Submission No 55

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Organisation: Anglicare Sydney and Anglicare Northern Inland

Date Received: 22 November 2021

Voluntary Assisted Dying Bill 2021

Anglican Community Services Submission

November 2021

Submission to the Standing Committee on Law and Justice
Inquiry into the Provisions of the *Voluntary Assisted Dying Bill 2021*

1. Overview of Anglican Community Services (Anglicare)

1.1 Anglican Community Services (trading as Anglicare, Anglicare Sydney and Anglicare Northern Inland) is a not-for-profit organisation of the Anglican Church and one of the largest Christian community service organisations in Australia. Anglicare exists to serve people in need in our community, enrich lives, and share the love of Jesus. We respect and value every person as made in the image of the living God. We seek to serve those who are ageing, vulnerable or marginalised by meeting material, physical, emotional, social and spiritual needs.

1.2 We operate a wide range of community and aged care programs across the Sydney Metropolitan, Illawarra, Shoalhaven, Blue Mountains and New England regions of New South Wales. Our 4,000+ staff and more than 2,000 volunteers work across a diverse range of services including community education for families; youth services; foster care and adoption services; mental health services, retirement living, social & affordable housing, emergency relief for people in crisis; aged care both through residential aged care facilities and community services; opportunity shops providing low-cost clothing; emergency management services in times of disaster; and chaplaincy in hospitals, prisons, in mental health facilities juvenile justice institutions and with the NSW Police Force.

1.3 Anglicare has extensive experience in designing and delivering aged care and carer specific services for older people including:

- 23 Residential Aged Care (RAC) facilities
- 2,400 approved beds in RAC with over 2,300 residents
- 4,368 older customers of residential in-home community care packages
- Over 2,700 dwellings in Retirement Living Villages
- Flexible respite programs, overnight cottage-based respite for older people
- 20 Centre-based respite services for older people
- Emotional Wellbeing for Older Persons program
- A Dementia Advisory and Carer Support Service - Nepean/Western Sydney

1.4 Anglicare also provides services which support people who experience mental illness through NDIS funded services, Early Intervention Mental Health Family Support, Child and Parenting Support other community outreach programs which support people who experience mental ill health, alongside personal and family counselling.

1.5 The Anglican Church Diocese of Sydney has produced a separate submission, to be read in parallel with this submission. Amongst other matters the Diocese of Sydney's submission details;

- general serious concerns with the current Bill- with which we concur, and
- specific concerns with the provisions of the Bill, around the prioritisation of Voluntary Assisted Dying over accessible high quality palliative care for all NSW residents, the lack of essential safeguards within this proposed Bill, and the need for more appropriate conscientious objection provisions.

1.6 We welcome the opportunity to make this submission and we give consent for this submission to be published. Our contact details are as follows.
Full Name: The Reverend Dr Andrew Ford

2. Anglicare's in principle opposition

2.1 Anglican Community Services (Anglicare) is opposed in-principle to the Bill.

2.2 Anglicare opposes physician assisted suicide in all its forms. In short, this opposition is driven by our commitment to life through all its stages, and our desire to help people live well until they die well naturally.

2.3 Our opposition is driven by our deep concern (validated by the experience in multiple jurisdictions) that legislation providing for physician assisted suicide and other forms of euthanasia can never truly protect the most vulnerable from abuse as they approach their death. Further, our opposition is founded in the ongoing vulnerability of the exceptions and limitations in the initial scope envisaged in this Bill, to erosion through legislative amendment over time (again, validated by the consistent widening in the scope of such legislation in other jurisdictions).

2.4 The Bill would force a fundamental change in the societal understanding of suicide – and would corrode the elemental sacred prohibition on one private citizen actively engaging in the ending of another person's life. Moreover, the Bill would change the relationship between medical professionals (who take an oath to provide life-affirming treatment and care) and patients, by introducing uncertainty and fear into these relationships.

3. Anglicare's position on palliative care

3.1 Anglicare is deeply committed to excellence in the delivery of end-of-life, palliative care services that holistically support a person's physical, emotional and spiritual wellbeing through the last stage of life. Anglicare has a nurse-led, palliative care team who assist our residential and community based aged care staff, to provide exceptional end-of-life care to our residents and clients. Anglicare considers physician assisted suicide to be the antithesis of this approach.

