No. 17

PARLIAMENT OF NEW SOUTH WALES

LEGISLATIVE COUNCIL

STANDING COMMITTEE ON SOCIAL ISSUES

CARING FOR THE AGED

INQUIRY INTO AGED CARE AND NURSING HOMES IN NEW SOUTH WALES

Ordered to be printed 30 September 1997,
according to Resolution of the House

Report Number 14 September 1997

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September 1997

Standing Committee on Social Issues, Report No. 14

ISBN 0 7313 1341 0

TERMS OF REFERENCE

1. That the Standing Committee on Social Issues inquire into, and report on, the state of nursing homes in New South Wales and in particular:

a) the extent to which the dignity, privacy, confidentiality and other rights of residents are protected;

b) the effect of transferring the responsibility and management of nursing homes from the Commonwealth to the State Government;

c) the likely impact of the introduction of entry fees and the increase in user-fees for nursing home residents;

d) the adequacy of supported hostel-type accommodation to meet the needs of independent ageing persons;

e) the use of existing capital infrastructure to expand services for the aged; and

f) the impact on the aged community of the decision of the New South Wales Government to close the Office on Ageing and create the new Ageing and Disability Department.

2. That the Committee report by Monday, 30 June 1997.

PLEASE NOTE:

The reporting date was extended by order of the House to 30 September 1997.

COMMITTEE FUNCTIONS

The functions of the Standing Committee on Social Issues are to inquire into, consider, and report to the Legislative Council on:

- any proposal, matter or thing concerned with the social development of the people in all areas of New South Wales;
- the equality of access to the services and benefits including health, education, housing and disability services provided by the Government and non-Government sector to the people in all areas of New South Wales;
- recreation, gaming, racing and sporting matters; and
- the role of Government in promoting community services and the welfare of the people in all areas of New South Wales.

Matters for inquiry may be referred to the Committee by resolution of the Legislative Council, a Minister of the Crown, or by way of relevant annual reports and petitions. The Committee has the legislative power to:

- summons witnesses;
- make visits of inspection within Australia;
- call upon the services of Government organisations and their staff, with the consent of the appropriate Minister;
- accept written submissions concerning inquiries from any person or organisation; and
- conduct hearings.

COMMITTEE MEMBERSHIP

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TABLE OF CONTENTS

CHAIR'S FOREWORD

As in most developed nations, the Australian aged population is growing and changing both in terms of numbers and as a proportion of the population. The cohort is set to rise even more substantially as the "baby boomer" generation retires. The shape of the age pyramid is changing significantly. Clearly, this demographic trend has implications for social policy as the community faces the diverse and complex needs of this group.

Evidence shows that the majority of aged citizens are healthy and independent with only 7% requiring residential care. Older people make an invaluable contribution to their families, local communities and society as a whole. Numerous community organisations, for example, rely heavily upon the time and expertise readily given by these individuals. The healthy aged have positive ways of interacting with the community.

The Committee has been asked to look at the adequacy of nursing home arrangements including the protection of residents' dignity, privacy and confidentiality and to make recommendations to the New South Wales Parliament arising from our Inquiry.

Given the imminence of the Commonwealth's changes the Committee released an Interim Report on 30 June 1997 which outlined the changes which were the subject of the *Aged Care Bill* before Federal Parliament at that time and commented upon them. The Committee felt that there were a number of broader issues which it wished to investigate further. It has included such issues in this its Final Report.

As always, the Committee is grateful for the input it received from a number of individuals and organisations who took the time to make submissions and speak with the Committee. In addition, staff and residents freely shared their experiences with Committee Members during site visits to New South Wales nursing homes at Waverley, Summer Hill and a number of rural centres including Cessnock, Baradine, Trangie, Walgett and Warren in addition to Wudinna and Elliston on the Eyre Peninsula in South Australia.

Once again my Parliamentary colleagues set aside time to consider a range of complicated issues under exceptionally tight deadlines and I thank them for this.

I also wish to thank the Committee's Secretariat staff who performed an excellent task within a very strict time frame. Ms Tanya van den Bosch had prime responsibility for conducting the initial stages of this Inquiry and preparing the Interim Report. Ms Anita Westera, a secondee from the Ageing and Disability Department, brought considerable experience and expertise to the Inquiry and was responsible for completing the Final Report. I am grateful to both of these women for the careful manner in which they undertook the complex research associated with this topic. Committee Officers, Ms Jane Millet and subsequently Ms Heather Crichton were actively involved in all aspects of the Inquiry. Ms Millet assisted in the early phase of the Inquiry while Ms Crichton was primarily responsible for all administrative aspects of the Inquiry process and the production of both the Interim and Final Reports. Additional research assistance for the Interim Report was provided by Ms Gabrielle Leahy, a Macquarie University postgraduate student undertaking an internship at Parliament.

I commend this Report to the government and the community.

THE HON. ANN SYMONDS, M.L.C.
COMMITTEE CHAIR

EXECUTIVE SUMMARY

On 31 October, 1996 the Standing Committee on Social Issues received a reference from the Legislative Council of the Parliament of New South Wales to inquire into the state of nursing homes and hostels in New South Wales and report to the Legislative Council by 30 June, 1997. This date was subsequently extended to 30 September, 1997.

