the contravention iii. is in any way, directly or indirectly, knowingly concerned in, or party to, the contravention by the approved provider (who should be defined as a person 'involved in the contravention').	Support in principle	
Recommendation 110	**Private right of compensation for certain contraventions of the general duty**		
110.1.	The new Act should provide:		
110.1.	(a) that an order may be made on the application of the Australian Aged Care Commission to a court of competent jurisdiction that an approved provider that has contravened the civil penalty provision (referred to in Recommendation 109), or a person involved in the contravention, pay damages for any loss and damage suffered by a person as a result of the contravention, and	Support in principle	The AMA supports in principle this recommendation. Also, see our comment under 109.1.
110.1.	(b) for a private right of action for damages in a court of competent jurisdiction by or on behalf of a person who has suffered loss and damage as a result of any such contravention, in which proceeding any findings or admissions of the contravention in another proceeding may be adduced in evidence as proof that the contravention occurred.	Support in principle	
Recommendation 111	**A wider range of enforcement powers**		
111.1.	The new Act should confer on the quality regulator:		
111.1.	(a) a wider range of enforcement powers, including enforceable undertakings, infringement notices and banning orders	Support	
111.1.	(b) the power to impose a sanction suspending or removing the group of people responsible for the executive decisions of a provider and appoint an external administrator of the provider, or manager of specified assets or undertakings of the provider	Support	
111.1.	(c) the power to impose a sanction to be applied to a non-compliant provider revoking the provider's approval unless the provider agrees to the appointment of an external administrator or manager.	Support	
Recommendation 112	**Strengthened powers for the quality regulator to undertake investigations and inquiries**		

112.1.	From 31 December 2021, the *Aged Care Quality and Safety Commission Act 2018* (Cth) should be amended to confer on the Aged Care Quality and Safety Commissioner the following additional statutory functions and powers, to be exercised in connection with, or for the purposes of, its functions conferred by that Act:	Support	
112.1.	(a) the function of conducting inquiries, including into complaints (see Recommendation 114) or reported serious incidents (see Recommendation 118)	Support	
112.1.	(b) a power to enter and search the premises of residential aged care facilities and other non-residential aged care workplaces without warrant or consent	Support	The AMA supports this recommendation. However, in order to properly implement this function, the AMA believes that the Aged Care Quality and Safety Commission should increase the number of accreditation auditors who have experience in clinical care. Also, Accreditation audits to focus more on quality care than documentation compliance – the accreditation process should ensure that quality of care is considered a more essential indicator of quality than the existence of paperwork.
112.1.	(c) a power to compel the production of documents and information relevant to the performance of its functions	Support	
112.1.	(d) a power to compel by notice an officer, employee or person acting on behalf of an approved provider to appear before an officer authorised by the quality regulator for examination.	Support	
112.2.	The new Act should confer on the Australian Aged Care Commission responsibility for general administration of the Act. The new Act should authorise the Commission to conduct inquiries and exercise any of its powers for the purpose of the general administration of the Act.	Support	
112.3.	For the avoidance of doubt, these powers should also be available to Aged Care Quality and Safety Commission and subsequently the Australian Aged Care Commission for the purposes of their prudential regulatory and financial risk monitoring functions.	Support	
Recommendation 113	**Greater weight to be attached to consumer experience**		
113.1.	From 1 July 2021 onwards, the quality regulator, whether it be the Aged Care Quality and Safety Commissioner or the Australian Aged Care Commission, should:	Support	
113.1.	(a) ensure that consumer experience reports for a service are informed by consumer experience interviews with at least 20% of care recipients or services users (or their families)	Support	The AMA supports this recommendation. The AMA however warns that the 20% of care recipients need to include a certain proportion/percentage of special needs groups CALD, ATSI and LGBTI. That proportion/percentage should be pre-defined by the Commission, in order to enable adequate capturing of experiences of all those receiving care.