3.2 Anglicare believes that every person is uniquely made in the image of God and has dignity and worth, whatever physical or mental capabilities they possess or whatever circumstances in which they find themselves. For people who are nearing the end of their lives, and/or experiencing physical or psychological pain, a dignified and enriched life includes their right to receive and refuse medical treatment and be accepted and cared for well by our community.

3.3 A person's autonomous decisions cannot be viewed in isolation from their relationships, and the expectations placed on them by family, carers, friends and the community at large. People who are facing life-limiting (terminal) illness have no less dignity and worth in our community than their healthy counterparts, and we resolve to care for peoplein this situation by restating that they have value and purpose as individuals and as part of our community, even amidst pain and grief. They are not a burden to us, and they are not a burden on our society. We seek to uphold their value and worth by providing excellent palliative care services and honouring a

person's decisions regarding their wishes should their body require management of significant symptoms, such as pain.

3.4 We support the process of natural dying, which includes the management of significant symptoms (pain, breathlessness, nutrition needs). The level of intervention required for any individual is based on a collaborative decision between the person dying and their treating physicians. Whilst we are aligned with the Bill's intention to provide choices to a person facing a life-limiting illness, we do not agree that dignity and compassion are embedded in a decision to end a life through an act of administering a substance through voluntary assisted dying. We believe that dignity and compassion in such circumstances includes:

- *Active empathy:* we attempt to understand a person's feelings, experiences and wishes, and act accordingly to assist in supporting their living. We understand and appreciate a person's desire to refuse treatment that would prolong their life, and support them in that choice by providing a palliative approach to their care, inclusive of promotion of advanced care planning.
- *Honouring a dignified and enriched life:* we speak and act upon our belief that a person who requires intensive physical and/or psychological support is not a burden to us, and continues to have inherent value and worth as a person and member of our community. We reinforce to all our residents and clients in this situation that they are valued by us and the community, even when they feel like their lives may be burdensome to others.
- *Excellent palliative care support:* we provide services to people in residential care homes or in their homes to compassionately relieve their physical and psychological pain with a holistic approach.

4. Primacy of palliative care for life-limiting illness

4.1 Anglicare is therefore committed to the provision of a palliative approach to care for all residents and clients with a life-limiting illness and the provision of excellent end of life care.We desire to carry out and promote justice and compassion in all of our end-of-life care – a dignified and enriched life where the individual is honoured and understood, with an empathetic response to the person as they approach death, addressing all their needs. It is our hope and goal that everyone in our services and across the community has access to consistent and expert palliative care to live through their last days with dignity. Anglicare's palliative care practice is shaped by international and national standards and our approach improves the quality of life for a patient and their family when faced with a life- threatening illness. Palliative care entails the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical psychosocial and spiritual (World Health Organisation, 2021[1]):

All people approaching the end of their life require some level of support and access to a range of health and other support services. The range and depth of services required is dependent on the nature and length of the illness.

Anglicare will enable all persons, whether living at home or in a residential setting, to access the appropriate services and care they require. These include advance care planning, symptom

[1] WHO Definition of Palliative Care, available here: https://www.publichealth.com.ng/who-definition-of-palliative-care/#:~:text=The%20World%20Health%20Organization%20%28WHO%29%20defines%20palliative%20care,pain%20and%20other%20problems%2C%20physical%2C%20psychosocial%2C%20and%20spiritual%E2%80%99.

management, and end of life care, ensuring the best quality of life possible. [Anglicare Palliative Model of Care Module]

4.2 In accordance with our standard, Anglicare provides palliative care in a manner which:

- promotes relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- neither hastens nor postpones death;
- integrates the psychosocial and spiritual aspects of the person;
- helps people live as actively as possible until death;
- helps the family cope during the person's illness and in their own bereavement;
- uses a team approach to address the needs of the person and their family; and
- enhances quality of life which may also positively influence the course of illness.