The Committee was asked to report on the current state of nursing homes and hostels and examine the likely effects on New South Wales of Commonwealth Government proposals for changes to aged care as contained in the *Commonwealth Aged Care Act, 1997*. The specific issues of inquiry are: the protection of residents' rights; the likely impact of a user-pays system of funding; the adequacy of 'hostel-type' accommodation; and the use of existing capital infrastructure for the aged. Beyond these issues relating to residential facilities, the Committee has been asked to comment on the impact on the aged community of the closure of the Office on Ageing and the creation of the Ageing and Disability Department.

The Interim Report of this Inquiry was tabled on 30 June 1997, and made a number of recommendations about improving aged care for people in New South Wales. This report builds on the work of the Interim Report, and takes into account the developments which have occurred since its tabling. This Final Report highlights the need for a strategic approach to aged care in New South Wales.

The Inquiry process included extensive research undertaken between November 1996 and September 1997. The Committee has heard from the principal stakeholders: consumers; private for-profit aged care providers; government and non-government not-for-profit aged care providers; and other interest groups such as government departments, local government bodies, community groups, researchers and health professionals.

Chapter One, Aged Care in New South Wales: Setting the Scene examines the policy and administrative context within which aged care sits in New South Wales. There is currently no national or New South Wales framework and/or agreed set of principles to guide the planning and delivery of services for older people. This is compounded in New South Wales by the absence of a lead agency to undertake strategic policy and planning for aged care. As a result, older people who require accommodation, care and support are not always provided with the support services they need. Services are fragmented, and the linkages which need to be made, such as between aged care and general and mental health care, transport and accommodation, are not well made.

This Chapter makes a number of recommendations about the need to improve aged care at the policy and administrative level to ensure that older people in New South Wales have equitable access to affordable, quality aged care services which are responsive to their needs.

Chapter Two, Ensuring Quality Services: Current Arrangements examines the current safeguards of residents' rights and notes that, generally speaking, the quality of care in nursing homes is high. Quality control is supervised predominantly by the Commonwealth through a comprehensive range of mechanisms, including Outcome Standards, Charters of Rights and Responsibilities, Mandatory Residential Agreements, Commonwealth Standards Monitoring Teams, a consumer advocacy body and a complaints mechanism. The State has only the nursing home licensing provisions under the *Nursing Homes Act, 1988*, and the *Nursing Homes Regulation, 1996* and recourse to the Health Care Complaints Commission.

However, there is a significant degree of non-compliance with Outcome Standards and despite the comprehensive monitoring, there is a reluctance to impose sanctions. The Committee heard that there are a number of important workforce issues which need to be addressed if quality care for residents is to be achieved. There is concern about the use of medication and restraint practices, particularly for people with dementia who have challenging behaviour. The Committee makes a number of recommendations about improving the quality of care provided by staff in residential aged care services, including the need for appropriate training for staff and management on the care needs of their clients.

Chapter Three, Ensuring Quality Services: New Arrangements considers the ways in which residents' rights will be protected through the examination of the quality control regime proposed by the Commonwealth's accreditation system, complaints mechanisms and prudential arrangements for the accommodation bonds.

Since the tabling of the Interim Report of this Inquiry further details about the reforms have been released, and on the whole, are considered to adequately protect the rights of residents. The establishment of an independent Complaints Resolution Committee has been welcomed by consumer groups. However, the Committee remains concerned that residents will not have direct access to that Committee. The prudential arrangements are widely regarded as providing protection for residents' accommodation bonds, but there is concern that the funds will not be sufficient to generate the amount of money needed to upgrade facilities. The Committee is concerned that a number of significant details about the standards monitoring regime have not yet been made available.

Chapter Four, Residents with Special Needs addresses the needs of particular sub-groups of residents whose needs are not well met, and whose rights will continue to be compromised under the new arrangements. The Committee heard that people with dementia make up a significant proportion of residents and yet staff generally are not skilled in caring for their particular needs. In addition to staff training, the availability of specialist staff who can provide advice and support to residential services, such as a network of community psychogeriatric teams, would assist the aged care industry to better meet the needs of residents with dementia and those with mental health problems.

People of diverse cultural and linguistic backgrounds also can be disadvantaged in aged care services, as these are generally not designed or delivered in a culturally appropriate way. Similarly, the Committee has found that particular needs of indigenous Australians requires a quite different response to that of non-Indigenous Australians.

The Committee heard much evidence about the difficulties facing rural and remote communities, and undertook a study tour of a number of communities, in particular to look at the operation of the Multi-Purpose Service models. The issue of younger people with disabilities who reside in aged care facilities was a major concern to the Committee, and highlights the need for improved planning and funding of appropriate services for this group of residents.

The removal of the subsidy for those people who entered hostels for accommodation and social reasons, rather than care needs, will have significant implications particularly for older people who are financially disadvantaged.

Chapter Five, Financing Aged Care considers the current (pre -1 October 1997) and future (post - 1 October 1997) funding arrangements for residential aged care, in particular the new system of funding the upgrading and maintenance of aged care facilities by the imposition of accommodation bonds. The Committee is concerned that industry needs will not be adequately met by the accommodation bond scheme, and that the limited Commonwealth capital grants program will be insufficient to meet the capital needs. While in the Interim Report the Committee noted its concern that the accommodation bond system may lead to a two-tiered system with the loss of access to quality care for poorer individuals (concessional residents), the Committee has since heard that the subsidy for concessional residents should be sufficient to prevent this happening.

