CHAPTER FIVE:

FINANCING AGED CARE

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5.1 THE CURRENT FUNDING SYSTEM

5.1.1 RECURRENT FUNDING

Commonwealth funding for nursing home care currently falls into three categories: CAM, SAM and OCRE. Note, however, that funding structures will change with the Aged Care Reforms to be introduced on 1 October 1997.

a) CAM (Care Aggregated Module)

These funds are provided to pay for the nursing and personal care of residents. CAM funding is provided at different levels for different residents based on the level of care each resident requires. Residents are classified according to their care needs using the *Resident Classification Instrument.* This places residents into one of five categories, with Category One residents requiring the most care, and Category Five residents requiring the least. More funding is provided for those residents with higher care needs. This removes the disincentive to admit residents with greater (and thus costlier) needs.

As discussed in Chapter 2 of this Report, nursing homes are required to provide evidence that the CAM funding that they received from the Commonwealth was spent on the personal and nursing care of their residents, and not used for non-care related expenses or kept as profit. The audit process used by the Department of Health and Family Services to verify the expenditure of CAM is called validation (Senate Community Affairs References Committee, 1994: 2). Funds which are subject to a validation process are known as acquitted funds. Validation identifies any CAM funding not spent on care, and this is recovered by the Department. There is a margin of error accepted by the Department, so that if expenditure is up to 1% less than CAM funding, this may be retained by the proprietor (Gregory, 1993: 12).

b) SAM (Standard Aggregated Module)

SAM funding is for non-nursing care costs, such as food, administration, and building maintenance. SAM funding is a uniform grant, with all nursing homes receiving SAM at the same rate. Unlike CAM, any unspent SAM funds are kept by the operator as profit or surplus (Gregory, 1993: 2). This provides an incentive for operators to reduce SAM costs, so that they can increase their surplus.

c) OCRE (Other Cost Reimbursed Expenditure)

These funds are provided to reimburse staff related costs such as superannuation, workers' compensation and payroll tax. Nursing homes in each State receive OCRE at a rate based on the average costs of these staff-related expenses in their State. OCRE funds are also validated by the Commonwealth Department of Health and Family Services.

5.1.2 RESIDENT CONTRIBUTION

In addition, residents also contribute to their care costs. The standard (and maximum) contribution is 87.5% of the full single pension plus rent assistance - now $26.40 a day. A small number of nursing homes have been allowed to charge above this rate in return for a higher level of services. These homes are called "exempt" homes, and they must gain approval through a formal application process.

The key strength of the uniform maximum resident contribution is that it ensures no person with a care need is excluded from residential care due to lack of means. However, it also means that all residents pay the same amount, despite varying levels of wealth. One providers' association told the Committee:

> *we do have in nursing homes a large number of residents who are quite wealthy and simply pay, under present arrangements, 87.5 per cent of the pension as the total cost of meeting their care. That is not really appropriate; they can afford to pay more* (Bennett, Evidence - 5 May 1997).

5.1.3 CAPITAL FUNDING

Until the 1996-7 Budget, the Commonwealth contributed to the upgrading and replacement costs of nursing homes through capital grants. The amount available for capital grants has been progressively cut back in recent years, and in the 1996-7 Federal Budget, only $10 million is available in special circumstances for capital funding for residential aged care facilities (NCOSS, 1996-7: 52). The focus for the funding is on rural and remote facilities.

Under the Commonwealth's capital grant system, voluntary (non-profit) sector nursing homes could apply for capital grants for building and upgrading nursing homes. The grants contributed up to two-thirds of the cost of replacement, or one-third of the cost of upgrading. There was an indexed cap on the amount which can be paid for each bed's replacement or upgrading. In 1994 the maximum was $25,750 for bed replacement and $8,600 for upgrading. The proprietor was required to pay the

remaining costs. The amount set aside by the Commonwealth for non-profit sector capital grants varied year by year. In 1992-3, the amount provided to the voluntary sector was $10 million, compared to $1.5 million for 1993-4 (Gregory, 1994:10).

Private sector nursing homes received annual funding over a ten year period to contribute to the costs of upgrading and rebuilding. This additional funding covered approximately 20% of the cost of rebuilding and 30% of the cost of upgrading. The proprietor was required to pay the balance of the building costs. In 1992-3 $11 million was allocated for funding over a ten year period. In 1993-4, the figure was $33 million (Gregory, 1994: 10-11).

State Government Nursing Homes were and are ineligible for Commonwealth capital grants.

The capital funding system that has been in place is acknowledged by all stakeholders as having been inadequate to provide sufficient capital to ensure good quality nursing home stock. In 1993, Professor Robert Gregory was commissioned by the (then) Commonwealth Department of Human Services and Health to assess the capital funding system for nursing homes. His *Review of the Structure of Nursing Home Funding Arrangements* (1994:1) concluded that:

> *...The current system of nursing home funding does not seem to provide sufficient incentive for the maintenance of the quality of nursing home buildings and the replenishment of nursing home capital stock over time.*

For Stage Two of the Review, Professor Gregory commissioned a survey by the Australian Valuation Office to assess the quality of nursing home stock. This survey indicated a need "for substantial improvement in nursing home buildings" . The survey revealed faults that included: homes that breach fire and health regulations; bathrooms with insufficient space for a nurse to assist the resident in the shower; lack of grab rails and ramps; insufficient heating or cooling (Gregory, 1994: 3-4). The substandard homes were, and are, still operational.

Professor Gregory found that the capital funding system was largely responsible for the poor quality of nursing home buildings, noting that:

> *the lack of incentive to maintain good quality nursing home stock is a result of the funding system, under which nursing homes receive a set amount for each resident, based on resident frailty, which is the same regardless of the age or condition of the building* (Gregory, 1994: 3).

He further noted that:

> *... to upgrade or replace a nursing home would result in higher capital costs but no additional income to service the investment* (Gregory, 1994: 3).

Based on the Australian Valuation Office survey, Professor Gregory estimated that between $100 million and $125 million per year is needed to upgrade existing nursing home stock and maintain its quality (Gregory, 1994: 5).

The *Commonwealth Aged Care Act, 1997,* in particular the sections relating to facilities being given the power to raise accommodation bonds, seeks to meet these capital requirements.

5.2 NEW FUNDING ARRANGEMENTS: FROM 1 OCTOBER 1997

5.2.1 RECURRENT FUNDING

The main change to be introduced in October 1997 in relation to recurrent funding is that funding will no longer be separated into CAM, SAM and OCRE, and care related funds will not be quarantined and validated. This was briefly mentioned in Chapter Two.

Witnesses and submissions revealed considerable apprehension about the likely impact of a change to a non-acquitted recurrent funding system without the CAM/SAM distinction. The Council on the Ageing, for instance, submitted:

> *Combining the CAM/SAM allocation will almost certainly have a deleterious effect on funds allocated to adequately qualified care staff* (Submission 36).

The NSW Nurses' Association gave evidence that the change to:

> *a single funding source, without a separation of the care funding from the remainder of the funding, may lead to a situation where the residents' rights and meeting of the needs of residents will be very much endangered* (Moait, Evidence - 5 May 1997).

The Executive Director of the Australian Nursing Homes and Extended Care Association (ANHECA), Ms Sue Macri, was ambivalent about the impact of the quarantining of CAM funds:

> *... it has allowed the nursing and personal care staff to have a budget and to work to that budget. But I also have to say that there have also been some enormous constraints... for the operation of the nursing homes.... So you have got to say that in some respects the CAM budget has been very good, in terms of being quarantined, but I don't know that means it has always been managed particularly well* (Macri, Evidence - 5 May 1997).

Nor did ANHECA believe that the elimination of CAM will mean that providers can reduce care. The Committee was told that ANHECA members were warned that

> *... anybody who deems this as an opportunity to cut back on nursing and personal care staff with a view to getting greater returns on their investments, quite frankly at the end of the day will fall foul of the new accreditation standards [and] if you are not meeting those standards by the year 2001 you will go out of business because you will not be getting any government funding* (Macri, Evidence - 5 May 1997).

However, Ms Macri continued:

> *I don't know whether that has quite sunk in with some of the CEOs, administrators and proprietors out there* (Macri, Evidence - 5 May 1997).

The Commonwealth does not believe that an acquitted CAM funding mechanism will be necessary to maintain standards of care because the accreditation standards will ensure standards remain high. A representative of the Commonwealth Department of Health and Family Services told the Committee:

> *there is an amount of money provided per resident - which amount varies according to how dependent the resident is - and we expect the nursing homes and hostels to provide the relevant care for those people; and, to go along with that, to strengthen the quality assurance mechanism of looking at standards in the facilities. The way in which that strengthening will occur is through the accreditation process* (King, Evidence - 5 May 1997).

Mr King added that the accreditation standards require appropriate levels of staffing:

> *One thing that I ... should make clear is that the accreditation standards include a staffing requirement that you have sufficient qualified staff there for the mix of residents that you have. That is also stated in the Bill, to make clear that we have not pulled back from that ambition. We are just not into trying to define even the amount of money that is spent on that category ...* (King, Evidence - 5 May 1997).

The draft of the accreditation standards does not, however, specify exactly what number of qualified staff are sufficient for various mixes of residents. The Committee is concerned about the potential for the abolition of CAM to lead to reductions in numbers of qualified staff, and consequently standards of care (see Recommendation 12).

In addition, the Committee was told that validation is an important accountability mechanism which seeks to ensure that public funds are spent in the manner for which they were intended. It was explained to the Committee that:

> *For the money that you get through CAM you have to be very accountable. Any money that you do not spend, apart from 1 per cent, you have to give back to the Government* (Banfield, Briefing - 12 December 1996).

According to a 1994 Senate Report on CAM and SAM funding, 75% of homes validated had to repay CAM funds to the Department. Between July 1987, when CAM/SAM funding was introduced, and April 1992, some $50 million in misapplied CAM funds had been recovered (Senate Community Affairs References Committee, 1994: 3 - 5).

The Committee notes that most CAM funding which is incorrectly used is a result of honest mistakes: the distinction between care related costs and other costs is not always clear. However, at June 1994, 27 homes were under investigation by the Australian Federal Police for fraudulent misuse of CAM funds, with an estimated value of $4,627,000 (Senate Community Affairs References Committee, 1994: 3 - 5).

There are critics of the CAM/SAM funding system. Some providers argue that the validation process is time-consuming for both the Department and the proprietors. Other problems relating to the CAM funding include that there is some difficulty in determining whether certain expenses are CAM or SAM, which can cause problems for proprietors validating their CAM expenditure. Cash flow problems can occur as a result of the Department recovering in subsequent years CAM funds which were misapplied, whether innocently or fraudulently. The system is also said to be somewhat inflexible in a multi-skilled workplace, because CAM paid staff cannot do SAM duties, unless the time-consuming paper work is done for validation purposes (Gregory, 1993).

In addition, the Committee heard during its site visit to Allandale Nursing Home that accepting CAM funding from the Commonwealth resulted in the facility being obligated to abide by Outcome Standards as a condition of funding. Consequently, the facility was no longer able to group residents together according to their capabilities, so residents of different mental capacities were mixed together in wards, which, the staff told the Committee, was a disadvantage for residents. The Outcome Standards prevent a resident being moved from one part of the nursing home to another without their permission or without medical need.

Despite these problems, the Committee believes that there have been significant benefits arising from the CAM/SAM funding system, both in relation to reducing the incentive to cut care costs, and as an accountability mechanism, and that these outweigh the disadvantages. The Committee recognises that the planned amalgamation of nursing homes and hostels may make it unsuitable for the CAM/SAM funding and validation system to continue in its present form.

In its Interim Report the Committee recommended that the validation process should continue and care funds continue to be quarantined under the *Commonwealth Aged Care Act, 1997.* As the Act has now been proclaimed, the Committee recognises that it is highly unlikely that any such changes to the Act will be made. However, the

Committee believes that there are significant concerns regarding quality of care and appropriate staff mix to provide that care to warrant continued review.

RECOMMENDATION 45:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services include as part of the independent review of the *Commonwealth Aged Care Act, 1997* close scrutiny of the quality of care provided to residents, including drawing out the relationship between the care provided in facilities and related staffing profiles.

5.2.2 CAPITAL FUNDING ARRANGEMENTS

In response to the overwhelming need for an increase in capital funds to allow nursing home stock to be brought up to standard, the Federal Government has proposed that certified residential aged care facilities be allowed to charge an accommodation bond from 1 October 1997.