4.3 We believe that a compassionate and dignified death is a natural one that is neither hastened nor prolonged, where care is provided through relief from pain, and reassurance is given that the person is valued by us. As an organisation, we do not define a person by their *pain,* rather we focus on their *life.* One essential component to enhancing someone's quality of life is the relief of their pain. Enhancing a person's quality of life also entails other aspects such as supporting them in what brings meaning to them in their life. We support an individual to transcend physical barriers [of pain] so that they can appreciate and experience the things that matter most to them in their life. This includes social, familial, spiritual, physical or any other domain for enjoyment and experience of life and relationships. Our goal is to support people to keep experiencing the things that matter most to them in their lives, until their death.

4.4 People across our community who are facing life-limiting illnesses and nearing their death require access to consistent and adequate palliative care. We believe that this goal could be achieved through a more rigorous approach to training and educating health professionals (both nurses and physicians) and greater resourcing of palliation support (across residential and community care). It is generally accepted across the aged care sector that there is an under-resourcing of palliative care nurse specialists (community and residential settings) and palliative care support to assist someone to die in their home.[2] This is unfortunate given that it is often a person's desire to stay in their home for their death. The administration and management of proper palliative care requires intensive 24/7 support and oversight of the dying person. Whilst clinical community support workers can provide some of this assistance, there is a greater onus on the partner (who in the case of the elderly patient is usually frail themselves), family and close friendswho are willing to be involved in the care of their loved one. This places a lot of strain and pressure on the family and social support networks. Inadequate resourcing of palliative care support programs in the community increases pressures on families, carers and other servicesthat are not equipped to provide palliative care.

4.5 In some cases, excellent palliative care is an essential component to a compassionate and dignified death. We recommend that excellent palliative care services continue to be prioritised, adequately funded, and offered across the entirety of this State. We strongly urge

[2] Palliative care roundtables - Palliative care (nsw.gov.au): https://www.health.nsw.gov.au/palliativecare/Pages/Palliative-Care-Roundtables-2017.aspx

the NSW Government to continue to commit resources to the provision of palliative care support for this vulnerable cohort of people facing a life-limiting illness. We acknowledge that this continues to be a significant task for Federal and State Governments, service providers and medical professionals. Nevertheless, we are committed to jointly achieving this goal that everyone facing a life-limiting illness knows that they are valued and cared for by their community and provided a dignified and compassionate death through palliative care support.

4.6 Significant advances in palliative care continue to be made. We are concerned that the introduction of the provision in this Bill will both curtail further improvement in practice, but moreover perversely result in a less equitable provision of appropriate public funded palliative care services across the entirety of the State of NSW.

Anglicare continues to recommend that Palliative Care funding and resources across NSW include as a minimum:

- **consistent support and services across metropolitan and all regional/remote areas;**
- **support and services for residential aged care and home care;**
- **improved and increased training for physicians and nurses; and**
- **increased community awareness of advance care planning and the end-of-life support and service that are available.**

5. Specific provisions of concern in the Bill

5.1 Noting Anglicare's in-principle opposition to the Bill and physician assisted suicide, we have specific concerns pertaining to the provisions in the Bill that provide only a very limited *institutional conscientious objection* to providers of Residential Aged Care.

5.2 Section 89(1) of the Bill provides for residential facilities to determine that they *'will not provide services relating to voluntary assisted dying at the establishment or facility'*.[3] Section 89(2) of the Bill goes on to provide that, for the purposes of section 89(1), a residential facility *'may refuse to do any of the following'* matters, including:[4]

(a) participate in the request and assessment process;

(b) participate in an administration decision;

(c) prescribe, supply or administer a voluntary assisted dying substance;

(d) store a voluntary assisted dying substance; or

(e) be present at the time of the administration of self-administration of a voluntary assisted dying substance.