The Committee remains concerned that the financing of aged care may place an unnecessary burden on frail older people to pay for their care needs, and believes that there must be a review of sustainable financing options to meet the long term care needs of older people in the future.

Chapter 6, Impact of Reforms and Future Directions addresses the impacts of the *Commonwealth Aged Care Act 1997* on the New South Wales Government and related services, including regulation of aged care, and the effect of the Commonwealth's proposal to transfer the responsibility and management of residential aged care to the State Government. The impacts of the Act are far-reaching, including public hospitals, guardianship board applications, public housing, and community care. These impacts highlight the need for a holistic approach to aged care, including making the linkages between aged care and related accommodation, care and support services which older people use.

The transfer of responsibility for residential aged care has raised considerable concern in the aged care sector, as well as Government. The Committee received strong evidence that aged care should not be considered within the health context, either at the administrative level or through the funding mechanisms. The recent decision of the Health and Community Services Ministerial Council to enter into bilateral negotiations about a range of reforms to aged care is of concern to the Committee, particularly as there are no agreed national parameters or principles about aged care to guide such negotiations.

The Chapter also considers how existing services can be expanded to provide more responsive and innovative accommodation, care and support options for older people both now and in the future.

The Committee believes that the information and recommendations embodied in this Report, if implemented, will effect significant improvements in the provision of aged care in New South Wales.

SUMMARY OF RECOMMENDATIONS

RECOMMENDATION 1: (Chapter 1)
The Committee recommends that the total responsibility for aged care in New South Wales rest with the Minister for Aged Services, and through the Minister, the Ageing and Disability Department, including responsibility for all aged care policy, planning and related program funding, and that the Department be adequately resourced to take on this role.

RECOMMENDATION 2: (Chapter 1)
The Committee recommends the Minister for Aged Services negotiate with the Commonwealth Minister for Family Services to develop a National Aged Care Strategy, including the establishment of a sub-group of the Health and Community Services Ministerial Council.

RECOMMENDATION 3: (Chapter 1)
The Committee recommends the Minister for Aged Services take up with relevant State and Commonwealth Ministers the need for regular meetings of Ministers on matters in relation to aged care planning and provision.

RECOMMENDATION 4: (Chapter 1)
The Committee recommends the Minister for Aged Services charge the Ageing and Disability Department to develop a NSW Aged Care Strategy which is consistent with the principles and directions established at the national level (as per Recommendation 2).

RECOMMENDATION 5: (Chapter 1)
The Committee recommends that the Minister for Aged Services and the Minster for Health ensure that the consultations on the NSW Healthy Ageing Strategy include a comprehensive discussion on the provision of aged care services in New South Wales.

RECOMMENDATION 6: (Chapter 1)
The Committee recommends that the Ageing and Disability Department conduct a review of relevant aged care legislation following the development of a NSW Aged Care Strategy (as per Recommendation 4) and provide advice to Government on whether the interests of older people, service providers and Government would be better served if there was a single NSW Aged Care Act developed.

RECOMMENDATION 7: (Chapter Two)
The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ensure that the Commonwealth Department of Health and Family Services collects data concerning breaches of accreditation standards and publishes them annually.

RECOMMENDATION 8: (Chapter Two)
The Committee recommends the Minister for Aged Services request of the Commonwealth Minister for Family Services to include State and Territory representatives on the Residential Aged Care Workforce Review Committee, and extend the Terms of Reference to include community aged care services.

RECOMMENDATION 9: (Chapter Two)
The Committee recommends that the Ageing and Disability Department include in the NSW Aged Care Strategy (see Recommendation 4) the development of a New South Wales aged care industry training framework, which builds on the work of the Commonwealth's Residential Aged Care Workforce Review Committee, and includes community care workforce issues.

RECOMMENDATION 10: (Chapter Two)
The Committee recommends that, as part of the development of a New South Wales aged care training framework (see Recommendation 9), the Ageing and Disability Department work with relevant stakeholders and the NSW Vocational Education and Training Accreditation Board (VETAB) to review existing accredited or approved aged care programs to ensure that they are driven from a social model of care perspective, as well as including the relevant clinical components.

RECOMMENDATION 11: (Chapter Two)
The Committee recommends that all nursing and personal care staff in New South Wales residential care facilities be trained to an Assistant in Nursing Course Certificate III level by the year 2000 and that a range of programs be made available to ensure equitable access to training.

RECOMMENDATION 12: (Chapter Two)
The Committee recommends that the Ageing and Disability Department include in its monitoring of the impact of the *Commonwealth Aged Care Act, 1997* information which will reflect the quality of care for residents and appropriate staffing profiles.

RECOMMENDATION 13: (Chapter Three)

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services change the complaints resolution process outlined in the third exposure draft of the *Commonwealth Aged Care Act, 1997 Principles*, Chapter 3, Part 1: Committee Principles to provide for residents to have direct access to the independent Complaints Resolution Committee without first having to lodge their complaint with the Secretary of the Department of Health and Family Services.

