THE LAW SOCIETY
OF NEW SOUTH WALES

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Dear Dr Popple,

REVIEW OF AGED CARE RULES

Thank you for the opportunity to contribute to the Law Council of Australia's submission in response to the Review of Aged Care Rules. The Law Society's Elder Law, Capacity and Succession Committee contributed to this submission.

Section 602(12) of the *Aged Care Act 2024* (Cth)(**Act**) requires that the Senate Community Affairs Legislation Committee begin a review of any rules made for the purposes of the below listed provisions, within three months after the day the rules are tabled in the Senate. The *Aged Care Rules 2025* (**Rules**) and the *Aged Care (Consequential and Transitional Provisions) Rules 2025* (**Consequential Rules**) (together the '**Collective Rules**') were tabled in the Senate on 27 October 2025 and 29 October 2025 respectively. Our submission focuses on rules provided for by virtue of section 17 of the Act, relating to restrictive practices in relation to an individual, and under Chapter 4 of the Act, which deals with funding of aged care services.

Section 17 – Restrictive practice in relation to an individual

Our members observe that, in NSW, there are differing interpretations of the requirements of the State and Commonwealth law in relation to restrictive practices, not only among legal practitioners, but also medical practitioners and hospitals. Issues observed by our members include:

- General Practitioners' (**GPs**) views regarding what constitutes a restrictive practice often differ from the Commonwealth legal definition. If a GP disagrees that a practice constitutes a restrictive practice, it creates difficulties for aged care providers seeking to obtain consent from substitute decision-makers regarding the use of such a practice;
- a lack of awareness among many legal practitioners that an appointment of enduring guardianship with health or medical and dental functions is not adequate to support consent to restrictive practices, and that explicit inclusion of restrictive practices in the appointment instrument is needed;

- a resulting lack of understanding, especially among family members, about why state-based substitute decision-making instruments, such as an appointment of an enduring guardian prepared by their lawyers, are not adequate for consenting to restrictive practices; and
- a lack of awareness in hospitals that residential aged care homes do not have the same rights to use restrictive practices as hospitals. Consequently, members have observed, at times, that residents subject to restrictive practices may revert to their former behaviours after chemical or mechanical restraints either wear off or are removed after discharge. Members observe that such occurrences can lead to repeated admissions to hospital or, if the hospitals or ambulances refuse to take the resident, may risk potential harm to staff in residential aged care.

In relation to differing interpretations of restrictive practice, the definitions of 'restrictive practice' under section 17-5 of the Rules refer to restraints 'for the primary purpose of influencing an individual's behaviour', and chemical restraint explicitly excludes the use of medication prescribed for a diagnosed mental disorder, a physical illness or condition and end-of-life care for the individual. In our members' experience, a GP may provide an opinion on providing a chemical restraint to assist an individual who has a clear condition or illness arising from the natural incidence of ageing, rather than to restrain the individual because they are causing themselves or others harm.

However, the treatment arising from this opinion may constitute a 'restrictive practice' under the Act, if it is judged to be for the 'primary purpose' of influencing the individual's behaviour. The definition seeks to identify a specific and clearly defined condition, whereas the approach of the GP may be to take a broader, holistic, whole-of-person approach. The issue is that ageing, in itself, gives rise to mental disorders, illnesses and physical conditions that may not be strictly categorised as narrowly as the Act requires, but which manifest themselves as behaviours that impact the individual or others. The problem is the inherent ambiguity and conflict between the holistic assessment made as to whether the restraint recommended or prescribed by the GP is being made to treat the symptom or the cause of the behaviour. In both cases, the prescription is designed to influence and remove negative behaviours to avoid harm or further deterioration to the individual or others. The requirement for the primary purpose to be limited to influencing an individual's behaviour may be overly simplistic.

Further, our members note the practical difficulty of applying the Commonwealth legal definition of restrictive practice in NSW. For example, a GP prescribing a psychotic medication that influences the individual's behaviour, which would be regarded as a restrictive practice under the Act, requires, in NSW, consent from an enduring guardian with a restrictive practices authority, if the individual has lost capacity. Without an appointment of an enduring guardian with a restrictive practices authority, an application must be made to the Guardianship Division of the NSW Civil and Administrative Tribunal for the appointment of a guardian with a restrictive practices authority, or a variation to an existing suitable instrument for the authority. To support the application, the GP must complete supporting documents or a Health Professional Report Form.[1] However, as explained above, some GPs may disagree that the medication is a restrictive practice, leading to difficulties for

[1] https://ncat.nsw.gov.au/documents/forms/gd_form_health_professional_report_form.pdf.

legal practitioners or family members in obtaining guardianship appointment with a restrictive practices authority.

In our members' experience, those working in the aged care sector are caught in a difficult position when it comes to responding to potentially challenging behaviours among residents, notwithstanding that every effort is made to avoid using restrictive practices. The cohort comprises not only those with dementia related conditions (many of whom show no violent tendencies), but also those with acquired brain injury, long-term psychiatric patients who have grown older and developed geriatric conditions, or those with degenerative brain disorders that can include violent behaviours, such as Huntington's disease. The lack of purpose-built and adequately funded and resourced residential care facilities for older people with extreme behaviours also contributes to the difficulty for aged care providers in balancing the safety and rights of the older people, with the workplace health and safety of staff.

Chapter 4 – Funding of aged care services

We note that practical insights into the operation of funding changes under the new Act and Collective Rules are limited at this early stage, as the Act and Collective Rules were only implemented from 1 November 2025. This is partly because, in the community context, many clients are under transitional arrangements, and the full impact of the funding changes will not be felt until there is a sufficiently large cohort of individuals under the new funding regimes.