5.3 Sections 89(1) and 89(2) are expressly stated to be subject to Divisions 2 and 3 of Part 5 of the Bill.[5] Division 2 places a number of obligations on residential facilities to provide access for:

[3] *Voluntary Assisted Dying Bill 2021* (NSW), section 89(1) [public consultation draft]
[4] *Voluntary Assisted Dying Bill 2021* (NSW), section 89(2) [public consultation draft]
[5] *Voluntary Assisted Dying Bill 2021* (NSW), section 89(3) [public consultation draft]

(a) registered health practitioners or other persons to provide residents with access to information about voluntary assisted dying;[6]

(b) medical practitioners for the purpose of facilitating first and final requests for voluntary assisted dying;[7]

(c) relevant practitioners to attend on permanent residents for the purpose of first assessments for voluntary assisted dying;[8]

(d) relevant practitioners to attend on a resident who is not a permanent resident at the facility in certain circumstances for the purpose of first assessments for voluntary assisted dying;[9]

(e) relevant practitioners to attend on permanent residents for the purpose of consulting assessments for voluntary assisted dying;[10]

(f) relevant practitioners to attend on a resident who is not a permanent resident at the facility in certain circumstances for the purpose of consulting assessments for voluntary assisted dying;[11]

(g) relevant practitioners to attend on permanent residents for the purpose of obtaining written declarations for voluntary assisted dying;[12]

(h) relevant practitioners to attend on a resident who is not a permanent resident at the facility in certain circumstances for the purpose of obtaining written declarations for voluntary assisted dying;[13]

(i) relevant practitioners to attend on permanent residents for the purpose of applications for administration decisions for voluntary assisted dying;[14]

(j) relevant practitioners to attend on a resident who is not a permanent resident at the facility in certain circumstances for the purpose of applications for administration decisions for voluntary assisted dying;[15]

(k) permanent residents to obtain access to voluntary assisted dying substances, or for practitioners to attend to administer voluntary assisted dying substances;[16] and

(l) a person who is not a permanent resident to obtain access to voluntary assisted dying substances, or for practitioner to attend to administer voluntary assisted dying substances, in certain circumstances.[17]

5.4 Anglicare endorses the approach set out in section 89 of the Bill of enshrining the right of facilities to refuse to participate in physician assisted suicide or any other form of euthanasia. However, this right of refusal should not be subject to the obligations imposed under Division 2. These

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[6] *Voluntary Assisted Dying Bill 2021* (NSW), section 90 [public consultation draft]
[7] *Voluntary Assisted Dying Bill 2021* (NSW), section 92 [public consultation draft]
[8] *Voluntary Assisted Dying Bill 2021* (NSW), section 93(2) [public consultation draft]
[9] *Voluntary Assisted Dying Bill 2021* (NSW), section 93(3) [public consultation draft]
[10] *Voluntary Assisted Dying Bill 2021* (NSW), section 94(2) [public consultation draft]
[11] *Voluntary Assisted Dying Bill 2021* (NSW), section 94(3) [public consultation draft]
[12] *Voluntary Assisted Dying Bill 2021* (NSW), section 95(2) [public consultation draft]
[13] *Voluntary Assisted Dying Bill 2021* (NSW), section 95(3) [public consultation draft]
[14] *Voluntary Assisted Dying Bill 2021* (NSW), section 96(2) [public consultation draft]
[15] *Voluntary Assisted Dying Bill 2021* (NSW), section 95(3) [public consultation draft]
[16] *Voluntary Assisted Dying Bill 2021* (NSW), section 97(2) [public consultation draft]
[17] *Voluntary Assisted Dying Bill 2021* (NSW), section 97(3) [public consultation draft]

obligations directly contradict the intent of section 89, by compelling facilities to enable physician assisted suicide to occur on the premises of the facility.

5.5 Anglicare submits that, consistent with the position in various other states, the Bill should be amended to ensure that facilities and organisations have the right to choose whether or not to participate in physician assisted suicide. Specifically, Anglicare presses that facilities and organisations should have the right to determine whether any of the activities contained in Division 2 will be permitted to be undertaken at their facilities.

5.6 In both Western Australia and Victoria, guidelines published by the relevant Departments of Health ensure that facilities and organisations have the ability to refuse to participate in physician assisted suicide or any form of euthanasia on their premises.

5.7 Relevantly, the Western Australian guidelines state at paragraph 3.3 under the heading *'health service involvement in voluntary assisted dying'*:[18]

'Different health services, such as private and public hospitals, community health services, primary care services, residential aged care facilities and others will have varying levels of involvement in voluntary assisted dying. Health services determine what level of involvement they have. This will depend on the type of care the service normally provides, the skills and expertise available within the service and the values of the service.'