RECOMMENDATION 14: (Chapter Three)

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure the proposed accreditation-based system for quality control in residential aged care facilities embodies the following principles:

- an independent complaints body similar in structure to the Ombudsman's Office;
- the maintenance of the Commonwealth Department of Health and Family Services' role in monitoring the accreditation standards which are currently being developed;
- a separate unit within the Department of Health and Family Services to be responsible for imposing sanctions on facilities which fail to meet the accreditation standards;
- automatic application of the hierarchy of sanctions available under the *Commonwealth Aged Care Act*, 1997 for facilities failing to meet the same standard on three consecutive visits; and
- public access to accreditation standards reports, including posting the accreditation inspection reports in the foyer of each facility.

RECOMMENDATION 15: (Chapter Four)

The Committee recommends that the Ageing and Disability Department take into account the findings of the evaluation of the National Residential Dementia Training Initiative, and any recommendations of the NSW Advisory Group for the Initiative in its consideration of an aged care training framework (as per Recommendation 9).

RECOMMENDATION 16: (Chapter Four)
The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ensure that Dementia Training is included in the training curriculum for aged care services, or any other training program being considered by the Residential Aged Care Workforce Review Committee.

RECOMMENDATION 17: (Chapter Four)
The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to determine what dementia training will be made available by the Commonwealth in the future.

RECOMMENDATION 18: (Chapter Four)
The Committee recommends that, should the Commonwealth not provide dementia training in the future, the Minister for Aged Services develop and implement a training program similar to that offered under the National Residential Dementia Training Initiative, or contract out for the development of such a program, and that the Commonwealth be approached to provide funding for such a program.

RECOMMENDATION 19: (Chapter Four)
The Committee recommends that the Ageing and Disability Department consider allocating funds from within the NSW Action Plan for Dementia Care to support the establishment and/or ongoing viability of a central dementia resource centre for staff and management of aged care services.

RECOMMENDATION 20: (Chapter Four)
The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ascertain the whereabouts of resources produced under the National Action Plan for Dementia, previously housed at the Clearing House and Resource Centre at Monash University, and the possibility of including these resources in the collection to be established under Recommendation 19 above.

RECOMMENDATION 21: (Chapter Four)
The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services make available the findings of the environmental design consultancy undertaken as part of the National Action Plan on Dementia Care.

RECOMMENDATION 22: (Chapter Four)
The Committee recommends that when developing the NSW Aged Care Strategy, and contributing to the National Aged Care Strategy, the Ageing and Disability Department take into consideration developments in dementia and psychogeriatric care which have occurred internationally as well as within Australia, such as the cluster and group home models which have been developed in Europe.

RECOMMENDATION 23: (Chapter Four)
The Committee recommends that the development of the NSW Aged Care Strategy (see Recommendation 4) include the provision for a comprehensive network of community psychogeriatric teams.

RECOMMENDATION 24: (Chapter Four)
The Committee recommends that the Ageing and Disability Department and the NSW Health Department fund the establishment of a comprehensive network of community psychogeriatric teams, including funding for a budget-holding role which can be used for short-term interventions in community care settings and residential care services for people with challenging behaviours.

RECOMMENDATION 25: (Chapter Four)
The Committee recommends that the Ageing and Disability Department include in its monitoring of the impact of the *Commonwealth Aged Care Act, 1997* the appropriateness of funding for people with dementia.

RECOMMENDATION 26: (Chapter Four)
The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services release the report prepared by the Alzheimer's Association Australia on respite needs for people with dementia and their carers as soon as possible.

RECOMMENDATION 27: (Chapter Four)
The Committee recommends that the Minister for Aged Services negotiate with the Commonwealth Minister for Family Services to improve access to residential and day respite care in dementia-specific facilities and facilitate the development of more responsive and flexible models of respite care.

RECOMMENDATION 28: (Chapter Four)
The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure that all residential aged care facilities with residents of non-English speaking backgrounds be required to provide the services of a professional interpreter or phone interpreter for all medical assessments, consultations and any negotiations concerning accommodation bonds or residents' fees where a resident needs such services to communicate effectively.

RECOMMENDATION 29: (Chapter Four)
The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure that the Resident Classification Scale recognises the additional resources needed to meet the needs of non-English speaking background residents with low levels of fluency in English, and that higher funding be allocated accordingly.

RECOMMENDATION 30: (Chapter Four)
The Committee recommends that the Minister for Aged Services support the NSW Clustering Service being funded on a five-year basis, and approach the Commonwealth Minister for Family Services to request this.

RECOMMENDATION 31: (Chapter Four)
The Committee recommends that the specific needs of people of diverse cultural and linguistic backgrounds who use aged care services be addressed within the NSW Aged Care Strategy to be developed under Recommendation 4.

RECOMMENDATION 32: (Chapter Four)
The Committee recommends that the specific needs of indigenous Australians should be considered within the context of the NSW Aged Care Strategy to be developed under Recommendation 4, and developed in close consultation with indigenous Australian representatives.

RECOMMENDATION 33: (Chapter Four)
The Committee recommends that the Ageing and Disability Department include in the NSW Aged Care Strategy to be developed as per Recommendation 4 of this Report a review of the Multi-Purpose Service model, including discussion of the most appropriate management structures for this type of service.