The accommodation bond may be charged for all residents whose assets exceed $22,500, or $45,000 for couples. Residents who stay less than six months will not be required to pay the bond, but will pay an administration fee which would be calculated based on what the proprietor would have received for the length of stay from the accommodation bond, interest and user fees (Commonwealth Department of Health and Family Services, *Aged Care Fact Sheet 2*, 1997).

The accommodation bond will be held by the proprietor while the resident is in the facility, and the proprietor will be able to "draw down" up to $2,600 each year, for a maximum of five years or $13,000, as well as keeping any interest raised on the bond. The remainder of the entry contribution must be returned to the resident when he or she leaves or turned over to the estate in the event of death. Only facilities which have been accredited (or certified in the transition period) will be permitted to charge accommodation bonds. Prudential arrangements have been designed to protect residents' bonds, and these have been discussed in Chapter Three.

Residents who are required to pay an accommodation bond may negotiate with the provider to make periodic payments rather than a lump sum. Periodic payments will be equivalent to the amount of money the provider could have expected to receive from the interest and draw down of a lump sum accommodation bond (Commonwealth Department of Health and Family Services, *Aged Care Fact Sheet 3*, 1997). The accommodation bond will be "rolled over" with residents who transfer facilities: they will not be required to pay a second bond. The new proprietor will be able draw down only what remains of the original five year draw down period. Therefore, a proprietor

accepting a transferring resident who has been in a residential aged care facility for (say) three years will be able to draw down only two years' worth of funds (Commonwealth Department of Health and Family Services, *Aged Care Fact Sheet 2*, 1997).

The likely amount of the average accommodation bond is at this stage unknown. The amount of the contribution will be negotiated between the proprietor and the resident, with no maximum set by the Government, so long as the resident is left with assets of $22,500. However, sections 58-3 and 58-4 (2) (a) of the *Commonwealth Aged Care Act, 1997* create an artificial cap equivalent to ten times the basic pension rate, because facilities receiving bonds over this amount will have their other payments affected.

As a guide to estimating the amount of the average accommodation bond the Commonwealth Government has noted that hostels (which have been charging entry contributions for some years) charge on average $26,000.

However, the hostel entry contribution is not an appropriate base for comparison for two reasons. Firstly, the hostel industry is dominated by charitable and religious service providers. Without the profit motive there is less incentive to charge higher contributions.

Secondly - and this is where the proposal for accommodation bonds differs from the entry contributions for hostels - until the last Federal Budget, hostels could apply for Commonwealth capital grants in addition to charging entry contributions, so entry contributions were not their only source of capital. The Commonwealth provided capital funding for aged care facilities in New South Wales to the value of $214.6 million from 1991-2 until 1995-6, with the vast majority of this being allocated to hostels (McMahon, Personal interview, 3 April 1997). The Commonwealth Department of Health and Family Service's NSW Aged and Community Care Branch Manager told the Committee that:

> *Over the last year or the last couple of years we have been looking at around about a third of new hostel places in New South Wales attracting capital. Prior to that it was about half* (McMahon - Evidence, 5 May 1997).

Hostel service providers have emphasised to the Committee the importance of having had access to Commonwealth capital grants to maintain hostel building stock. Isobel Frean from the Aged Services Association noted that:

> *The funding for hostels, the capital funding for establishment, upgrading, refurbishment and replacement has been based on a cocktail comprising capital funding grants from the Federal Government, the entry contributions ... from residents who have the capacity to contribute and variable fees imposed on those with incomes over and above the pensions* (Frean, Evidence - 28 April 1997).

Ms Frean told the Committee that the quality of hostel stock would have been reduced if hostels had not had access to capital grants in addition to entry contributions. She further commented that the reduction in Commonwealth capital funding would lead to higher entry contributions for hostels:

> *The Commonwealth capital funding regime will be replaced by user contributions and obviously if we are to maintain the levels of capital stock of hostels and undertake the improvements that have been identified and accepted by both governments, then it will be necessary for contributions to increase* (Frean, Evidence - 28 April 1997).

The Commonwealth Government has indicated that it will seek to ensure access for the financially disadvantaged, who will be known as concessional residents. To qualify as a concessional resident, an individual must be a full or part pensioner whose assets are less than $22,500, and who has not owned a home in the past two years. Concessional residents will not be required to pay an accommodation bond.

To encourage facilities to admit concessional residents, all facilities will have to meet a quota of admissions of concessional residents, which will be calculated according to demographics of the area. A target of 27% of all places will be targeted for concessional residents, with facilities in Local Government Areas with higher numbers of poorer people will have larger quotas of concessional residents than those in wealthy areas (Commonwealth Department of Health and Family Services, *Aged Care Fact Sheet 13*, 1997b).

In addition, the Commonwealth will pay an extra subsidy for concessional residents. The initial proposed subsidy was $5 per day to the facility for each concessional resident. However, after much lobbying by the Uniting and Catholic Churches, a significant increase in the amount was secured. The capital subsidy for concessional residents is now $7 per person per day for those facilities which have up to 40% concessional residents, and $12 per person per day for those which have more than 40%. The subsidy seeks to compensate for the inability of facilities to charge an accommodation bond of concessional residents.

A subsidy of $2 per day will also be provided for residents who do not qualify as concessional residents but who are only able to provide a small accommodation bond (Commonwealth Department of Health and Family Services, *Aged Care Fact Sheet 13*, 1997b). Such residents will be known as "assisted residents".

5.2.3 USER FEES

Currently all residents make a maximum contribution equivalent to 87.5% of the full pension plus rent assistance.

It is a little known fact that nursing home fees paid by self-funded retirees are tax-deductible. As most people currently in nursing homes are regarded as requiring some level of medical care, fees can be claimed back under the medical expenses rebate item. Hostel fees are not deductible as residents have traditionally required personal care, not medical care. The Department of Health and Family Services is clarifying how this will operate under the new arrangements, when the distinction between hostels and nursing homes has been removed. People who receive a full pension are not eligible to claim their fees as a tax-deduction.

From 1 October 1997 the maximum fee will be increased for all except full pensioners, based on an income assessment. The extra fees will be charged at a rate of 25 cents for every dollar above the income "free area" for pensions ($49/week for singles, $86/week for couples) with a maximum fee of $60 per day, or $420 per week. The $60/day charge would occur for someone earning in excess of $52,000 p.a. (Submission 15). Income testing will be conducted by the Department of Social Security and the Department of Veterans' Affairs. Residents can refuse to submit details of their income, in which case they will be charged at the highest rate (Commonwealth Department of Health and Family Services, *Aged Care Fact Sheet 7*, 1997).

The stated rationale for the rise in fees is that residential care for the elderly is becoming increasingly costly, and will continue to do so with the ageing population. The Commonwealth Government believes that those whose income exceeds the pension should assist with the costs of their residential care. As discussed previously, the real extent of the increasing costs is uncertain at this stage.

5.3 USER FEES AND ACCOMMODATION BONDS: THE LIKELY IMPACTS

5.3.1 IMPACT ON RESIDENTS

Residents and potential residents are clearly worried about how the accommodation bonds and higher user fees will impact upon them. To some extent, this is a result of lack of understanding about the nature of the changes combined with what could be described as scaremongering by the media. More information about the changes would dispel some ungrounded fears.

The Commonwealth anticipates that the effects of the accommodation bond will be to enable facilities to be upgraded, resulting in higher building standards and consequently improved quality of life for residents. A number of providers agreed. Mr Warren Bennett, from the providers' organisation ANHECA submitted:

> *The principal benefit of the new funding arrangements relates to the significant injection of funding to aged care facilities from entry deposits for capital upgrading and rebuilding* (Submission 15).

Moreover, Mr Bennett believes that the combined changes imposing the accreditation system and accommodation bonds would give providers incentive to meet standards, because:

> *If you don't attain and maintain accreditation in the next three years, then you lose every cent of government funding and you are out of business. ... The incentives to upgrade the building are there. If you do not, you are out of business* (Bennett, Evidence - 5 May 1997).

Some witnesses before the Committee were concerned that accommodation bonds are inappropriate for nursing home residents. Elderly people entering nursing homes differ from their counterparts who negotiated entry contributions for hostels. They require 24 hour nursing care, they have probably been admitted urgently and straight from hospital, they have a high level of dependency, and may be confused.

Geriatricians from Westmead Hospital submitted:

> *Entry to a nursing home is a catastrophic event in any persons life, the effect of which should not be minimised. ... Frequently it is a result of a crisis necessitating acceptance of the first available bed, often not in the nursing home of first choice* (Submission 54).

The Committee heard that hostel residents are in a different situation, because:

> *If they are considering going into a hostel type accommodation, they have the opportunity to prepare before they actually make that move, and prepare not only mentally, but prepare their finances in accordance with it, and they had the choice* (Johnson, Evidence - 21 April 1997).

This concern was also reflected in the submission received from Governor Phillip Hospital:

> *... there is a fallacy in equating hostels and nursing homes (as they presently exist) ... To some extent hostel entry is a matter of choice (a "lifestyle" decision, pre-planned). For most people there is no choice in Nursing Home admission with many being admitted after hospitalization or in other crisis* (Submission 59).

The Combined Pensioners and Superannuants Association believes that it will be difficult for residents to get a fair deal when negotiating their accommodation bond:

> *I do not think the Commonwealth Government understands the relationship between the proprietor and the would-be residents. There seems to be in the Bill a notion that it is an equal relationship. The Association strongly believes that that is not the case. We are looking at a very vulnerable group of people who may not be able to negotiate in their own best interests* (Benson, Evidence - 12 May 1997).

The Committee believes that it may be inappropriate for frail and elderly people needing nursing home care to be required to negotiate accommodation bonds directly with proprietors, without any government-set limit on amounts which can be charged. The Committee is concerned that, given the control on bed numbers and the high demand for beds, proprietors will be in a position to request high accommodation bonds. Some residents will be more disadvantaged than others such as elderly people from non-English speaking backgrounds, due to difficulties in communicating in English.

In addition, the Committee understands that people with cognitive impairments, such as dementia, may also be disadvantaged by the need to pay an accommodation bond. The Committee understands that many facilities currently reject prospective residents who have dementia and, despite the fact that the majority of people with dementia do not need specialist facilities, the specialist facilities which are available may choose to take residents who can afford to pay the highest accommodation bonds, even though their need for specialist care may not be as great as others.

The Committee understands that the Commonwealth is not keen to provide guidelines for appropriate levels of accommodation bonds, even though the *Commonwealth Aged Care Act, 1997* provides for the Minister to set a cap on levels. While the Committee understands that the level of accommodation bond is a private matter between the individual and the proprietor, and subject to the capacity of the individual to pay, it believes that prospective residents should be provided with some guidelines or indication as to amounts which they can expect to pay. These guidelines should be distributed to residential aged care facilities, Aged Care Assessment Teams and advocacy services for guidance in negotiations, and would most usefully be in the form of a table, with recommended accommodation bonds for varying asset levels.

RECOMMENDATION 46:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Social Security develop and distribute guidelines for appropriate accommodation bond levels for residential aged care facilities to residential aged care facilities, Aged Care Assessment Teams and relevant advocacy services.

The Committee was made aware that 'creative' accounting practices are already happening which require people to pay more than the maximum fees outlined in the Act. In particular, the Committee heard that:

> *(an) ethno-specific religious charity pressured a family to sign agreements for a total of $30,000 per annum in fees for hostel care. ...(T)his was an attempt to subvert the provisions of the new Aged Care Act. Despite an appreciation of this fact, the family felt it was necessary to proceed*

because their mother, who has dementia, has lost her (second) language and must live with others speaking her (original) tongue (The Aged-Care Rights Service, Submission - 8 September 1997).

In addition, the Committee heard the same family was required to provide $26,000 per parent for the accommodation bond, **as well as** an interest-free loan to a separate company of $150,000 per parent. The records will therefore only show the rather modest accommodation bond of only $26,000 per person has been paid to the aged care facility. The Committee is most concerned that accounting practices will become even more 'creative' under the new arrangements. The Committee understands that advocacy services such as the Aged-Care Rights Service are now included in the aged care legislation, however it believes it is important that such services are adequately resourced to monitor and advise on accommodation bond and fees agreements.

RECOMMENDATION 47:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure that advocacy services such as the Aged-Care Rights Service are adequately resourced to monitor the accommodation bond and fees agreements and provide advice and advocacy services on behalf of prospective and current residents.