113.1.	(b) take consumer experience reports into account in accreditation, assessment and compliance monitoring processes	Support	
113.1.	(c) publish consumer experience reports for each aged care service, informed by consumer experience interviews	Support	
113.1.	(d) establish channels (including an on-line mechanism) to allow aged care recipients and their families to report their experiences of aged care and the performance of aged care providers, all year round.	Support	
Recommendation 114	**Improved complaints management**		
114.1.	The new Act should provide that at all times one or more of the Assistant Commissioners of the Australian Aged Care Commission ('Complaints Commissioner') be designated to exercise and perform:	Support	The AMA supports this recommendation. The AMA Resourcing Aged Care Position Statement 2018 envisages an independent body (for example, an Aged Care Ombudsman) for relevant parties to report and appropriately address concerns regarding aged care.
114.1.	(a) the functions of: i. complaints handling ii. complaints referral and coordination iii. promoting open disclosure and publishing information about complaints iv. consideration and determination of requests to maintain confidentiality of the identity of complainants	Support	
114.1.	(b) in relation to these functions, powers to: i. apply enforceable undertakings, whereby the provider agrees to take certain steps or actions ii. issue directions to providers iii. refer complaints to a more appropriate complaints body or regulator, and to obtain information on the action taken, if any, by that complaints body or regulator	Support	
114.1.	(c) before deciding to close a complaint or continue an investigation, a duty to advise complainants of the proposed outcome of complaints, and seek their views on: i. the way the process has been handled by the Commission ii. the provider's response to the process iii. the proposed outcome of the process	Support	
114.1.	(d) a duty to publish reports at least every six months on: i. the number of complaints received ii. the subject matter of complaints by general topic iii. the number of complaints by provider and service iv. the outcomes of complaints v. the average time for conclusion of complaints vi. satisfaction with the outcomes of the complaints handling process.	Support	
114.2.	The new Act should provide that complaints are to be made to the Australian Aged Care Commission at first instance. If a complainant is not satisfied with the Commission's handing of a complaint or the outcome, the complainant may refer the matter to the Inspector-General. The Commission should refer to the Inspector-General any complaints about the Commission itself, its performance of its functions and exercise of its powers.	Support	
114.3.	The new Act should also set out the role of advocates in the complaints processes of the Commission and the Inspector-General.	Support	
Recommendation 115	**Protection for whistle-blowers**		
115.1.	The new Act should contain comprehensive whistle-blower protections for:	Support	

115.1.	(a) people receiving aged care, their family, carer, independent advocate or significant other	Support	
115.1.	(b) an employee, officer, contractor, or member of the governing body of an approved provider who makes complaints or reports suspected breaches of quality and safety standards or other requirements of the Act.	Support	The AMA supports this recommendation and has recommended that the safeguards for whistle-blowers are put in place in our submission to the Royal Commission. As evidenced by many case studies presented to the Royal Commission, abuse and neglect of older persons in RACFs can be systemic and implemented at the management level. The role of whistle-blowers in such cases then becomes crucial. In the AMA view, it is important that relevant safeguards are put in place for the protection of whistle-blowers as well as regulation for urgent mandatory investigations where concerns have been raised. Whistle blowers can often be employees of RACFs who have little or no awareness of protections available to them, who may be of lower socio-economic background, and prevented from speaking because of fear of losing their job. Noting the workforce can be from a range of different cultural backgrounds, with potentially low English language proficiency, and often limited by the type of visa that allows them to work in Australia, the fear of speaking up can be significant. In the AMA view, putting in place relevant legislated safeguards for them may help lead to earlier identification of concerns and ultimately to the improvement of services provided to older people in aged care.
Recommendation 116	**Graded assessments and performance ratings**		
116.1.	From 1 July 2021, the Aged Care Quality and Safety Commissioner should adopt a graded assessment of service performance against the Aged Care Quality Standards.	Support	The AMA supports the introduction of a graded system for service performance. In the AMA view, this will help older people and their carers make informed choices about their care, by being able to compare different providers.