RECOMMENDATION 34: (Chapter Four)

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ascertain the progress of the Scoping Study on Older People and Mental Health, and to request a meeting of State and Territory representatives to advance the work program and promote improved linkages between accommodation, treatment, care and support service systems for older people with mental health needs.

RECOMMENDATION 35: (Chapter Four)

The Committee recommends that Minister for Health ensure that all residential aged care facilities in New South Wales be required to set aside a private interview room for residents to consult with health personnel, including mental health specialists. The private room should be located as centrally as possible to ensure that the less mobile residents are able to access it.

RECOMMENDATION 36: (Chapter Four)

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to include in the Aged Care Rights Principles a specific reference to a right to sexual relations.

RECOMMENDATION 37: (Chapter Four)

The Committee recommends that the Minister for Aged Services ensure that any impediments preventing residents of aged care facilities under the age of 60 years accessing Home and Community Care services and other State services be removed as a matter of urgency.

RECOMMENDATION 38: (Chapter Four)

The Committee recommends that the Minister for Aged Services approach the Commonwealth to make the financial arrangements necessary to ensure access of residents of aged care facilities under the age of 60 years to Home and Community Care services.

RECOMMENDATION 39: (Chapter Four)

The Committee recommends that the Minister for Aged Services and the Commonwealth Minister for Family Services resolve the issue of transporting residents of aged care facilities under the age of 60 years to day centres and other Home and Community Care services.

RECOMMENDATION 40: (Chapter Four)

The Committee recommends the Minister for Aged Services approach the Commonwealth Minister for Family Services to (1) develop a joint strategy to facilitate the transfer of the 929 younger people currently residing in aged care facilities out of these facilities into more appropriate accommodation options in the community, where possible, and (2) where this is not possible, ensure that younger persons receive the appropriate therapy and services they need.

RECOMMENDATION 41: (Chapter Four)

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to review the levels of Commonwealth payments for existing and subsidised residents of hostels (or low care residential aged care facilities, as they will be known) who do not have personal care needs.

RECOMMENDATION 42: (Chapter Four)

The Committee recommends that the Minister for Aged Services closely monitor the demand for Home and Community Care (HACC) services which is expected to rise as a result of the implementation of the *Commonwealth Aged Care Act, 1997* and, if demand is greater than the funds available, the Minister negotiate with the Commonwealth Minister for Family Services to secure additional funding for the Program.

RECOMMENDATION 43: (Chapter Four)

The Committee recommends that if the monitoring of the *Commonwealth Aged Care Act, 1997* shows that there is increased demand for public housing and boarding houses as a direct result of the Act, then the NSW Minister for Aged Services and the NSW Minister for Housing commence negotiations to secure additional funding under the Commonwealth/State Housing Agreement, and that additional resources are provided to monitor and licence boarding houses in New South Wales.

RECOMMENDATION 44: (Chapter Four)

The Committee recommends the Minister for Aged Services include a review of the appropriateness of the allocation of high care places/beds, in particular in rural and remote areas, in the review of the *Commonwealth Aged Care Act, 1997* and development of the National and NSW Aged Care Strategies.

RECOMMENDATION 45: (Chapter Five)

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.

RECOMMENDATION 46: (Chapter Five)

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.

RECOMMENDATION 47: (Chapter Five)

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: (Chapter Five)

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: (Chapter Five)

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.

RECOMMENDATION 50: (Chapter Five)
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.

RECOMMENDATION 51: (Chapter Five)
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.

RECOMMENDATION 52: (Chapter Five)
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.

RECOMMENDATION 53: (Chapter Five)
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.

RECOMMENDATION 54: (Chapter Five)
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.

RECOMMENDATION 55: (Chapter Five)
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: (Chapter Five)
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.

RECOMMENDATION 57: (Chapter Five)
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.

RECOMMENDATION 58: (Chapter Five)
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.

RECOMMENDATION 59: (Chapter Six)
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.

RECOMMENDATION 60: (Chapter Six)
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.

RECOMMENDATION 61: (Chapter Six)
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.

RECOMMENDATION 62: (Chapter Six)

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.

RECOMMENDATION 63: (Chapter Six)

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.

RECOMMENDATION 64: (Chapter Six)

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.

GLOSSARY & ABBREVIATIONS

ACCOMMODATION BOND	The accommodation bond is the money required to be paid to the proprietor of a residential aged care facility in exchange for admission to an aged care facility. The amount of the accommodation bond will be negotiated between the proprietor and the resident. The proprietor may draw down a maximum of $2,600 per year for five years, and may keep any interest raised on the bond. The remainder must be refunded to departing residents or their estate. The Government has set no limit on the amount which may be charged for the accommodation bond, but a resident must be left with a minimum of $22,500 in assets.
ANHECA	Australian Nursing Homes and Extended Care Association. Industry group representing aged care service providers.
ASA	Aged Services Association. Industry group representing non-profit aged care service providers.
CADE UNITS	Residential care units designed for confused and disturbed elderly people.
CAM - CARE AGGREGATED MODULE	This is the funding providing by the Commonwealth to nursing homes to subsidise the nursing and personal care of residents.