We include below some early observations from our members.

Support at Home program

Support at Home is a program to help older people remain at home as they age by delivering coordinated care and services to meet their assessed ageing related care needs. On 1 November 2025, it replaced the Home Care Packages Program and Short-Term Restorative Care Programme.

Under Support at Home, funding is based on assessed and prioritised need, with funding for each Support at Home participant available under a 1-8 classification system. At the same time, individuals who are fully or partly self-funded are required under Chapter 4, Part 3, Division 2 of the Act to pay more for all Support at Home service types (apart from clinical services, which the Government funds).[2] Members note that, under this approach, individuals may opt to limit their use of fee or contribution-based services, due to cost considerations. This creates a risk that some supports necessary for individuals to maintain health and wellbeing may not be accessed. Where this occurs, unmet need may further poorly impact such individuals, including by potentially leading to more acute episodes, requiring hospitalisation and potentially requiring earlier entry to residential care.

We consider that, alongside clinical services, other services, which individuals may choose not to access due to cost, are essential, particularly where older people have reduced capacity to manage these needs independently. These services include:

[2] See also *Aged Care Rules 2025* (Cth) r 314-10.

- meal preparation, noting that, for older people who may not be able to prepare their own meals, access to this support remains essential to maintaining adequate nutrition, health and overall wellbeing; and
- infection control and management of environmental hazards, noting that, for older people who may have reduced capacity to identify or manage such risks, access to these supports remains essential to maintaining health, safety and wellbeing.

We suggest that comprehensive education for older persons and their authorised substitute decision makers is necessary to ensure informed decision-making under the new Act and Collective Rules. This education should cover the extent of fees and charges that individuals may be required to meet, the rationale for these costs, and any alternative strategies that may be considered, such as relocating to a more suitable environment, capable of providing the required services.

The language of the Act focuses on support at home being delivered to the individual's nominated home. Whether the home is the best place for the person to reside or contains all the elements for support to be provided is not addressed in the Act. The assumption that everyone can 'live at home' and receive all the support they require gives rise to an assumption that the Act will provide all the services to remain at home. Education around the funding arrangements should clarify the range and limitations of the services set out and available under Chapter 1, Part 3, Division 2-3 of the Rules, and the contribution rate participants would need to make to obtain such services.

Under the previous Home Care Package system, the funding level on an annual basis was preserved. However, under Support at Home, funding is based on service delivery, with excess funds retained by the Government, and invoicing for such services being undertaken on a payment in arrears basis. We acknowledge the aim of this approach is to create an equitable system. However, in practice, our members have observed that it becomes difficult for a service provider to estimate the service delivery needs across an organisation month to month, and to manage working capital requirements. This has implications for staffing and other resourcing, including the number of staff required, and whether employees or agency staff are used. This uncertainty may lead to more reliance on agencies rather than employees. We note that agency services are often more costly, and that agency staff may have less familiarity with individual clients, affecting continuity and quality of care.

Care management

Under the new Act and Collective Rules, for ongoing services, 10% is deducted from each participant's quarterly budget to fund care management activities.[3] Currently, it is unclear whether the 10% cap will be sufficient for adequate care management in all cases. In our view, with the new tiered 1-8 funding classification system and short-term pathways, including for palliative care and restorative care, care and

[3] Department of Health, Disability and Ageing, 'Funding classifications for Support at Home': https://www.health.gov.au/our-work/support-at-home/funding-for-support-at-home/funding-classifications-for-support-at-home?language=en.

services for many clients are expected to rise in complexity. In the higher tiers of funding classification, care and services may include the need for multidisciplinary interventions and multi-disciplinary teams. We note that, currently, services under Support at Home are generally provided for by individual workers in the client's home, or otherwise in the community, where the environment cannot be controlled and where, unlike residential care, supports are not immediately available. These factors have an impact on both the time and resources required for adequate care management.

We note that the minimum time-based claim that can be made for care management is specified in minutes.[4] In practice, care management is not always provided in such blocks of time. Certain forms of care management occur nearly every time a care worker or provider interacts with a client. As an example, observing the client and their environment may lead to a decision to recommend an assessment, in case there is a need for increased services, funding or a short-term pathway (such as home modification or some form of assistive technology). This may then lead to phone calls and further consideration and action over several hours or, sometimes, days.

In our view, the Government's expectations of what care management entails requires a great amount of documentation and administration. Such evidence of care management is desirable, but we query whether the administrative burden is disproportionate.

Regional and vulnerable communities

In our view, it is too early to know whether grants for thin markets, such as regional and rural areas, and for very vulnerable communities, including homeless older persons and older persons living in situations of severe hoarding and squalor, are adequate. We note that service provision in thin markets is very expensive and complicated, given the great distances that may need to be travelled, the conditions in which care and services may need to be delivered, and the difficulty of obtaining staff or agency workers away from larger centres. We also note that care and service delivery to very vulnerable communities, including those older persons who are homeless or at risk of homelessness, those who are drug or alcohol addicted, those living in poverty and more, is very complex. This is particularly so given the many factors that play into these outcomes and the need for specialised and, often, multi-disciplinary interventions.

If you have any queries about the items above, or would like further information, please contact Mimi Lee, Policy Lawyer, on 02 9926 0174 or mimi.lee@lawsociety.com.au.

Yours sincerely

Ronan MacSweeney
President

[4] Support at Home program claims and payments business rules guidance (Stage 1 – November 2025) 21.