116.2.	The Australian Aged Care Commission should continue to use graded assessment from 1 July 2023 onwards.	Support	
Recommendation 117	**Star ratings: performance information for people seeking care**		
117.1.	By 1 July 2022, the Australian Government should develop and publish a system of star ratings based on objective and measurable indicators that allow older people and their families to make meaningful comparisons of the quality and safety performance of providers. The star ratings and accompanying material should be published on My Aged Care.	Support	
117.2.	The star ratings should incorporate a range of measurable data and information including, at a minimum:	Support	
117.2.	(a) graded assessment of service performance against standards	Support	
117.2.	(b) performance against relevant clinical and quality indicators	Support	
117.2.	(c) staffing levels	Support	
117.2.	(d) robust consumer experience data, when available.	Support	
117.3.	The overall star rating should be accompanied by appropriate additional information on performance and outcomes, in a readily understandable form and capable of comparison across providers. This should include all performance information that is relevant to the performance of a service provider, even if it is not reflected in the overall star rating outcome. For example, it should include:	Support	
117.3.	(a) details about current and previous assessment by the quality regulator, whether it be the Aged Care Quality and Safety Commissioner or the Australian Aged Care Commission, including notices of non-compliance, sanctions, withdrawal of accreditation or approved provider status	Support	
117.3.	(b) benchmarked performance for all quality indicators that are suitable for publication, including changes in performance over time	Support	
117.3.	(c) consumer experience information	Support	
117.3.	(d) serious incident reports data	Support	
117.3.	(e) complaints data.	Support	
117.4.	The Australian Aged Care Commission should assume responsibility for the star ratings system from 1 July 2023 onwards.	Support	
Recommendation 118	**Serious incident reporting**		
118.1.	The Australian Government should, in developing a new and expanded serious incident reporting scheme:	Support	The AMA supports this recommendation. The AMA has in the past called for guidelines around the timeliness of the response of the oversight body. While the time required to conduct an incident investigation will vary, there should ideally be guidelines or requirements for the maximum time an investigation's (initial and final) response should take, perhaps varying with varying severity of the incident (risk matrix guided). This may aid the perception of responsiveness and transparency of such a body, and assist whistle-blowers, residents, families and staff members practically and emotionally in the event of a serious incident. It may also assist with the resourcing of the body. The AMA also calls for a clinician (with experience in older people) to be involved in conducting a screening and assessment of each case to ensure that it is in fact a 'serious incident'. This would also allow the aged care workforce to have greater confidence that this is really about serious incidents assessed by people who actually understand how challenging it can be working in aged care. The AMA is aware that a consultation process is already occurring for a Serious Incident Reporting Scheme and this process should be considered before developing a completely new Scheme.
118.1.	(a) ensure that the new scheme: i. includes all serious incidents, including in home care, regardless of whether the alleged perpetrator has a cognitive or mental impairment ii. supports the matching of names of individuals accused of being involved in a serious incident with previous serious incident reports	Support	
118.1.	(b) require the quality regulator to publish the number of serious incident reports on a quarterly basis at a global level, at a provider level, and at a service or facility level	Support	

118.1.	(c) confer a statutory power on the quality regulator to: i. requisition a plan of responsive action from a provider who has reported a serious incident ii. obtain evidence from the provider to satisfy itself that the responsive action has been taken and is effective iii. satisfy itself as to whether or not the responsive action has been taken and is effective iv. require the provider to take further or additional steps, in circumstances where the quality regulator is not satisfied with the effectiveness of the responsive action.	Support	
Recommendation 119	**Responding to coroner's reports**		
119.1.	The new Act should provide that the Australian Aged Care Commission is required to:	Support	
119.1.	(a) maintain a publicly available register of reports made to the Australian Aged Care Commission or other Commonwealth entity by a State or Territory coroner that involve the death of a person in aged care	Support	
119.1.	(b) publish a response to the report on the publicly available register within three months of its receipt	Support	
119.1.	(c) provide annual reports to the Inspector-General of Aged Care detailing any action taken in response to coroner's reports, and assessment of the impact of such action.	Support	
Recommendation 120	**Approval of providers**		
120.1.	The new Act should provide for the commencement by 1 July 2024 of new approval requirements for all aged care providers to ensure their suitability, viability and capability to deliver the kinds of services for which they receive subsidies.	Support	