CONCESSIONAL RESIDENTS	Concessional residents are full or part pensioners who have less than $22,500 in assets, and have not owned a home in the last two years. Concessional residents will be exempt from accommodation bonds.
DHAFS	Commonwealth Department of Health and Family Services.
ENTRY CONTRIBUTION OR ENTRY FEE	The entry contribution is now known as an accommodation bond. See accommodation bond.
EPAC	Economic Planning Advisory Council.
FDP - FINANCIALLY DISADVANTAGED PERSONS	See concessional residents. Note that poorer individuals are referred to in this Report as financially disadvantaged (uncapitalised, to distinguish them from concessional residents).
HACC	Home and Community Care.
HCCC	Health Care Complaints Commission.
NANHPH	National Association of Nursing Homes and Private Hospitals. Industry group representing aged care and private health care service providers.
NCOSS	Council of Social Service of New South Wales.
NESB RESIDENTS	Residents from a non-English speaking background.

NURSING HOMES AND HOSTELS	Currently there are two types of residential facilities for the aged - nursing homes and hostels - this will change after 1 July 1997, when the nursing home and hostel systems will be amalgamated and renamed "residential aged care facilities". Up until 30 September 1997, nursing homes are residential aged care facilities for people requiring nursing care 24 hours a day. Hostels provide personal care and support in daily living tasks such as feeding, dressing and showering but no nursing care. According to State regulations, nursing homes require a registered nurse to be on duty at all times, but hostels are not required to have nursing staff.
OCRE - OTHER COST REIMBURSED EXPENDITURE	This is the funding provided by the Commonwealth to nursing homes to subsidise staff related costs such as workers compensation and superannuation.
OUTCOME STANDARDS	The minimum standards of care required by the Commonwealth for nursing home residents.
PROVIDERS	Organisations and individuals who provide nursing home or hostel services.
RCI	Resident Classification Instrument. This classifies nursing home residents according to their care needs.
SAM - STANDARD AGGREGATED MODULE	This is the funding provided by the Commonwealth to nursing homes to subsidise the non-care related costs of residents, such as food and laundry.

RESIDENT CLASSIFICATION SCALE	The system under the *Commonwealth Aged Care Act, 1997* to assess the care needs of all residents of aged care facilities. Facilities are paid subsidies according to the care levels of its residents.

OLDER PEOPLE AND RESIDENTIAL AGED CARE: FACTS AND FIGURES

OLDER PEOPLE:

- 2.2 million people (12% of Australia's population) are people aged 65 and over. This has increased from 1.3 million (9% of the population) in 1976, and is expected to reach 3.5 million (16%) in 2016.
- The number of people aged 80 and over has increased from 218,000 in 1976 to 485,200 in 1996, and is expected to grow to 852,100 in 2016.
- 17% of older people have a profound or severe handicap (that is, requiring some help for self-care, mobility or communication).
- 7% of older people live in residential aged care facilities.

RESIDENTIAL AGED CARE SERVICES:

- There are 62,645 hostel (lower dependency) places and 75,008 nursing home (higher dependency) places in Australia as at 30 June 1996. In NSW there are 21,206 hostel places and 29,905 nursing home places (Society of St Vincent De Paul, 1996: 11).
- The median length of stay for hostels in 1995-96 was 746 days; for nursing homes it was 356 days.
- The majority of residents are women (75% hostels and 72% nursing homes).
- 75% of nursing home funding comes from the Commonwealth, with the remainder coming from resident contributions. Total Commonwealth outlays in 1995-96 were $2,001 million.
- Hostels receive less than half of their funding from the Commonwealth, the remainder coming from resident fees and entry payments. Total Commonwealth outlays in 1995-96 were $417 million.
- 55% of nursing home places are privately owned and operated for profit (Gregory, 1993); 39% of nursing home beds are operated by charitable and religious organisations, and are not operated to make a profit. The remainder, 6%, are State Government operated (Gregory, 1993:).

Source (except where otherwise stated): *Older Australians at a Glance,* Department of Health and Family Services, 1997.

INTRODUCTION

CONTENTS:

• THE INQUIRY PROCESS

On 31 October 1996 the Legislative Council of the New South Wales Parliament passed the following motion:

1. *That the Standing Committee on Social Issues inquire into, and report on, the state of nursing homes in New South Wales and in particular:*

   a) the extent to which the dignity, privacy, confidentiality and other rights of residents are protected;

   b) the effect of transferring the responsibility and management of nursing homes from the Commonwealth to the State Government;

   c) the likely impact of the introduction of entry fees and the increase in user-fees for nursing home residents;

   d) the adequacy of supported hostel-type accommodation to meet the needs of independent ageing persons;

   e) the use of existing capital infrastructure to expand services for the aged; and

   f) the impact on the aged community of the decision of the New South Wales Government to close the Office on Ageing and create the new Ageing and Disability Department.

2. *That the Committee report by Monday, 30 June 1997.*

On 27 May 1997, the Legislative Council passed a motion extending the Committee's report-by date to 30 September 1997. This reflected the impossibility of the Committee completing by 30 June the site visits and extensive consultations necessary for an Inquiry of this depth, complexity and public importance.

However, given the imminence of the Commonwealth's changes that were the subject of some of the Terms of Reference, the Committee thought it essential that an Interim Report be released on the original report-by date. That Report, which was tabled on 30 June 1997, forwarded 55 recommendations, many of which are included in this final Report.