RECOMMENDATION 48:

The Committee recommends that the Minister for Fair Trading request that the Commonwealth Minister for Family Services arrange for mediation powers to be delegated to the Residential Tenancies Tribunal if the advocacy services as proposed in Recommendation 47 are found not to be sufficiently resourced.

RECOMMENDATION 49:

The Committee recommends that the Minister for Aged Services, together with the Commonwealth, monitor the impact of charging of accommodation bonds through the collection of relevant data (such as from Aged Care Assessment Teams, NSW Department of Housing, NSW Health, and Licensed Boarding Houses) and that data be collected on an ongoing basis and presented to subsequent meetings of Health and Community Services Ministers.

Many nursing home residents simply are not in a position to negotiate entry into a residential aged care facility. Some will have relatives or friends who will assist them, but these may not always be operating in the best interest of the resident. According to evidence received by the Committee, the Guardianship Board is likely to face a vastly increased workload as it will be required to negotiate accommodation bonds on behalf of residents.

The Aged-Care Rights Service commented:

> *We are extremely concerned about the implications for the Guardianship Board, the Public Guardian and the Protective Commissioner of these Commonwealth changes... The wall of work heading towards the Guardianship Board is incredible. People who do not have the capacity to enter into a legal arrangement and have not given power of attorney will need a legally appointed representative in order to sell a home and pay an accommodation bond* (The Aged-Care Rights Service, Evidence - 12 May 1997).

Similarly, NCOSS suggested that:

> *... the estimate was a 200 per cent increase in the number of cases they (the Guardianship Board) will have to hear. They already have a three-month waiting list for new hearings* (Moore, Evidence - 8 September 1997).

The Committee understands that the impact of the *Commonwealth Aged Care Act, 1997* on the use of the Guardianship Board and the Public Guardian will be included in the review of the Act and implications for States and Territories which was agreed to at the recent HCSMC meeting in Cairns (ADD submission - 11 September 1997). The Committee believes that should the increase be as significant as anticipated, then New South Wales should be duly compensated by the Commonwealth for the additional resources which will need to be allocated to ensure that the rights of prospective residents of aged care facilities in New South Wales are protected.

RECOMMENDATION 50:

The Committee recommends that the Minister for Aged Services assess the likely growth in demand for the Guardianship Board and the Office of the Public Guardian, and negotiate an agreement to have the Commonwealth fund any increase in services resulting from the aged care reforms.

The above concerns regarding agreements about fees and accommodation bonds may be mitigated to a certain extent if there was greater time for the implications to be considered. The current period is seven days from the time one enters a facility and is quite limited, particularly for those who enter directly from an acute hospital admission (60% of nursing home residents). The Committee recognises that this is often a time of severe stress and trauma for people, and people are not well placed to be entering into such long term and financially significant agreements. The Ageing and Disability Department suggested a period of approximately two months, which would afford people sufficient time to make an assessment of their ability to return to their homes and/or to come to terms with their inability to do so. This period would also allow time for proper negotiations and prospective residents to seek appropriate financial advice (ADD Submission - 11 September 1997). The Committee considers that it would be important to ensure that the agreements were back-dated from the date of entry, so operators did not lose out on any funding during that period.

RECOMMENDATION 51:

The Committee recommends that the Minister for Aged Services request the Commonwealth Minister for Family Services to extend the period in which residents of aged care facilities must sign an agreement from seven days to two months.

Many potential residents have expressed apprehension about the possibility that they will be required to sell the family home to pay their accommodation bond, and that they will be unable to access nursing home care unless they do so. Ms Betty Johnson from the Older Women's Network explained:

> *They would be unwilling to sell their only asset, which is a home. Research reveals that people want to be able to leave the nursing home and go back to their homes, but if one's home is gone, one cannot go back home. ... I will put up with a lot rather than sell my home, because I do not want to insecurity of having nowhere to go* (Evidence - 12 December 1996).

For the majority of residents, there appears to be no protection of the family home, except under certain circumstances. The value of the home is included in the calculation of assets upon which the accommodation bond is assessed, unless the spouse of a resident, or a carer of five years who is in receipt of a carer's pension, is still living in the home. For those pensioners who do sell their home or lease it out, their pension entitlements will be affected. This is because homes are exempt assets according to pension calculations, but they are no longer exempt when converted into cash or leased out for income. Some pensioners and part pensioners may lose their pension entitlements as a result.

The Commonwealth Minister for Family Services has emphasised that people will not be required to sell their home to enter a nursing home. However, the Committee has heard that already people are being put under pressure to sell their homes:

> *One highly respected religious charity wrote to a family with threats to "approach the Guardianship Board" if their father did not sign a hostel agreement by midday on a certain date. It also wrote that their father must sell his home* (Aged-Care Rights Service Submission - 8 September 1997).

The Commonwealth Minister for Family Services argues that the option of making periodic payments will enable people who do not wish to sell their home to avoid doing so. However, there is no obligation for a proprietor to accept an offer to make periodic payments. Providers may not find it convenient to accept a resident who cannot pay a lump sum, particularly if they have to pay out a departing resident, or the estate of a deceased resident. To choose between a lump sum payee and a periodic payee will not be difficult for some providers, and, with waiting lists for beds, providers will be in a position to pick and choose.

One charitable provider told the Committee:

> *The real problem that we see is that if a large proportion of the people who are coming in decide that instead of paying an upfront entry contribution or accommodation bond, that they want to pay by installments, then that capital base that we have for the development of new facilities could disappear* (MacDonald, Evidence - 21 April 1997).

The manager of a hostel in country New South Wales was opposed to periodic payment of entry contributions, arguing that it "will create additional problems for operators, and increase administration costs" (Submission 12).

The Committee also heard that following the announcement of the prudential arrangements that a number of facilities were now planning **not** to offer a choice between the payment of a bond or periodic payments:

> *Although the Act says that it is the consumer's option to nominate a periodic payment, in fact it is being offered on a take-it or leave-it basis, with no option to pay a lump-sum accommodation bond.... [As a result] this is giving people pension problems, because rather than investing their money in the accommodation bond they are going to have to invest it at sufficient yield to service a periodic payment* (Fisher, Evidence - 8 September 1997).

The Committee acknowledges it is appropriate that people with sufficient means contribute to the costs of their care. However, any system of financial contribution must be equitable, and the Committee believes that people should not be forced to sell their home to raise an accommodation bond.

The Committee suggests that alternative methods for raising finance should be developed to enable people to pay accommodation bonds without being forced to sell their home. Such financing mechanisms could include annuities insurance.

RECOMMENDATION 52:

The Committee recommends that the Minister for Aged Services urge the Commonwealth Minister for Family Services to develop alternative methods for residents of aged care facilities to raise funds for an accommodation bond that enable them to retain ownership of the family home.

A number of witnesses have suggested that one possible implication of the higher user fees and accommodation bonds is that it will discourage people who need residential care from using it. This could occur when older people themselves are unwilling to pay an accommodation bond, or when their families are unwilling for them to do so.

The Council on the Ageing, for example, told the Committee:

> *What I fear, and what some older people fear, is that ... it could create a system in the community where there are increasing numbers of older people who have a real need for care but cannot access it. ... I have had many people say to me that, it is my inheritance and there is no way they are going to touch my inheritance* (Evidence, 21 April 1997).

This situation could result in increased strains on carers. The Ethnic Communities' Council submitted:

> *This situation can cause a great deal of pressure on both the older person in need of full time care and on the families who are unable to provide that care. The cost to families can be immense and for women, who are still seen as the care giver by many ethnic communities, may result in being forced to care for an aged relative. De-skilling, isolation, burnout and loss of income are only some of the possible effects on many migrant women* (Submission 65).

The Committee is most concerned at the increased potential for elder abuse which could result from the increased charges and fees:

> *A further likely impact is that more older people will be forced to stay at home in exploitative, abusive or neglectful situations. In particular, older people are at increased risk of financial abuse because of the introduction of accommodation bonds* (ADD submission - 5 September 1997).

The proposed system could also lead to the practice of "granny dumping" which has occurred in other countries which require payment to access care. Granny dumping is the practice of leaving elderly relatives outside residential care facilities anonymously to avoid payment.

Other scenarios which may lead to an increased risk of abuse of older persons include cases where other family members reside in the family home, and their accommodation needs would be threatened by the need to sell the home to pay the accommodation bond. In these circumstances, the *Commonwealth Aged Care Act, 1997* provides for hardship applications, which allows for special consideration for the waiving of the accommodation bond. For example, if an older person lives in a rural area and the assets cannot be readily realised, or is part of an extended ethnic family where a large group lives in the same house, an application can be made to the Department of Health and Family Services to waive the payment of the bond. However, the person must first sign an accommodation bond agreement, and then make a hardship application.

The Committee heard the concern that:

> *... the fact that you have to sign an accommodation bond agreement promising to pay money and then put in an application for determination that you do not have to pay the money is ... too great a risk* (Fisher, Evidence - 8 September 1997).

The potential for the accommodation bond to create a two-tier system is of considerable concern. The Aged-Care Rights Service warned:

> *The principal danger of the system is the development of a two-tier nursing home system between those with assets and the less well off* (Fisher, Evidence - 12 May 1997).

A two-tiered system of care would occur where people who are able to pay a large accommodation bond are able to obtain better care or accommodation than those who are unable. One service provider described to the Committee how accommodation bonds are likely to be between $20,000 and $26,000 for a bed in four-bed ward, rising to approximately $40,000 for a twin room, and up to $88,500 for a single room with ensuite (Bennett, Evidence - 5 May). This would clearly place a single room out of reach of many residents, and reveals that wealthier residents are in a position to obtain better services, and accommodation more conducive to protecting their rights to privacy and dignity. Moreover, it is unlikely that concessional residents will be provided with the more expensive types of available accommodation, and that any beds set aside for concessional residents according to the Commonwealth determined quota will be in multi-bed wards.

With concessional residents' quotas being based on the numbers of poorer people in each Local Government Area, quotas will differ from area to area. The Committee is concerned that this creates a disincentive to build and operate residential aged care

facilities in poorer socio-economic areas, which may mean that residents in those areas will be forced to accept accommodation some distance away from their community. Some witnesses have told the Committee that there is a likelihood that the differentiated concessional residents' quotas will result in poorer quality facilities in less wealthy areas. One witness noted that:

> *It may not be able to be carried out in such a level way so that we will, without question, have the same level of care being able to be provided in one of the "silvertail" suburbs of Sydney or Melbourne or Brisbane as you would in perhaps the working-class or unemployment suburbs* (Moait, Evidence - 5 May 1997).

Mr MacDonald compared the likely situation for Leichhardt with that of Turramurra:

> *[Leichhardt] has been traditionally a low income area. 80% of the residents of Leichhardt, that is of the hostel and the self care, would have been financially disadvantaged people who paid no entry contribution at all. .... If we were to rely solely on accommodation bonds, at a rate of no more than 20% of the population coming in, it would not even begin to meet the needs, whereas if you go up to Turramurra, there may be facilities in Turramurra, they will have no problems raising enough money to fund reconstruction of a lovely nursing home when they need to do it* (Evidence - 21 April 1997).

The Committee notes that several witnesses expressed philosophical concerns about the accommodation bond's impact on equity of access to residential care. One charitable provider told the Committee:

> *What we fear most from the accommodation bonds is that we will have a two queue system in nursing homes.... if you are able to pay accommodation bonds you will be able to find access relatively easy. If you are not, you will be squeezed into that sector of nursing homes where there is a longer queue and you will have to wait longer. I envisage people will be ringing up, ringing around trying to find a place and the operators will be saying I have some places for your mother if she could pay $80,000 but I am sorry I am full up to my target for people who cannot pay. I have got six or seven on my waiting list* (Herbert, Evidence - 21 April 1997).

Reverend Herbert further noted that a two queue system already operates in hostel admissions, but:

> *the issue of queuing is not as intense in a hostel because the need for a person to enter a hostel is not of the same urgency as the need for a person to enter into a nursing home* (Herbert, Evidence - 21 April 1997).

The Aged-Care Rights Service has similar fears:

> *... Our general impression is that, at the bottom third of the market, and it is anticipated that the concessional residents will form that group, it will be a real fight for a bed. This is going to be a system where there is room at the top but, by the time you take into account all the people who would now be financially disadvantaged people, plus those with a spouse still in the family home, or those with an adult child on a pension still in the family home, there is not much room for competition. They will have to take the bed offered, if there is a concessional fee bed in their area* (Fisher, Evidence - 12 May 1997).