…

Some health services or facilities may adopt policies that prohibit or substantially limit the provision of voluntary assisted dying services within their premises. This may be because their views are considered not to align with voluntary assisted dying . . .' (emphasis added).

5.8 Similarly, the Victorian guidance states:[19]

'If an aged care service provider is concerned about a person taking the voluntary assisted dying medication at a residential aged care service, staff may meet with the person to discuss the concerns, and potential alternatives that are respectful of the person's individual circumstances and the organisation's needs. This may include discussions and exploration of the following alternatives:

- *the person may be able to go to a carer's, family member or friend's home when they plan to take the voluntary assisted dying medication*
- *the person may remain at the service and consider an external referral for a health service/provider to provide additional care provision in relation to voluntary assisted dying.'*

5.9 Anglicare strongly advocates that facilities and organisations should have the right to choose whether they support physician assisted suicide and whether any or all of the activities contained in Division 2 will be permitted to be undertaken at their facilities. This approach is consistent with the position in Western Australia and Victoria.

[18] Western Australian Voluntary Assisted Dying Guidelines, paragraph 3.3, available here: https://ww2.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-guidelines.pdf

[19] Voluntary Assisted Dying Guidance for Aged Care Providers, page 6, available here: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vad-guidance-aged-care-providers

5.10 Anglicare presses that, at an absolute minimum, the protections in section 89 of the Bill that permit facilities to decide not to provide physician assisted suicide should be maintained.

5.11 Anglicare further asserts that, at an absolute minimum, the following amendments should be made to the Bill:

(a) an amendment to section 89(3), so that the right to decide not to provide physician assisted suicide is not subject to Part 5, Division 2, subdivision 3, which outlines the process for the administration of a *'voluntary assisted dying substance'*;

(b) an amendment to Part 5, Division 2, Subdivision 3 to make it clear that there is no obligation on approved providers of residential aged care to allow physician assisted suicide (i.e., the administration of a *'voluntary assisted dying substance'*) to be administered at their facility; and

(c) amendments to section 97 to expressly provide that, in the event that a permanent or non-permanent resident of a residential facility is preparing for the administration of a *'voluntary assisted dying substance'* and they reside at a facility which does not provide physician assisted suicide, the facility with engage with the resident to transfer them to an alternative location where the resident can receive the *'voluntary assisted dying substance'*.

5.12 Although Anglicare maintains its in-principle opposition to the Bill, the amendments proposed would assure Christian residential aged care providers of legislative protection for refusing to engage in any or all elements in the provision of physician assisted suicide. These amendments would still enable residents in Anglicare facilities to engage in the administrative process that underpins physician assisted suicide while at an Anglicare facility, but would permit Anglicare to require the resident to be transferred to another facility (or a private residence) in order to access the *'voluntary assisted dying substance'*. This ensures that the act of physician assisted suicide does not take place at an Anglicare facility and that Anglicare personnel are not compromised through assistance required to be rendered to prematurely end the life of a resident.

5.13 Anglicare endorses the advertising requirements contained in section 98 of the Bill. Should the Bill pass we intend to clearly communicate to all existing and potential residents that Anglicare does not provide physician assisted suicide or euthanasia in any form, so that this could never be a surprise to residents, their carers, families, or support networks.

5.14 Anglicare includes the proposed amendments to section 89 and 97 of the Bill at **Annexure 1** of this submission, for your consideration.

5.15 Although places of specific health care delivery, at their best Residential Aged Care facilities are home for those who live there. Proponents of the Bill note that people should not be restricted from lawful choices in their home. Affirming and enabling the individual's choice drives this Bill. The amendments proposed here would not significantly constrain choice for those who want to make use of the provisions under the Bill. However, it would require a preliminary choice to select a Residential Aged Care facility that provided this 'service'. Critically, these proposed amendments would also clearly affirm the choice of the vast majority of the residents in our Residential Aged Care facilities, for they have chosen a home within these communities alongside other resident, staff and visitors which are places to live well to the end and to experience life-affirming care.

CONCLUDING STATEMENT

Anglicare Sydney and Anglicare Northern Inland appreciate the opportunity to contribute to the Standing Committee's deliberations on this very important issue.