During the course of the Inquiry the Committee received 91 submissions, heard formal evidence from 28 witnesses and held briefings with 12 people. In addition to hearing evidence at Parliament House, Committee Members made site visits to residential aged care facilities in Sydney's eastern suburbs (Waverley) and inner west (Summer Hill) in

addition to five rural towns (Cessnock, Baradine, Trangie, Walgett and Warren). This allowed the Committee to gain an understanding of the operations of nursing homes, hostels and Multi-Purpose Services and to talk to residents, relatives, staff and management. Committee Member, the Hon Elisabeth Kirkby, MLC visited hospitals and residential aged care facilities in West Wyalong, Temora and Coleambally in rural New South Wales.

During the course of the Inquiry, the Committee also travelled to Wudinna and Elliston in South Australia, to compare and contrast the model of Multi Purpose Services on the Eyre Peninsula with those in New South Wales.

• PRINCIPLES UNDERLYING THE REPORT

The Committee believes that the provision of aged care in New South Wales, and any negotiations regarding the future provision of aged care, needs to be underpinned by some clearly articulated principles.

The paramount principle is that older people in New South Wales are valued members of our society. The Committee notes that there has been some debate in recent times about the 'costs' associated with an ageing society, and believes this is quite often a grossly unfair and simplistic debate which does not take into account the substantial contribution to society which many older people have made over a very long period, and continue to provide.

The Committee also believes that older people have the right to respect and autonomy, and to be supported to retain their autonomy. Respect for older people as equal citizens should not be diminished on account of frailty or cognitive impairment.

In addition, the Committee believes that older people should be provided with opportunities to maximise their participation in society for as long as they choose, and with choices about care options when these choices need to be made. To that end, services need to be developed so that the opportunities and choices for older people are in fact real, and not just developed in ways which suit service planners or providers.

The Committee believes that older people should have the right to contribute to the development of policy and programs which are aimed to support them, and provided with the means to do this. This Committee received submissions from a number of older people, and heard evidence from a range of consumers and their advocates during the course of this Inquiry.

These principles have underpinned the approach of the Committee in its conduct of this Inquiry, and the Committee has striven to reflect these in the recommendations it has made. The Committee strongly believes that the planning and provision of services which support older people should also be underpinned by a similarly articulated set of principles.

• DEVELOPMENTS SINCE THE TABLING OF THE INTERIM REPORT

In the time since the tabling of the Interim Report of this Inquiry on 30 June 1997 there have been a number of developments in regard to the policy and planning for aged care. These include the:

- passage of the *Commonwealth Aged Care Act, 1997* in June by the Senate, providing for the commencement of a significant component of the reforms as of 1 October 1997;
- tabling of the Senate Community Affairs References Committee's Report on Funding of Aged Care Institutions;
- securing of additional funds for concessional residents after much lobbying from the Uniting and Catholic Churches;
- announcement of funding rates for the Resident Classification Scale;
- release of details regarding the prudential arrangements for accommodation bonds; and,
- progress continues on the quality assurance process, scheduled to commence as of 1 January 1998.

Policy developments in this time which will also impact on aged care in New South Wales include: the Health and Community Services Ministerial Council (HCSMC) meeting in Cairns in late July 1997, which included agenda items on the impact of the *Commonwealth Aged Care Act, 1997* on States and Territories (initiated by New South Wales) and a revised discussion paper on the possible transfer of aged care to the States and Territories; and continued negotiations on the Commonwealth-State Housing Agreement, Disability Agreement and Health Care Agreement (formerly known as Medicare Agreement).

This final Report incorporates these developments and reflects on their impact for aged care in New South Wales.

• STRUCTURE OF THE REPORT

The remainder of the Report is structured as follows:

Chapter One, *Aged Care in NSW: Setting the Scene*, examines the policy and administrative context within which aged care sits in NSW.

Chapter Two, *Ensuring Quality Services: Current Arrangements*, examines the current safeguards of residents' rights, and highlights the important workforce issues which need to be addressed if quality care for residents is to be achieved.

Chapter Three, *Ensuring Quality Services: New Arrangements*, considers the ways in which residents' rights will be protected through the examination of the quality control regime proposed by the Commonwealth's accreditation system, complaints mechanisms and prudential arrangements for the accommodation bonds.

Chapter Four, *Residents with special needs*, addresses the needs of particular sub-groups of residents whose needs are not well met, and whose rights will continue to be compromised under the new arrangements. These include people with dementia and mental health needs, people of diverse cultural and linguistic backgrounds and indigenous Australians, people who only require accommodation and social support, and younger people with disabilities who live in aged care facilities.

Chapter Five, *Financing Aged Care*, considers the current (pre -1 October 1997) and future (post - 1 October 1997) funding arrangements for residential aged care, in particular the new system of funding the upgrading and maintenance of aged care facilities by the imposition of accommodation bonds, and discusses the need for a review of sustainable financing options to meet the long term care needs of older people in the future.

Chapter 6, *Impact of Reforms and Future Directions*, addresses the impacts of the *Commonwealth Aged Care Act 1997* on the NSW Government and related services, including regulation of aged care, and the effect of the Commonwealth's proposal to transfer the responsibility and management of residential aged care to the State Government. The Chapter also considers how existing services can be expanded to provide more responsive and innovative accommodation, care and support for older people both now and in the future.