The Combined Pensions and Superannuants Association told the Committee that they feared:

> *there will be real problems with access and standards of care for concessional residents within nursing homes and I think there will be regional variations as well* (Benson, Evidence - 12 May 1997).

Residents wishing to transfer from one facility to another may also face difficulties of access because the new proprietor can not renegotiate the accommodation bond, and can only draw down what is left of the five year drawn down period. Geriaction submitted that:

> *people who move between institutions will have great difficulty when the individual institutions they negotiate with have bond levels that are substantially higher or substantially lower and also when their $13,000 five year payment has been absorbed* (Submission 68).

Some of these initial fears about concessional residents not receiving equitable access to aged care have been allayed by the announcement of increased funding levels for this group. The initial rate of $5 per concessional resident per day was increased to $7 per resident if the facility had under 40% concessional residents, and $12 per resident for those with over 40%. The Committee heard evidence from the Uniting Church that the revised rates may even provide some incentives to take on concessional residents:

> *If a private operator has got, say, 29 or 30 per cent concessional (residents) there is going to be a big inducement on that operator to get up to the 40 per cent to claim the $12 a day* (Herbert, Evidence - 8 September 1997).

The Committee was heartened to hear that the increased rates may go some way to counteract the development of a two-tiered system of care, which had been a very real possibility under the previous funding levels. The Committee was cautioned, however, that "it is far too early to say what the end result will be" (Herbert, Evidence - 8 September 1997).

The Committee has also heard that there remain some groups of people who will still have difficulty accessing residential care. These include people who may have assets to pay an accommodation bond, but who need to be assessed or have a Guardian appointed:

> *A number of providers have said to me that they cannot take people on the assumption that six months later they will be able to get that assessment. They just cannot take the risk* (Moore, Evidence - 8 September 1997).

People who may need to transfer from one facility to another after a period of time and who have no retention amount left may also have difficulty accessing appropriate care. This is particularly of concern for those people who may have increased care needs which the facility may not be able, or willing, to provide:

> *If some facilities continue to provide what is now a hostel level of care, people may not choose to leave, they may have to leave. I believe there is concern about how attractive, for want of a better word, those people would be* (Moore, Evidence - 8 September 1997).

In the interests of promoting equity in the care system the Committee believes that access to funding available under the $10 million capital program for facilities with large numbers of concessional residents will be necessary.

RECOMMENDATION 53:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services allow facilities with high levels of concessional residents to have access to the Commonwealth's designated $10 million capital fund program.

The Committee is aware that there are other options available for raising capital for the residential aged care industry. One of these is detailed in Stage II of the Gregory Report (1994). Under this alternative model, Commonwealth subsidies for residents whose income and assets are in excess of a certain threshold (probably the pension threshold) would be reduced, and the resident would be required to pay some or all of the one-third of their accommodation costs previously subsidised by the Commonwealth as SAM funding. The amount the Commonwealth would have paid for the resident's SAM subsidy would instead be paid into a Nursing Home Building Fund. The Fund would be used to direct capital funding to those homes which need it the most (Gregory, 1994: 14)

According to Gregory's financial modelling, this model would provide sufficient funding to encourage proprietors to rebuild or renovate homes. He found that, compared to accommodation bonds, the benefits of this system include: the certainty that the funds raised will be used to improve infrastructure; the ability to fund homes based on priority need and to raise funds based on ability to pay; and the pooling of the varying amounts raised in different homes so that it can be focused on needy areas. This system would not create financial barriers to entry.

The potential problem of this alternative capital funding system include: the negative incentive to earn income when it is known that income testing will occur; the additional administrative requirements arising from income testing (though this will also be incurred with assessments for accommodation bonds); the need for extra monitoring by the Government to ensure that funding is spent as directed; and the increase in industry dependency on the Government.

Some members of the Committee would prefer this option to be used to raise capital, rather than the accommodation bonds, because it appears both more equitable and more likely to raise the necessary funds. The Committee acknowledges that the Commonwealth proposal for accommodation bond system is likely to be instituted and is outside the Committee's jurisdiction.

- **User Fees**

The higher user fees are not the subject of the same level of opposition as accommodation bonds. It would appear that most people accept that residents who earn more than the pensions should pay more for their services than pensioners do.

There is some opposition to the increase in fees for those pensioners who are hostel residents, but who, once the hostel and nursing home funding systems are amalgamated, will be required to pay more than they had previously. The Committee heard:

> *People on the full pension currently receive $31 a week disposable income after their care costs are taken from their pensions. That will be reduced to $26 a week. Older people in hostels will lose nearly $11 a fortnight. Given how little money they have, and given that people in hostels are generally more able to get out and do activities and to want to get around and spend money than people in nursing homes, there is a good argument for them to have more income* (C Moore, Evidence - 6 February 1997).

Hostel residents are likely to feel the impact of the higher fees because, with lower care needs, they are more active. It is clearly difficult to provide entertainment, clothes, transport and so on, for $26 per week.

The Committee is concerned that the more independent residents of low care residential aged care facilities (currently known as hostels) who are pensioners will be disadvantaged by the rise in user fees, and will have difficulties meeting their needs with their surplus income of $26 per week. The Committee believes it is appropriate that the Commonwealth subsidies for such residents be increased, and the resident contribution for such residents be decreased, to enable them to retain their current level of surplus income ($31 per week).

RECOMMENDATION 54:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to review the levels of Commonwealth payments of subsidies for pensioners who are residents of low care residential aged care facilities, and that the resident contribution for such residents be decreased so that their disposable income remains at the current level.

5.3.2 IMPACT FOR FACILITIES

The Committee is concerned that the accommodation bond scheme may not have the capacity to meet the industry's capital needs. The Gregory Report on nursing home capital funding examined the potential for an entry contribution to raise sufficient capital for rebuilding. Gregory (1994: 33) cast "considerable doubt on whether entry contributions *should* be used in nursing homes" given the high dependency and stress on residents at that time. In addition, his financial modelling led him to the conclusion that, while an entry contribution and higher user fees increases the likelihood that some homes would be able to improve their buildings, "it still seems to leave most homes unable to fund rebuilding' (Gregory, 1994: 34). Professor Gregory also noted that the facilities that will be able to rebuild will be those with the most wealthy residents, not those most requiring rebuilding.

The Commonwealth believes, however, that the new funding arrangements will raise sufficient funds, noting that, after Gregory's Report, the Department:

> *continued to work through those assumptions and issues. There are, though, a number of points which change things from the way in which he looked at it. One is that it was based upon the then hostels system, or the now hostels system. It does not include the idea of paying the higher subsidy for the concessional residents that we talked about ... In essence, we have continued to re-do the modelling around what are the revenue expectations from accommodation bonds, and we are quite confident that we will get about $130 million flowing in a year within four to five years, and building up to about $190 million after ten years* (King, Evidence - 5 May 1997).

Nevertheless, some proprietors are unconvinced that they will be able to finance refurbishment from accommodation bonds:

> *Certainly, on all the numbers that we have been able to put together, and remembering that it is still fairly indistinct at the moment ... but certainly on all the scenarios that we have done and calculated, no, it would fall very significantly short of the amount of money necessary to both provide for continuing upgrading of existing facilities and the construction of new facilities that are required as the population of older people expands as we go through to the year 2030-odd* (MacDonald, Evidence - 21 April 1997).

Similarly, the Aged Services Association submitted that the "ASA has some concerns about the ability of these arrangements to raise the estimated $130m" (Submission 66).

The Council on the Ageing also had doubts:

> *Despite the attempts by the Commonwealth Government to raise capital by entry fees, it is unlikely this amount will be sufficient to fund the increased accommodation required by the next generation or to achieve the minimum safety required in existing facilities* (Submission 36).

Providers are also concerned that there would be a gap of some years before there are sufficient funds to enable rebuilding. Berriquin Nursing Home, for example, submitted:

> *The main problem with this method of funding for refurbishment and maintenance of aged facilities is that it will take a considerable period of time for facilities to build up funds to carry out essential works* (Submission 26).

Another community-owned facility noted:

> *It would be at least eight to ten years before we had sufficient funds to undertake any major building project* (Submission 16).

This is a worrying scenario for the first generation of nursing home residents who will be charged accommodation bonds, but who may not benefit from it by improved infrastructure.

The Commonwealth dismissed this concern:

> *Those figures build up in the first couple of years, and certainly in the first year or two it will be lower than later on. It must be borne in mind that there will be an expectation that people will borrow to improve and that they will repay their borrowings by using the bonds* (King, Evidence - 5 May 1997).

The Commonwealth's expectation that funds raised by the accommodation bonds will provide a basis against which providers can borrow to upgrade their facilities is problematic. The prudential arrangements require that the funds be lodged with approved trust funds, and therefore providers will not have direct access to the accommodation bond funds. These arrangements have been greeted by the Aged-Care Rights Service as generally positive, saying that "we feel we can genuinely advise people that the money will be safe" (Evidence - 8 September 1997).

However, there is concern that:

> *(t)he trickle of interest initially from the trust funds will be insufficient to service rebuilding programs .. immediately; it will take a couple of years for them to build up into a steady flow* (Fisher, Evidence - 8 September 1997).

This view was reinforced by the Uniting Church:

> *the Federal Government has created a system which does not seem to be able to provide the capital funds to the industry* (Herbert, Evidence - 8 September 1997).

The Committee heard that the situation will be particularly difficult for smaller organisations, such as those catering for people of culturally diverse backgrounds. These organisations will need to use their assets as guarantee for loans for upgrading:

> *The issue of (the trust funds) taking a few years (to build up) is actually quite important in the context of needing to get accreditation over the next few years. If you cannot get certified now, and you cannot raise the capital over the next few years to get certified later then you cannot go on* (Moore, Evidence - 8 September 1997).

As a large aged care provider, the Uniting Church is confident it will be exempted from the prudential arrangements, however, it shares the concern of NCOSS for the ability of smaller organisations to upgrade their facilities:

> *... for small organisations ... whose only asset is indeed the nursing home or hostel they are operating, what assets can they put up to give that guarantee?* (Herbert, Evidence - 8 September 1997).

The Uniting Church suggests that the Federal Government could assist smaller facilities run by not-for-profit organisations by providing the guarantee for loans taken out for capital upgrade. These smaller facilities would include those in rural towns, as well as small ones for people of diverse cultural and linguistic backgrounds.

RECOMMENDATION 55:

The Committee recommends the Minister for Aged Services monitor the capacity of smaller providers of residential aged care services to upgrade their facilities in order to achieve accreditation.

RECOMMENDATION 56:

The Committee recommends that in the event that smaller providers are found to be experiencing difficulties in obtaining funds for upgrade, then the Minister for Aged Services should discuss with the Commonwealth Minister for Family Services the possibility of the Commonwealth Government acting as guarantee for the funds.

As noted previously, the Commonwealth Government has retained a small capital program of $10 m for the next four years. The priority targets for these funds include rural and remote facilities which are likely to find it difficult to raise capital via accommodation bonds. In its submission to the Senate Community Affairs References Committee Inquiry Community Services Australia noted that:

> *We would argue that $10 million will basically cover two facilities of around 30 beds based on $100,000 per bed, taking into account additional costs associated with remoteness. In Australia, the ability of the church to provide those beds of course has been because of the capital grants available. For under $10 million, you cannot provide or meet those services at the current level or demand in rural and remote areas* (1997: 34).

RECOMMENDATION 57:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services increase funding for Commonwealth capital grants for residential aged care facilities to ensure that rural and remote facilities are able to access sufficient capital to maintain and improve facilities.

5.3.3 THE NEED FOR SUSTAINABLE FINANCING OPTIONS TO BE DEVELOPED

The Commonwealth is seeking to meet the industry's need for capital through an accommodation bond and higher user fees. The Committee has two major concerns with the proposals: whether the accommodation bond and higher user fees will address the need for equitable access to the residential aged care system, and whether it will meet the industry's capital needs.

While the Committee was initially concerned that the concessional residents quotas and the concessional residents' subsidies may be inadequate to ensure that financially disadvantaged individuals have equal access to care and accommodation of satisfactory standards, it is now satisfied that the increased rates for concessional residents will help to prevent the development of a two-tiered aged care system.