120.2.	Applicants for approval as a provider or existing approved providers may seek approval from the Australian Aged Care Commission to provide particular kinds of aged care services, or general approval to provide all kinds of aged care services attracting Australian Government funding.	Support	
120.3.	A current approved provider should be taken to be approved to provide the kinds of services they have been regularly providing from the commencement of 12 months prior to the commencement of the new Act (or since their approval, whichever is more recent), and there should be an administrative process to record all such approved providers' scopes of approval.	Support	
Recommendation 121	**Requirement of continuing suitability for approval**		
121.1.	The new Act should provide that approvals are ongoing but subject to continuing suitability, including (in addition to the matters referred to in sections 63D and 63J of the *Aged Care Quality and Safety Commission Act 2018* (Cth)), the fitness and propriety of the provider and its key personnel, the provider's capacity to deliver high quality and safe services within its scope of approval, and the provider's performance in delivering high quality and safe services of the kinds for which they are approved.	Support	
121.2.	In cases where the Australian Aged Care Commission becomes aware the approved provider may no longer be suitable to remain a provider or to retain its current scope of services for which it is approved, the Commission must consider on notice to the provider whether to revoke the provider's approval or limit its scope of approval.	Support	
Recommendation 122	**Aged Care Quality and Safety Commission capability review**		
122.1.	The Australian Government should urgently conduct a review of the capabilities of the Aged Care Quality and Safety Commission, including its assessor workforce, and should take any necessary steps to enhance the Aged Care Quality and Safety Commission's capabilities in light of the outcome of the review.	Support	The AMA supports this recommendation. The AMA has previously warned how the impact of the COVID-19 pandemic in the aged care sector has brought to the forefront the need for a stronger role of the Commission. The AMA has called for an increase in number and improved capacities of the assessor workforce, including increase in number of assessors who have clinical skills. In the AMA view, currently the Commission lacks capacity to ensure the implementation of the Charter of Aged Care Rights and to adequately sanction the aged care providers who fail to meet the quality standards.
	Transition and implementation		
Recommendation 123	**An implementation unit**		
123.1.	Pending the establishment under the new Act of the Australian Aged Care Commission, an administrative unit or body should forthwith be established by the Australian Government (through the Australian Department of Prime Minister and Cabinet) and properly staffed and resourced to implement and direct implementation of the Royal Commission's recommendations (**implementation unit**).	Support	The AMA supports this recommendation. In the AMA view the implementation of the new arrangements and the Royal Commission's recommendations should start as soon as possible.
123.2.	Pending the establishment of the office of the Inspector-General of Aged Care under the new Act, an officer should be appointed to the role of Inspector-General under temporary administrative arrangements. That officer should monitor the implementation of recommendations and should report to the responsible Minister and to the Parliament at least every six months on the implementation of the recommendations.	Support	
123.3.	From the commencement of the new Act, the Australian Aged Care Commission should implement and direct implementation of the recommendations of the Royal Commission. The Inspector-General of Aged Care should continue to monitor and report on the implementation of recommendations, in accordance with the requirements of that Act.	Support	
Recommendation 124	**Evaluation of effectiveness**		
124.1.	The Inspector-General of Aged Care should undertake independent evaluations of the effectiveness of the measures and actions taken in response to the recommendations of the Royal Commission, five and ten years after the tabling of the Final Report.	Support	The AMA supports this recommendation. In our submission to the Royal Commission, the AMA called for a scientific evaluation of the impact of government policies on the wellbeing of older Australians. This will lead to proper policy adjustments and revisions as needed.
Additional matters raised in Counsel Assisting's final submissions			
Paragraph reference	**Subject of additional matters**		
Para 312 – 314	My Aged Care and improved provider search function		
Para 333 – 351	Care at home		
Para 340 – 345; 356 – 364	Allied health care		
Para 636(c) and 658	Workforce: short term arrangement to increase wages		

Para 711 – 726	Direct employment of care workers		
Para 770 – 771	Informal carers: leave entitlement		
Para 1321 – 1324; 1326	Financing		
Para 1339 – 1345	Capital financing		

Request for public response to remarks made by Commissioner Briggs			
Transcript reference	**Subject of remarks made by Commissioner Briggs**		
T9691.11–42	Aged care policy principles		
T9699.29–9701.37	System design and governance		
T9710.20–9711.21	Program management		
T9723.17–9724.12	Restraints		
T9751.27–9752.24	Provider leadership and culture		
T9756.41-9757.18	Research and data governance		
Transcript of 23 October 2020	Capital financing		