Grant Millard

Chief Executive Officer

Annexure 1 – Proposed amendments to *Voluntary Assisted Dying Bill 2021* (NSW)

89 Participation in providing voluntary assisted dying services

(1) A health care establishment or residential facility may decide that it will not provide services relating to voluntary assisted dying at the establishment or facility.

(2) For the purposes of subsection (1), the health care establishment or residential facility may refuse to do any of the following or refuse to have persons employed by or at the establishment or facility do any of the following at the establishment or facility –

(a) participate in the request and assessment process;
(b) participate in an administration decision;
(c) prescribe, supply or administer a voluntary assisted dying substance;
(d) store a voluntary assisted dying substance;
(e) be present at the time of the administration or self-administration of a voluntary assisted dying substance.

(3) Subsections (1) and (2) are subject to the requirements of Divisions 2 and 3, except for Division 2, Subdivision 3.

(4) For the avoidance of doubt, a residential facility is not required to permit either –

(a) a person who is a permanent resident at the residential facility; or
(b) a person who is not a permanent resident at the facility

to access a voluntary assisted dying substance on the premises of the residential facility.

97 Administration of voluntary assisted dying substance

(1) This section applies if –

(a) the person has made an administration decision; and
(b) the person or the person's agent advises the relevant entity that the person wishes to self-administer a voluntary assisted dying substance or have the person's administering practitioner administer a voluntary assisted dying substance to the person; and
(c) the relevant entity does not provide, to persons to whom the relevant services are provided at the residential facility, access to the administration of a voluntary assisted dying substance at the facility.

(2) If the person is a ~~permanent~~ resident at the residential facility, regardless of whether they are a permanent resident or not a permanent resident, the relevant entity and any other entity that owns or occupies the facility must –

(a) if the person has made a practitioner administration decision – ~~allow reasonable access to the person at the facility by the following persons –~~
~~(i) the person's administering practitioner for the practitioner to administer a voluntary assisted dying substance to the person;~~
~~(ii) any other person lawfully participating in the person's request for access to voluntary assisted dying, including an eligible witness to the administration of the voluntary assisted dying substance by the person's~~

~~administering practitioner~~

take reasonable steps to engage with the resident and transfer them to alternative premises where they are able to have the voluntary assisted dying substance administered by their administering practitioner; or

(b) if the person has made a self-administration decision –

~~(i) allow reasonable access to the person at the facility by a person lawfully delivering a voluntary assisted dying substance to the person, and~~

~~(ii) allow reasonable access to the person at the facility by another person lawfully participating in the person's request for voluntary assisted dying, and~~

~~(iii) not otherwise hinder access by the person to a voluntary assisted dying substance~~

take reasonable steps to engage with the resident and transfer them to alternative premises where they are able to store and/or self-administer the voluntary assisted dying substance.

(3) ~~If the person is not a permanent resident at the residential facility—~~

~~(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place where the person may be administered or may self-administer a voluntary assisted dying substance, or~~

~~(b) if, in the deciding practitioner's opinion, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, subsection (2) applies in relation to the person as if the person were a permanent resident at the residential facility~~

The refusal of a person who is –

(a) a permanent resident of a residential facility; or

(b) not a permanent resident of a residential facility

to be transferred to alternative premises for the purposes of accessing a voluntary assisted dying substance does not in any way impact the ability of the residential facility to refuse to provide access to a voluntary assisted dying substance on the premises of the facility in accordance with section 89.

(4) ~~In making a decision for subsection (3)(b), the deciding practitioner must have regard to the following—~~

~~(a) whether the transfer would be likely to cause serious harm to the person,~~

~~(b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying,~~

~~(c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying,~~

~~(d) whether the place to which the person is proposed to be transferred is available to receive the person,~~

~~(e) whether the person would incur financial loss or costs because of the transfer~~

In making a decision as to appropriate premises to which a resident at the residential facility, regardless of whether they are a permanent resident or not a permanent resident, should be transferred, the deciding practitioner and the relevant residential facility must have regard to the following, and only support alternatives that are in the best interests of the resident –

(a) whether the transfer would be likely to cause serious harm to the resident;

(b) whether the premises to which the resident is proposed to be transferred are able to receive the resident; and

(c) the extent of financial loss or costs that the resident would incur because of the transfer.