The Committee believes that when an aged person is in need of a particular range of services, the community and the government has a responsibility to meet those needs if the individual cannot. The Committee accepts that it may be appropriate for residents to make a financial contribution to their care, but protection for frail elderly people must be clear in the guidelines.

In introducing the accommodation bond scheme and increased user fees, the Commonwealth has maintained that this will provide sufficient funds to maintain and upgrade the residential aged care system to a satisfactory standard for both current and future needs. However, the Committee is not convinced that the expected revenues will be realised, and is concerned that those most vulnerable in our society are being increasingly and unfairly required to pay for their own care needs.

The Committee believes that there is urgent need for improved aged care planning and for debate about sustainable financing options for aged care.

NSW Health submitted that there is an:

> *urgent need for governments to consider sustainable financial strategies to ensure that future generations of older people will have access to care and support appropriate to their needs* (Submission - 11 september 1997).

The Ageing and Disability Department also submitted that:

> *there is a need to consider reform of the taxation system to provide for sustainable financing of aged care in the future, rather than accept that dependence on a user pays system, which the Commonwealth reforms have moved towards, is the best or most desirable approach* (Submission - 11 September 1997).

The Accommodation Task Force, which is chaired by the Director General of the Ageing and Disability Department and jointly conducted with NSW Housing and Health Departments, has undertaken preliminary work on sustainable financing options for long term care, including aged care.

The Committee is aware that countries such as New Zealand and the United Kingdom have embarked on major inquiries into long term care financing, but in Australia "the level of debate about financing long term care has been limited" (Attachment 5, ADD Submission - 5 September 1997).

Research commissioned for the Task Force and undertaken by Ageing Agendas notes that:

> *... similar issues are being grappled with in almost every other OECD country ...and that there is considerable international interest in financing long term care and opportunities for Australia both to learn from the international debates and contribute to their development* (Attachment 5, ADD Submission - 5 September 1997).

The Committee believes that this is a fundamental debate which must be had, if we are to ensure equitable, affordable and quality care for older people in the future.

5.4 CONCLUSION

The Committee is concerned that without improved planning for aged care, including financing options, reforms to aged care will continue to be piecemeal reactions to emerging social and budgetary pressures. The recent High Court decision regarding the ability of States to collect revenue provides greater impetus for the need for sound planning for aged care, including comprehensive financial reform.

The Committee believes that the Commonwealth Government has a central role to play, whether through the taxation system or through incentives for individuals to take out long term care insurance products.

RECOMMENDATION 58:

The Committee recommends that the NSW Minister for Aged Services and the NSW Minister for Finance discuss with their relevant Commonwealth Government counterparts the need for more sustainable financing options for long term aged care, either through the taxation system and/or incentives regarding long term care insurance.

CHAPTER SIX:

IMPACT OF REFORMS AND FUTURE DIRECTIONS FOR AGED CARE

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As noted in the Introduction to this Report, aged care in New South Wales is currently operating in a volatile policy environment. The majority of this Report has focussed on the changes to the residential aged care sector which will be effected by the *Commonwealth Aged Care Act, 1997.* This Chapter considers the broad-ranging impacts which the Act will have on the New South Wales Government and related services.

However, the implementation of the Act is by no means the only change facing aged care in the future. The Commonwealth Government is continuing to push its proposal to transfer responsibility for residential aged care to State governments, and the projected demographic changes are requiring service planners and providers to re-think the capacity of existing services to meet the expected increase in need in the future.

6.1 IMPACT OF REFORMS FOR NSW GOVERNMENT AND RELATED SERVICES

The implementation of the *Commonwealth Aged Care Act, 1997* is expected to have significant impact on a range of New South Wales services. These may include, but are not limited to:

- acute hospital beds;
- palliative care beds;
- public housing;
- community care;
- boarding houses; and
- guardianship services (ADD submission - 5 September 1997).

The Committee was made aware that where entry contributions have been charged elsewhere, e.g. New Zealand, the result was a reduction in the use of nursing homes. It is therefore expected that this will lead to an increased demand on community care services as people chose not to sell their home to pay an accommodation bond.

It was submitted that:

> *In order to maintain the family estate intact residents and their families may be reluctant to use residential care. This will lead to an increased demand on already overloaded community, allied health and rehabilitation services* (Submission 54).

In its submission to the Senate References Committee inquiry, the Commonwealth Department of Health and Family Services estimated that up to 60% of nursing home entries and 20-30% of hostel entries follow hospital admissions (June 1997: 28). Therefore, it is likely that people will either remain inappropriately in acute hospital beds or prematurely discharged while arrangements for accommodation bonds are settled. As noted previously, the Guardianship Board has estimated that its workload will increase by 200% due to an increase in applications for the appointment of financial managers to negotiate payment of accommodation bonds.

The removal of eligibility for subsidy for those people who entered hostels for social and accommodation rather than care needs is expected to put increased pressure on public housing and boarding houses. The Committee understands that of the estimated 7,000 people who currently reside in hostels under this category, 5,000 are financially disadvantaged. While the Act provides for security of tenure for those currently residing in hostels, the pressure is expected to rise due to people no longer being able to take up this accommodation and support option.

The limited amount of capital funds available will impact on the ability of rural and remote communities to build local facilities, thereby increasing pressure on local rural hospital beds and continuing to result in older people having to leave their local communities in order to find suitable accommodation and care. The role of the Multi-Purpose Service as a model for aged care in rural and remote communities is discussed further in Chapter Four of this Report.

It is also clear that there will be a number of facilities which will not be certified and will be forced to close. Unless the closure of these services are managed carefully and co-operatively, it may result in further increases in pressure for acute hospitals, public housing and community care services.

There are concerns that a number of closed facilities will be used as 'unfunded' hostels, or unlicensed boarding houses.

The Aged-Care Rights Service noted that:

> *We have already encountered two commonly owned facilities in one regional area which are unlicensed, unfunded hostels to which ACAT teams have referred people. ...Inevitably, they are people who are hard to place due to their cognitive impairment and poor financial circumstances* (Submission - 8 September 1997).

It is therefore likely that the Ageing and Disability Department, which has responsibility for licencing boarding houses, will need to demonstrate vigilance in keeping track of these facilities.

NSW Health anticipates that:

> *State Government Nursing Homes would, in many instances, fail accreditation in both the short and long term* (Submission - 11 September 1997).

As such, these facilities will be ineligible for Commonwealth subsidies, and in order to continue operating would require significant financial input from the NSW Government. The Committee understands that these nursing homes historically have a higher proportion of younger people with a disability, and it will be important that the State's Disability Services Program is equipped and prepared to provide appropriate accommodation and support for these people.

The Committee understands that there has been little formal negotiation between the Commonwealth and relevant State Government agencies about the impacts of the *Commonwealth Aged Care Act, 1997*. To that end, New South Wales placed the matter on the agenda of the 31 July 1997 meeting of the Health and Community Services Ministerial Council. At the meeting it was agreed that:

> *States and Territories be involved on the review of the Aged Care Act and that the review report to HCSMC in addition to the Commonwealth. It was agreed that this review should, in addition to Commonwealth requirements, monitor and review the impacts of the Commonwealth Aged Care Act, 1997 on all States' and Territories' aged care services, health services and related community care* (Attachment 4, ADD Submission - 5 September 1997).

The Committee understands that States are to be invited to nominate two to three representatives to participate in the review. The Committee also understands that, as a result of the Cairns meeting, the Commonwealth has instigated meetings of State and Territory officials on a quarterly basis to monitor the impact of the Act.

Notwithstanding this, the Committee is very concerned that there is no joint meeting of Health and Community Services Ministers in the foreseeable future; the only scheduled meeting is the November 1997 Health Ministers' meeting. The Committee believes that the more appropriate Minister to be engaged in any national discussions regarding aged care is the Minister for Aged Services.

RECOMMENDATION 59:

The Committee recommends the Minister for Aged Services represent New South Wales in any discussions about aged care at the next Health Ministers meeting scheduled for November 1997.

The Committee was made aware of a joint project which has been established by ADD and NSW Health to establish data systems to measure the impact of the *Commonwealth Aged Care Act, 1997* on all aspects of the service system in New South Wales. The project is expected to have a whole-of-government approach to monitor the degree of increased demand on New South Wales services as a result of the Act.

The project is expected to inform the Commonwealth's review process and evaluate the extent of cost-shifting as a result of the Commonwealth's reforms. ADD noted that:

> *(W)e do not expect the Commonwealth to monitor the impact of the Act in as comprehensive and detailed way as the NSW Government would require* (ADD submission - 5 September 1997).

6.2 IMPACT OF UNIFYING THE RESIDENTIAL AGED CARE SYSTEM

After 1 October 1997, hostels and nursing homes will no longer be differentiated under Commonwealth funding and resident classification systems, and all will be named "residential aged care facilities".

This reform has found considerable support in the community. One advantage of a merged hostel and nursing home system will be the flexibility to provide for "ageing in place". That is, residents who are admitted into what is now considered a hostel will not be required to move into another facility when their care needs increase if those needs can be met on site. Instead, each residential aged care facility will be permitted to provide services across the care spectrum and funding will be provided accordingly. Under the existing system, with its separation between hostels and nursing homes, residents are required to move from hostels to nursing homes once their care needs and dependency increases. In practice, this sometimes creates a situation where residents in hostels run by organisations which have both hostel and nursing home beds in the building or in concurrent buildings are required to move across the hall or next door. An amalgamation would, in theory, avoid this situation.

The Australian Catholic Health Care Association saw benefits in the changes, in that:

> *the bringing together of the nursing home and hostel systems will in theory improve access by increasing nominal choice. It will allow for 'ageing in place'. The system reforms have the potential to encourage service specialisation and the consequent enhancement in quality of life and care for the consumers of these services* (Submission 46).

The Uniting Church also believes that the idea has merit:

> *We support completely the idea of the merger of the two organisations in the sense of the ability to then provide ageing in place. There is no doubt that ageing in place is beneficial to older people in terms of avoiding the*

> *kinds of traumas that are caused by people even having to shift from a room in one building to a room in another building right next door* (MacDonald, Evidence - 21 April 1997).

However, it is likely to be a number of years before residential aged care facilities raise sufficient capital to undertake the infrastructure changes necessary to provide the full spectrum of aged care services in one facility. Until then, it is probable that residential aged care facilities will focus on providing care to people either with high care needs or low care needs, depending on the suitability of the facility.

The Aged Services Association told the Committee that:

> *There are capital requirements that obviously would need to be fulfilled in order to achieve [ageing in place], and there is concern and anxiety as to whether the accommodation bond arrangement will in the short-term generate the sorts of resources that will be necessary simply to upgrade to age in place* (Frean, Evidence - 28 April 1997).

The Uniting Church's Uniting Ministry with the Ageing had similar concerns, giving evidence that although they support amalgamation in principle:

> *simply in a sense changing the names of these two facilities and taking off the names nursing home and hostel and calling them an aged care facility in the short-term is not going to make any difference at all to the level of resident that will be catered for in that particular facility. ... It is going to take fifteen years before enough of those buildings are put up to actually start to change the mix within the system so that the person can actually age in place* (MacDonald, Evidence - 21 April 1997).

Facilities wishing to cater for the full range of care needs will need to consider changes to staffing structures, equipment and buildings. For example, hostels will need to be refitted to include hospital style beds, commodes, call buttons, hoists, and other equipment needed for residents with higher care needs.

Some submissions expressed concern about the amalgamation's potential to give hostel care a more medical focus. The submission from the Local Governments and Shires Association noted that the planned amalgamation:

> *has implications for the type of support required for residents in hostels and lends itself too easily to the implementation of an unsatisfactory medical model. This will mean that there will be no appropriate provisions made for independent older people who choose hostel residence for social and lifestyle reasons but do not require the care level of a nursing home* (Submission 47).

The amalgamation of the two residential care systems has implications for State regulations of nursing homes and hostels. The Committee received evidence that a number of Commonwealth changes to the hostel and nursing home systems are incompatible with current state regulations and legislation:

> *at least in the short to intermediate term ... there are some incompatibilities between the State legislation and the Federal legislation that would again restrict true ageing in place* (Frean, Evidence - 28 April 1997).

The incompatibilities arise because, while the Commonwealth will no longer distinguish between nursing homes and hostels following the reforms, State legislation and regulations maintain the distinction in several areas. State legislation currently has different requirements for hostels and nursing homes in the areas of licensing, workers' compensation and standards monitoring. This would mean that a residential aged care facility will be considered a nursing home under State requirements if it has a certain number of high care residents. As a result, such a facility will be required to obtain a nursing home licence, which would affect staffing, number of pan rooms, wheelchairs and other equipment. The number of high care residents permitted before a hostel must obtain a nursing home licence appears to differ in differing Area Health regions: Illawarra, for instance, would permit up to four high care residents; while Broken Hill indicated that if there is even one high care resident, the hostel must become a nursing home (Frean and Ireland, Evidence - 28 April 1997).

The Department of Fair Trading, whose Code of Practice for retirement villages also covers hostels, may find that some of its regulations for hostels are in conflict with the proposed Commonwealth changes. Consideration will have to be given about whether hostels will continue to be subject to the Retirement Village Code of Practice under the Department of Fair Trading, or whether they will be licensed by NSW Health.

Regulations for hostels and nursing homes differ under building codes in force in New South Wales. Under the existing Building Code, nursing homes are regarded as Class 9A buildings, while hostels are Class 3. The main difference between these two classes of buildings relate to fire and safety issues. For example, all Class 9A buildings are required to have fire and smoke alarms, and fire proof doors in corridors. Class 3 buildings only require fire and smoke alarms if there are more than twenty residents, and each room must have a self closing door. If hostels and nursing homes become subject to the same funding and organisational structures, it would seem appropriate that building codes are amended accordingly. The Committee understands that the Building Code is under review, and is hopeful that the new Building Code will address the changes.

Some confusion also surrounds complaints mechanisms. Currently, both nursing home and hostel residents can direct complaints related to clinical standards or health care to the Health Care Complaints Commission (Submission 70). Non-health related complaints about nursing homes are referred to the Private Health Care Branch of New

South Wales Health, and those concerning hostels are referred to the Community Service Commission. These complaints processes will need to be simplified when nursing homes and hostels are amalgamated.

The need for the review of legislation governing elements of the aged care system has been discussed in Chapter 1 of this Report, and the Committee has recommended that this should be considered within the context of the development of a NSW Aged Care Strategy (Recommendation 6).

The Committee is not suggesting that State regulations be abolished. The Committee believes that aspects of the nursing home and hostel industry currently regulated by the State should continue to be regulated, at least until the impact of the Commonwealth changes can be assessed. However, some State regulations will need to be amended to make them compatible with the structural changes imposed by the Commonwealth.

6.3 COMMONWEALTH AND STATE GOVERNMENTS AND RESIDENTIAL AGED CARE: COMPLEMENTARY OR DUPLICATIVE ROLES?

The proposal to transfer responsibility for residential aged care to State Governments is premised on the belief that this will reduce administrative and regulatory duplication. Before considering the implications of the transfer, it is useful to consider the extent to which there is duplication between the two levels of government. As noted above, a number of pieces of Commonwealth and State regulations are inter-related.

The Committee received conflicting information about whether the current delineation of responsibilities resulted in duplication of services and functions by the Commonwealth and the States. Of the functions described above, it would appear that there is no duplication in the area of funding, nor of service provision. The small amount of State funding for nursing homes seeks to supplement Commonwealth funding, while only one layer of Government - the State - is involved in direct provision of residential aged care services.

Regulation is one aspect of aged care in which both the Commonwealth and State are involved. This has led to suggestions of unnecessary duplication. The National Association of Nursing Homes and Private Hospitals, for instance, told the Committee:

> *We support the need to eradicate duplication with the Commonwealth and the States, particularly their responsibilities to outcome standards* (Chadwick, Evidence - 6 February 1997).

The Victorian Government clearly believed that there was unnecessary duplication in the regulation of nursing homes: its response was to eliminate State regulations of Victorian nursing homes. The Committee was briefed by the Assistant Director - Aged Care, of the Victorian Department of Human Services, who informed the Committee that:

> *the position of the Government and the Department has really been about trying to simplify the regulation ... the view was taken that the States mirroring the Commonwealth's role in regulating was not necessary; that it did not need two levels of government to regulate in essence the same set of businesses and that it should simply be left to the Commonwealth* (Hall, Briefing - 2 May 1997).

However, consumer and union groups who briefed the Committee advised that there had been a diminution in quality of care in Victoria since the State regulations were repealed. A Professional Officer with the Australian Nurses' Federation (Vic) informed the Committee that:

> *We have had constant anecdotal evidence of problems that have been created in relation to standards* (Clutterbuck, Briefing - 2 May 1997),

though she noted that other actions by the Victorian Government, including the closure of the Melbourne School for Enrolled Nurses, had impacted on standards at the same time. Nevertheless, some 300 - 400 qualified nurses lost their jobs in nursing homes in the two years subsequent to deregulation, as staffing levels were no longer controlled (Clutterbuck, Briefing - 2 May 1997).

The Committee was told of specific examples of sub-standard care that had come to the notice of the Australian Nurses' Federation in Victoria. A disturbing case was that of a nursing home resident who fractured her arm in a fall, but after treatment died in the nursing home as a result of incorrect dosage of Morphalgin. Another resident who was discharged from hospital early following a knee replacement operation suffered from retention of urine which was not discovered for three days because of lack of observation by qualified staff (Clutterbuck, Briefing - 2 May 1997).

The consumer organisations that spoke to the Committee also heard anecdotal evidence about the decline in standards as a result of deregulation. One particularly distressing incident was a resident who was certified for admission to a mental institution by a GP due to perceived behavioural problems. The ambulance officer who was called to transport the resident to the mental institution found that the resident was suffering from a urinary tract infection (which can cause confusion and aggression in elderly people) and a broken hip (Healy, Briefing - 2 May 1997).

A number of witnesses informed the Committee that the State regulations and the Commonwealth regulations are complementary rather than duplicative, because they have a different focus:

> *The focus of the [Commonwealth] Outcome Standards which were developed in 1986/87 are such that they were attempting to change the culture in our nursing homes industry from one of being an institutionalised type care to emphasise homelike environment and residents' rights.*

> *The provision of quality care - that is the employment of qualified nurses - was taken as a given at that time* (Clutterbuck, Briefing - 2 May 1997).

The Senate Report which was a catalyst for the development of the Outcome Standards clearly saw them as existing as a complement to State regulations. It noted that:

> *The responsibility for maintaining standards of care in nursing homes rests primarily with the States which, as licensing authorities, regulate the minimum standards for staffing and facilities* (Giles, 1985: 113).

NSW Health views its regulatory role as complementary to Commonwealth regulation. Dr Wilson from NSW Health told the Committee that:

> *We have modified our practice over the past years, so that what we undertake has been complementary to the previous outcome standards that were applied by the Commonwealth. ... The Commonwealth had a process which was called the Outcome Standards, which looked at what was attempted to be achieved through the types of care that were there, whereas our regulations related to process and structure functions* (Wilson, Evidence - 12 May 1997).

However, Dr Wilson conceded that regulatory arrangements could be rationalised by allowing the State to be responsible for regulating all aspects of nursing homes.

NSW Health also sees its sanctioning powers as complementary to those of the Commonwealth:

> *The ability of the Commonwealth to respond where nursing homes were not meeting standards really related totally to the Commonwealth's ability to de-fund and say "We are not going to pay for beds in that institution", whereas we have a number of other sanctions that we can use in that sort of situation* (Wilson, Evidence - 12 May 1997).

The Australian Nursing Homes and Extended Care Association (ANHECA), a providers' organisation, noted that it was only where the State officials were inspecting in relation to the Outcome Standards, which are incorporated in the Nursing Home Regulation, 1996 that duplication occurred. The Executive Director of ANHECA told the Committee:

> *I would be quite happy to see the State Department of Health in its regulatory role of looking at the building, the licensing, the Poisions Act and all of those sorts of issues, which are very important, and making sure that buildings are conforming and looking at those sorts of things...The problem that we have is that if a nursing officer goes in from the State Department of Health looking at those [outcome] standards, the*

> *officer can be looking at them totally differently or from the point of view of a different objective than somebody coming in from the Commonwealth* (Macri, Evidence - 5 May 1997).

Similarly, the Uniting Church's Uniting Ministry with the Ageing submitted:

> *There is minor overlap where both State and Federal Government sometimes inspect for the enforcement of outcome standards, which could easily be overcome by transferring sole responsibility to the Federal Government* (Submission 53).

It would appear, then, that duplication does occur in relation to some facets of regulation, but that other areas are complementary rather than duplicative.

RECOMMENDATION 60:

The Committee recommends that the State retain its regulatory role until the impact of Commonwealth changes can be assessed, and, in particular, the efficacy of accreditation is determined. Thereafter it may be appropriate that one level of Government be responsible for all regulation, providing that all current facets of regulation of standards are maintained.

The Committee notes, however, that there are clear areas of commonality of responsibility between the Commonwealth and the New South Wales Government, in particular in regard to planning for aged care services across the spectrum of the care continuum, and resource allocation. In recent years the Commonwealth has initiated a number of programs which overlap those which State Governments have responsibility for providing, and which focus predominantly on the provision of high level care in the community. These include Community Aged Care Packages, Nursing Home Options pilot, the Respite Options project, the Transition Care project and the Psychogeriatric Care and Support Unit. In addition, the Commonwealth Respite for Carers program provides respite care for people in the community. These programs have substitutable functions with the HACC program, community mental health and psychogeriatric programs. The absence of clear co-ordination for planning for these services, including resource allocations, inhibits the development of aged care services which are flexible, innovative and responsive to local or regional needs.

6.4 THE EFFECT OF DEVOLUTION OF RESPONSIBILITY FOR AGED CARE FROM THE COMMONWEALTH TO THE STATES

In mid-1996 the Commonwealth Minister for Family Services announced the Government's intention of transferring responsibility for aged care from the Commonwealth to the States. The stated objectives of so doing were that it would enable consumers better access to services across the care spectrum, that it would result in less duplication of administration and services and the better use of resources.

The Commonwealth also believes that devolved responsibility for aged care would be more efficient and cost effective. In broad terms, the initial plan was for the States to be given responsibility for aged care assessment programs, residential aged care (nursing homes and hostels), and community aged care (Halton, Briefing - 12 December 1996, and briefing document).

The Committee understands that the issue of the transfer of aged care was discussed at the Health and Community Services Ministerial Council (HCSMC) meeting on 31 July 1997 in Cairns. A Discussion Paper was included in the agenda papers for the meeting which outlined a range of types of program reform in aged care that could be negotiated on a bilateral basis. The reforms ranged from improving continuity of care through e.g., improving assessment of older people's needs, to the transfer of responsibilities between jurisdictions. The meeting agreed to the following in relation to aged care:

- that States/Territories negotiate bilateral aged care reforms with the Commonwealth based on reform options outlined in the Discussion Paper prepared for the meeting; and

- that a shorter version of a Discussion Paper be released publicly after 1 October 1997.

New South Wales was the only State/Territory which did not agree with these two decisions and has adopted the position that New South Wales will not engage in bilateral negotiations for aged care reform for the following reasons:

- a multilateral agreement best protects the interests of consumers through providing an integrated, national system of aged care;

- reform options will transfer financial risks to the States;

- the Commonwealth's reforms already involve significant cost shifting to States/Territories, for example in hospital, public housing and community care; and

- the Commonwealth has not considered the implications of changes to residential care for States/Territories (ADD submission 5 September 1997).

The capacity of the Commonwealth to enter financial agreements with States/Territories in regard to the transfer of aged care has also been limited by changes which were made to the *Commonwealth Aged Care Act, 1997* to secure its passage in the Senate. For transfer to occur amendments would need to be made to the Act, and passed by the Parliament.

The Committee notes that the aged care sector is in the midst of fundamental changes to structure, to funding levels and mechanisms, and to the regulatory regime. The ramifications of these changes will not fully be understood for several years, and changes to Commonwealth and State responsibilities would better be made after the current reforms have been assessed.

The NSW Government has indicated that it is unenthusiastic about the proposed transfer. The NSW Minister for Aged Services is on the record expressing "grave alarm" about the devolution proposal, particularly if it were to go ahead without any funding guarantees (NSW Minister for Aged Services, 7 April 1997).

Ms Jane Woodruff, the Director-General of the Department of Ageing and Disability, informed the Committee that:

> *the NSW Government has made no decision to accept a transfer of aged care, preferring to adopt a cautious position* (Woodruff, Briefing document, 1996: 4).

When the transfer was initially being canvassed, the State Government formed a consultative committee, chaired by the then Hon Patricia Staunton, MLC, to consult with the aged community and other stakeholders on the subject of the proposal for devolution. The Staunton Committee has reported to the Government, but the report has not yet been released to the public.

Submissions and evidence received by the Standing Committee on Social Issues prior to the July HCSMC meeting were wary of the proposal, and a large number of witnesses and submitters were opposed to the transfer. The issues raised in evidence and submissions are canvassed below.

There are potential benefits arising from a devolution of responsibility from the Commonwealth to the States. The current mix of Commonwealth and State functions is complex, especially when one includes HACC and health care as components in the continuum of care for the elderly, and there would be:

> *some advantages to having the responsibility for, and the care of, older people with one level of Government* (Ms Moore, Evidence - 6 February 1997).

A simpler system, with fewer administrative duplications, could be achieved by having one level of government responsible for all aspects of aged care. The focus could move from programs to individuals' care needs (Submission 81).

Some of the inflexibilities of the system could also be overcome by having one level of government responsible for all aspects of care. For example, the current situation where post-acute and sub-acute care must be provided by hospitals because acute care is a State responsibility could be changed to enable a resident to be treated in their nursing home where the qualified staff are available. This would not only be less disruptive for the resident/patient, but would be a significant cost saving for the community (Submission 18, Submission 10). Aged Services Australia told the Committee that the current proposals for change are an opportunity to reform such inflexibilities and other inefficiencies (Frean, Evidence - 28 April 1997).

The Uniting Ministry with the Ageing was unconvinced of the efficiencies which would result from devolution, submitting that they were unable to see how:

> *the straight transfer of functions from the Federal Government to the State Government will self-evidently produce a more efficient outcome for older Australians. This is not an area where there is a great deal of overlap of functions now between the two levels of Government* (Submission 53).

Potential problems with the transfer were also raised in evidence and submissions. There is some scepticism about the Commonwealth's motivation for the proposal. The NSW College of Nursing, for instance, feared that:

> *The current proposal appears to be motivated by a desire by Commonwealth Government to divest itself of responsibility for aged care provision to the elderly without any attempt to plan for future cost and service provision implications* (Submission 31).

NCOSS had similar concerns. Cathy Moore, from NCOSS, told the Committee:

> *Firstly, the current proposals appear to be driven solely by a cost-cutting agenda. I think one should have to be cynical about a Federal budget announcing cuts of $580 million to aged and community care, nine months before they plan to hand it over to the States* (Ms Moore, Evidence - 6 February 1997).

Similarly, the Local Governments and Shires Association were concerned that "any transfer of responsibilities should not be treated as cost saving exercise only" (Submission 47).

Funding is a key issue needing to be addressed in negotiations about devolution. A paper commissioned by the Ageing and Disability Department on the costs of the aged care transfer proposal and undertaken by Professor John McCallum of the University of Western Sydney in November 1996 considered the present and future costs associated with aged residential care facilities, the HACC program and Community Aged Care Packages. **The study estimated that in 1994/95 and 1995/96 the recurrent cost for aged care in New South Wales was approximately $1 billion per year.** Given the anticipated rapid growth in population of people aged 65 and over (as discussed in the earlier in this Report), if current costs were multiplied by the projected demographic changes, costs would be expected to increase by 18% by the year 2000, and by 56% by 2010. Using these assumptions, the cost of aged care would double by 2025, and treble by 2050 (Attachment 1, ADD Submission - 5 September 1997). The State is not a revenue raiser, and will therefore be reliant on the Commonwealth for funding. In view of recent expenditure cuts, the States would be required to manage aged and community care services with a significantly reduced budget, with or without the additional 10% funding cut recommended by the National Commission of Audit for programs transferred to the States through untied grants (Submission 81).

At the same time, the State will take on the political risks of being seen to be responsible if care standards fall. The prospect that funding for aged care would not keep up with any change in demographics is also cause for concern. In addition, there is no certainty that accommodation bonds and user fees will raise the funds necessary to finance capital rebuilding, so the States could be placed in a situation where they take over responsibility for a residential aged care system which has funding structures incapable of meeting its needs (Submission 16).

The Australian Catholic Health Care Association suggested that the Commonwealth should retain responsibility for funding because:

> *it would be difficult for the New South Wales State Government to ensure that the general base line position for any transfer of funds was not disadvantaging the State Government in terms of the growing dependency levels and demographic changes taking place in aged care* (Submission 46).

A key concern expressed in submissions and evidence was that once funding was devolved to the States, aged care would be competing with hospital and acute care services for funding (Submission 24; Submission 43). The need for any devolved funding to be in the form of tied grants was emphasised. The Committee understands that other States are already engaging in bilateral negotiations with the Commonwealth over aged care, including the possible rolling together of aged care funding with health care agreements. The Committee received strong evidence from representatives of NCOSS, the Uniting Church Board for Social Responsibility, and The Aged-Care Rights Service (TARS) that it would be disastrous for aged care if New South Wales was to adopt this approach.

The key reason why such a scenario is strongly objected to is the potential for cost-shifting from aged care to acute care.

If aged care funding is not quarantined, that aged care funding will be diverted to other areas because:

> *there are a number of political imperatives ... which tend to focus much more on things like acute hospital care at the expense of aged care, which is never seen as a really acute need* (MacDonald, Evidence - 21 April 1997);
>
> *the pressure of emergency acute services in health means that services such as ours would be a low priority. We think this is a terrible prospect and we would be horrified* (Herbert, Evidence - 8 September 1997); and
>
> *It would be extremely difficult for aged care funding to be protected from the high cost and high demand end of the health care system* (ADD, Submission - 5 September 1997).

The Committee also heard evidence that the huge amounts of money involved in health care funding would dwarf any significant negotiations about aged care funding if the two issues were considered at the same time. As Ms Moore from NCOSS informed the Committee, if the NSW Government was made an "inadequate aged care offer" which was put alongside

> *perhaps a slightly better offer in the health field and rolls it all together, I think it would be very tempting for any government with the political imperatives of the health system, and ...with an election coming* (Moore, Evidence - 8 September 1997).

In its Report on Funding of Aged Care Institutions, the Senate Community Affairs References Committee also expressed concern in Recommendation 28 that, in the event of a transfer of responsibility for aged care to States and Territories,

> *there needs to be certainty that transferred funds will be used for aged care services and not diverted to alternative programs* (June 1997: 78).

The Committee questions whether the State has the infrastructure to administer aged care adequately, or whether infrastructure will be required to be established, creating additional costs to the State. There appears to be a great deal of opposition to NSW Health taking responsibility for the management and administration of aged care, because of the inference that aged care would be construed as a health issue.

The Aged Services Association submitted that:

> *If the transfer is to occur, the NSW Government must adopt an holistic approach to aged care and recognise that aged care is not simply a health issue. Aged care is an important government responsibility which extends across a range of portfolio areas at State Government level including Housing, Transport, Community Services, Education, Local Government, Urban Affairs and Planning, Fair Trading, Ageing and Disability, Sport and Recreation, Tourism and Treasury. If the NSW Government accepts responsibility for aged care, it should establish a separate aged care portfolio under the control of a senior Minister or the Premier. Aged care should NOT be located within the NSW Health Department* (Submission 66).

The Ageing and Disability Department submitted that:

> *Old age is not an illness - rather a later stage in life. ... If our approach to ageing is viewed through the eyes of the medical and nursing professions, our concern is costs will rise (due to overservicing) and older people's independence will be constrained* (ADD Submission - 5 September 1997).

Staff attitudes toward aged care, both in the bureaucracies and aged care services, are also important:

> *Staff of a facility must have a paramount commitment to a resident rights model of care, rather than a medical model. ...The only Department with experience in considering the aged as people with special needs under an holistic model is the Ageing and Disability Department* (The Aged-Care Rights Service, Submission - 8 September 1997).

In addition, the Committee was made aware of the potential conflict of interest when it comes to placing people into residential aged care services. The 'gatekeepers' to residential care are Aged Care Assessment Teams, which are located as discrete units within acute care public hospital settings:

> *We are all too familiar with the situation whereby an aged person is shunted off to an unsuitable aged care facility which does not meet his or her needs, merely to free up an acute hospital bed* (The Aged-Care Rights Service, Submission - 8 September 1997).

The Committee believes that this is already a particular problem in rural areas, where the need to move people out of acute hospital beds into the first available residential care place/bed often results in people being moved long distances outside of their own community because of the lack of availability of a place/bed within their region.

The lack of success of devolution to the States of other programs was also discussed in submissions, which suggested that devolution had resulted in inferior services. Disabilities services is one program which was devolved unsuccessfully, according to its critics. Professor Anna Yeatman recently reviewed the Commonwealth-State Disabilities Agreement (CDSA), and found that there were inconsistencies in patterns and mixes of service types across State jurisdictions, that State governments revealed varying readiness and capacity to implement the agreement, and that the CSDA lacked a national implementation plan or process (cited in Submission 15).

Another example is the immunisation program, which was transferred to the States in 1984, at which time Australia had one of the highest rates of immunisation in the world. Australia's immunisation rates are now very low, which many believe to be a result of State governments' neglect (Submission 15).

There is concern amongst some sections of the community that the improvement in nursing home standards which has occurred over the last decade may be at risk if the national system of standards monitoring is dismantled. They believe that strong Commonwealth action has been responsible for the progress that has occurred in aged care (National Consumer and Community Service Organisations, 1996: 1). The national approach of the current standards is seen by many as one of the great strengths of the current system. One nursing home administrator warned that a devolution of responsibility "irrespective of how good the intent, will result in different approaches to management at State levels that will create confusion and concern for both residents and carers" (Submission 26). The Rev Harry Herbert concurred, asking:

> *why change a system now which works very effectively to the benefit of elderly people and creates this very important uniformity? And I am not sure, if you broke up the administration into all the States and Territories, whether you would not get certain inefficiencies rather than efficiencies ...* (Herbert, Evidence - 21 April 1997).

The Committee remains unconvinced about the necessity and desirability of devolution. However, the Committee believes that there are significant gains to be made from improved collaboration between Commonwealth and NSW Governments in regard to planning for aged care services, program development and resource allocation. To that end, the Committee is concerned about the decision not to participate in negotiations with the Commonwealth on reforms for aged care in New South Wales. As mentioned earlier, the NSW Government did not agree with the HCSMC decisions in regard to further reform of aged care, including the release of a Discussion Paper on the range of reforms proposed. The Committee appreciates the Government's concerns about bilateral negotiations, and reiterates its call in Chapter One of this Report for a uniform system of aged care.

RECOMMENDATION 61:

The Committee recommends that the Minister for Aged Services prepare a consultation document for the purposes of entering negotiations with the Commonwealth regarding improved planning and service provision for aged care in New South Wales.

The Committee heard evidence that New South Wales will miss out on the opportunities to improve elements of the aged care system if it does not participate:

> *...the NSW Government officers and the NSW Government have to be able to consider much needed improvements that could happen within the current context of responsibility. It would be a real loss if those types of improvements are not even considered because only multilateral negotiations are allowed* (Moore, Evidence - 8 September 1997).

The Committee is concerned that New South Wales should not be left behind and miss opportunities to improve aged care in ways which do not involve financial risk. As noted earlier, areas where change could be negotiated include planning and allocation of aged care resources, such as agreement to change the percentage of nursing home beds as opposed to the community care places, which would allow for more flexible models of care to be developed and care services which are more responsive to local needs. The failure of New South Wales to participate in any formal process with the Commonwealth raises the very real chance that New South Wales will fall behind other States and Territories in regard to aged care.

The Committee notes that the Senate References Committee also expressed concern about the proposed transfer of responsibility to the States and Territories, and included in its recommendations that further consultation needs to occur, and safeguards in place for the protection of all parties (Recommendations 27 and 28). In the event that the transfer does go ahead, the Committee believes that a number of safeguards are necessary:

- the State Governments and their constituent consumers must be assured that devolution is not just a cost-saving exercise. There must be an improvement in the provision of services and no diminution of quality of care;

- there must be adequate consultation and a realistic time frame for negotiations. There are a myriad of issues needing to be resolved - not the least of which are the exact breakdown of responsibilities and which State department will take on the administration of aged care;

- there must be a guarantee of national uniformity in standards of care and residents' quality of life;

- the States need to be certain of growth funding in the form of tied grants;

- New South Wales would need to develop, in consultation with stakeholders, a clear agenda for aged care in this State, which is driven from a community care perspective; and

- there needs to be concurrent debate about sustainable long term care financing.

6.5 EXPANDING AGED CARE SERVICES

The bulk of this Report has focussed on the current provision of aged care services and the impacts of the *Commonwealth Aged Care Act, 1997* on those services. Throughout the course of the Inquiry, however, it has become clear to the Committee that there is a need for improved **planning** for programs and services (as discussed earlier) as well as **provision** of programs and services. The Committee considers the following areas should be provided with an immediate increase in resources:

- psychogeriatric services for people with dementia and older people with mental health problems;

- respite care for carers, including the development of flexible and innovative options, in particular for carers of people with dementia;

- accommodation, care and support programs for younger people with a disability who currently reside in residential aged care services; and

- rehabilitation services.

In addition, the Committee has noted the importance of the provision of programs and services for older people who are well and do not use support services, including the need for the development and implementation of a comprehensive healthy ageing strategy.

6.5.1 EXISTING RESIDENTIAL SERVICES' INFRASTRUCTURE

This section briefly examines existing infrastructure to determine whether it could be used to expand services for older people.

- **Nursing Home Infrastructure and Programs**

As previously discussed, a recent study of the capital stock of the nursing home industry found that the quality of the buildings on the whole was poor, that some $100 -

$125 million each year was needed to upgrade and maintain the buildings, and that current capital funding is unable to successfully raise the necessary capital (Gregory, 1994).

Clearly, existing nursing home infrastructure will not be able to be used to expand residential services for the aged. Indeed, Gregory found that measures will need to be taken to raise the capital to maintain and rebuild facilities to enable the homes to maintain *existing* services at an appropriate standard. As the Council on the Ageing noted:

> *The existing capital infrastructure is already stretched beyond its limits so it is unrealistic to think that it could be used to further expand services* (Submission 36).

In its Interim Report of this Inquiry the Committee noted that it may be appropriate to allow residents of nursing homes to receive sub-acute treatment in nursing homes, as this is considerably less expensive than treatment in hospitals and less traumatic for the resident (Submission 18, Submission 10). In addition, the Committee is aware that staff in aged care services are increasingly providing palliative care for their residents. In its response to the Interim Report, NSW Health submitted that:

> *Changes in models of care in acute hospitals which have lead to increases in early discharge of patients and residents returning to aged care facilities much earlier following an acute episode* (Submission - 11 September 1997).

The Ageing and Disability Department noted that there needs to be further work done to achieve a better mix of services across residential care, housing, sub-acute and community care, concluding:

> *Providing sub-acute care in nursing homes should therefore be considered in the context of achieving a better balance of care in the system as a whole* (ADD Submission - 11 September 1997).

The Committee believes that the provision of appropriate care and support across service settings should be considered in the context of the NSW Aged Care Strategy recommended in Chapter One of this Report.

RECOMMENDATION 62:

The Committee recommends that in the development of the NSW Aged Care Strategy the Ageing and Disability Department consult with NSW Health to include consideration of the provision of appropriate care and support services across service settings, including sub-acute and palliative care.

- **Hostel Infrastructure**

The current state of hostels in New South Wales is generally good, with 88% having been built since 1960. Of those hostels built before 1990, 45% had been refurbished since 1990. However, there is a minority of hostels which are substandard, with 16% required by a government authority to upgrade (Gregory, 1994: 52).

Since 1989, charitable hostels have been able to access a Commonwealth contribution for capital funding costs, in addition to charging an entry contribution. The capital contributions are prioritised according to need, and the level of capital funding increases depending on the proportion of FDPs housed (Gregory, 1994: 48, 55). This program was curtailed under the last federal budget, so that only $10 million is now available for residential aged care facilities each year, with rural and remote areas to be specifically targeted.

Gregory described the funding sources for hostels, including Variable Capital Funding provided since 1989, variable user fees, and entry contributions, and concluded that hostels:

> *Should be able to access sufficient income to build and then maintain and upgrade stock into the future with no further call on Government capital funds* (Gregory, 1994: 57).

Only those with a higher than average FDP proportion should require additional capital funds.

Thus it would seem that hostel capital and infrastructure is sufficient to maintain the existing services. With vacancy levels in hostels (which will be known as low care residential aged care facilities) estimated to be around 6%, there may be room for some expansion of residential or respite residential services (Submission 15).

6.5.2 EXPANDING EXISTING COMMUNITY BASED PROGRAMS

- **Day Centres, Day Programs and Community Care**

Submissions suggested that expanded services could be provided through adequately resourced day centres. Existing infrastructure, administration and staff in residential facilities could be used to expand day services, if they received adequate funding. This would provide respite for carers and help overcome the social isolation that has in the past led elderly people to seek hostel accommodation.

Such day centres are a useful strategy to achieve the long term aim of reduced reliance on residential care:

> *One of the things that we do know is that the more services that are provided to healthy older people, the longer they will stay out of residential care. The more you can do to keep them interested and involved, the less likely they are to come into any kind of residential care. So it is absolutely vital to encourage [day centres] because they are a very low cost option for the government and they also make use of the considerable voluntary efforts that are available in the community* (MacDonald, Evidence - 21 April 1997).

The expansion of services for the aged may require the use of infrastructure existing outside of the residential aged care industry. This includes community facilities, churches and church facilities, and local council facilities. The Uniting Church believes that such infrastructure has great potential for provision of services to the aged.

Mr Les MacDonald, Executive Director of the Uniting Ministry with the Ageing explained to the Committee that mainstream churches are already involved in using their facilities for aged services:

> *... there is an extensive use of non-aged care facilities [which] already provide particular day care services. They are provided out of dozens, perhaps hundreds, of our parishes now. ... I think it is absolutely crucial to the cost efficiency of our overall system that we continue to provide incentives for not just the churches but any other organisations, community based organisation, who have those kind of facilities, to encourage them to use them when they are not being used for other services for these kind of activities in supporting the aged* (MacDonald, Evidence - 21 April 1997).

Day programs providing rehabilitation services, services for people with dementia and services for people with disabilities would be particularly useful.

- **Respite Care**

The provision of respite care services can do much to avert or at least delay the need for residential aged care services. The stress associated with caring is one of the main precipitators to carers relinquishing care and seeking residential placement for the person for whom they are caring, particularly for carers of people with dementia, chronic illnesses or debilitating injuries. However, service providers argue that there is low occupancy of respite care beds (Submission 15). Other evidence to the Committee is that there is a huge level of need for respite care.

One factor preventing access to respite care is the expense. One family carer who is in receipt of a Carer's Pension submitted to the Committee that respite care is well outside his means (Submission 1). Under Commonwealth changes to be introduced

on 1 October 1997, respite care recipients will be charged daily fees equal to 87.5% of the aged pension. Another reason for the lack of use of respite services is lack of awareness that the service exists (Submission 15).

For service providers of residential respite care, the uncertainty of ensuring that the place will be filled and revenue generated has inhibited services from expanding the number of places offered above that which they are required. The Committee understands that the Commonwealth has tried a number of strategies in recent years to improve the uptake of respite care, in particular residential respite places. The 'Respite Options' project was one such attempt, which sought to guarantee services that their respite beds would be utilised by offering a comprehensive booking service and funds for purchase of places for a specific period of time.

Funding was provided to the South Western Sydney Area Health Service for the operation of the pilot program. The pilot has in a sense been taken over by a more recent initiative of the Commonwealth, the Carer Respite Centres. There are 12 centres operating throughout New South Wales, with another four planned, and these centres provide a 'one-stop shop' for respite care, offering co-ordination, booking service, as well as some brokerage funding to top up existing service levels. The service includes community and residential respite services, and the client group includes those who would normally be eligible for HACC services, as well as people with a chronic illness.

RECOMMENDATION 63:

The Committee recommends that the Ageing and Disability Department, in developing the NSW Aged Care Strategy as proposed Recommendation 4 of this Report, consider the adequacy of the provision of respite care in New South Wales, including evaluation of flexible and responsive respite options to better meet the needs of carers and older people.

- **Supported Accommodation**

As noted previously in Chapter Four of this Report, the abolition of Hostel Care subsidies may remove hostels as supported accommodation options for older people who do not have personal care needs. Alternatives will have to be developed. The Aged Services Association told the Committee:

> *Government somewhere has to provide a systemic response. If it is not the hostel system, and I wouldn't have a real argument with that, it needs to be another appropriately funded response* (Ireland, Evidence - 28 April 1997).

Aged care workers from Governor Phillip Hospital submitted that independent aged persons:

> *... may however benefit from the social advantages of hostel-like environments. Loneliness is a very significant risk factor for ill-health. Nonetheless, Hostels are not necessary for independent older people. Other housing alternatives need to be developed* (Submission 59).

The existing alternatives are boarding houses and public housing, neither of which are entirely appropriate as accommodation for elderly people. Public housing is already under considerable strains, with substantial waiting lists for accommodation. This under-supply is likely to be exacerbated by planned cuts to funding for public housing. In addition, public rental accommodation does not address the need for social support that those seeking hostel care require.

The suitability of boarding houses is questionable because they are not required to offer services or care to residents, and they are not subject to outcome standards. Residents of boarding houses are not currently protected by tenancy regulations, though this is under review.

The Aged Care Alliance submitted that new accommodation alternatives are required because:

> *the combined effect of State and Federal policy changes in 1996/97 (aged care, housing, HACC, etc) raises serious concerns about the adequacy of accommodation for independent ageing persons of little means. The Alliance encourages the New South Wales Government to develop and fund, as a priority, a strategic approach to improving access to secure, affordable housing for older people* (Submission 82).

Victoria's Special Residential Accommodation Services were suggested as a possible model for New South Wales. The National Association of Nursing Homes and Private Hospitals noted that:

> *Such accommodation houses in Victoria are licensed by the State Government and have been able to fill the needs gap between care within the home and nursing home care regimes* (Submission 24).

Another Victorian program is the "moveable units" program, which are available to people who have assets less than $30,000. These portable housing units can be placed in the backyards of relatives or friends to provide support whilst maintaining independence (Submission 15). Moveable units may an appropriate means to meet the supported accommodation needs of some older people in New South Wales.

As noted earlier in this Report, there are a range of alternative support and accommodation options that could be developed in light of the Commonwealth reforms to aged care. The work of the Accommodation Task Force addresses this issue. In its response to the Interim Report of this Inquiry the Ageing and Disability Department noted that one example of an option might be the development of Assisted Care Living apartments by aged care providers (ADD Submission - 11 September 1997).

RECOMMENDATION 64:

The Committee recommends that in the development of the NSW Aged Care Strategy the Minister for Aged Services include discussion of the range of alternative supported accommodation options which might be available for older people, including assessing the Victorian moveable units program as an option for New South Wales.

6.6 CONCLUSION

Aged care is undergoing fundamental change, and this change is not limited to the implementation of the *Commonwealth Aged Care Act, 1997.* There is a clear need for improved planning for and provision of aged care services to meet current needs, as well as to prepare society for the future needs for accommodation, care and support services for older people. The Committee has made recommendations about the need for improved planning for aged care at both national and State levels in Chapter One of this Report.

The continued discussions regarding the transfer of aged care (COAG reforms) pose serious questions for New South Wales. The Committee is concerned that this issue is being pursued on a bilateral basis, without any agreed national framework or principles underpinning the delivery of aged care. The Committee believes that New South Wales must begin to consider the implications of the transfer seriously and engage in dialogue with the Commonwealth over the proposed reforms to ensure that older people in New South Wales are not left behind compared to those in other States and Territories (Recommendation 61). The Committee is also very clear in recommending that the lead agency for undertaking this responsibility, and responsibility for aged care matters more generally in New South Wales, is the Ageing and Disability Department.

The Committee is concerned, however, that the discussion of need for reform at the 'big picture' level does not obscure the need for reform at the local level of service delivery. The Committee believes there continues to be capacity for more flexible and innovative use of existing services, design of new services, as well as a need for enhancement of existing services. Further exploration of these issues needs to occur within the context of developing the NSW Aged Care Strategy proposed in Recommendation 4 of this

Report. While the Committee expects that some of these changes can be undertaken in a cost-neutral environment, it is clear that there will need to be additional resources if the future needs of older people in New South Wales, and their carers, are to be better met.