CHAPTER ONE:

AGED CARE IN NEW SOUTH WALES: SETTING THE SCENE

CONTENTS:

The Committee has been made aware of a number of key policy and administrative issues which affect the planning and delivery of aged care services in New South Wales. These include the absence of a clear agency to lead the policy development and planning for aged care in New South Wales, and the lack of a policy framework at both the national and state levels to provide direction for policy makers, service providers and consumers. In addition, the Committee has considered the impact of the closure of the Office on Ageing and the creation of the Ageing and Disability Department on the provision of aged care in New South Wales.

1.1 STRUCTURAL IMPEDIMENTS TO AGED CARE IN NEW SOUTH WALES

The Committee believes that there are a number of structural impediments to ensuring that older people in New South Wales have equitable access to affordable, quality aged care services which are responsive to their needs. The Committee believes that this stems primarily from the lack of a lead agency in New South Wales and an overarching ageing policy framework to meet the current and future needs of older people.

1.1.1 THE NEED FOR A LEAD AGENCY FOR AGED CARE IN NEW SOUTH WALES

Throughout the course of its Inquiry, the Committee has become increasingly aware of the fragmented nature of the administration and delivery of aged care programs, which is in part driven by the lack of a central lead agency which can pull the elements together and provide strategic direction for aged care in New South Wales. Responsibility for aged care falls primarily between two departments: firstly, the Ageing and Disability Department (ADD) which has primary responsibility for the Home and Community Care Program, the NSW Aged Care Policy Framework, NSW Action Plan on Dementia, and NSW Seniors Card program; and secondly, the NSW Health Department which funds acute and post-acute services, community nursing, psychiatric care and State Government Nursing Homes and long-stay beds in rural and remote hospitals. Both Departments jointly work on issues of common interest, for example the NSW Healthy Ageing Strategy which is currently being developed but, on the whole, work on quite separate pieces of the aged care system.

The Committee believes that this fragmentation affects the delivery of services to older people, and precludes the development of linkages between elements of the aged care system (eg. between community and residential care) and between other related service systems (eg. acute hospitals, mental health teams, transport etc.). It also limits the capacity of New South Wales to take a leadership role in regard to aged care, to articulate a clear vision for services for older people in New South Wales, and engage pro-actively with the Commonwealth in dialogue over the *Aged Care Act, 1997* reforms.

The Committee believes it is important that there be a single lead agency for aged care in New South Wales, and that this should be the Ageing and Disability Department, with the Minister for Aged Services responsible for aged care matters. The Committee received evidence that ADD has recently established a distinct Ageing Policy Unit within the Strategic Policy and Planning Division, and also established an advisory committee on aged care matters comprising key stakeholders (ADD Submission - 8 September 1997). The Committee believes that these changes will enable ADD to assist the government to articulate a clear vision for meeting the current and future needs of older people in New South Wales.

The Committee's opinions were also shaped by the strong objections to the inclusion of aged care within a health care framework which were put to them. The Committee heard that previous consultations held by the then MLC, the Hon Patricia Staunton, also confirmed this perspective:

> *the support for aged and community care not being held within the health portfolio was immense. It surprised me how widely that view was held around the table, which consisted of 30 or 40 representatives of different organisations* (Moore, Evidence - 8 September 1997).

Much of this evidence was provided to the Committee in relation to the proposed COAG reforms, where it was made quite clear to the Committee that any transfer of aged care funds should be kept quite separate to funds provided through health care agreements. The Committee also heard that ageing should not be regarded as a health issue, but a normal part of life, and incorporation of aged care within a health framework could 'medicalise' the ageing process and further disempower older people.

As noted above in the discussion of principles which have been the foundation of the process of this Inquiry, the Committee is of the strong opinion that aged care should be provided to people in a way which promotes the independence of individuals and maximises their participation in social life. A 'social' model of care includes providing care for people in their own homes for as long as possible and people chose, and the development of policies and programs which support this goal. The principles of the Healthy Ageing Framework which the Government is currently preparing should also be extended to those who require care or are in receipt of aged care services. **It is the clear preference of older people to remain living in their own homes; this is also a more cost-effective option for Government.** The Committee is concerned that if responsibility for aged care was placed with the NSW Health Department then the emphasis will be on the higher care need end of the aged care spectrum, with limited development of programs and policies for those at the lower end of the care spectrum. This is already reflected in the current regulatory role which NSW Health has, which is related to nursing homes only and does not include hostels.

RECOMMENDATION 1:

The Committee recommends that the total responsibility for aged care in New South Wales rest with the Minister for Aged Services, and through the Minister, the Ageing and Disability Department, including responsibility for all aged care policy, planning and related program funding, and that the Department be adequately resourced to take on this role.

1.1.2 THE LACK OF A COHERENT AGED CARE POLICY

The main thrust of this Inquiry has predominantly been on the way in which accommodation, care and support needs of older people are currently being met, and on the administrative and policy changes which have occurred or been proposed. Therefore, much of the Committee's deliberations have focussed on those older people who have relatively higher levels of care needs, for which the residential aged care sector provides. Throughout the course of the Inquiry, however, the Committee has had reinforced the fact that residential care is not a discrete entity, but forms part of a broader, more complex system of care for older people. This broader system includes both community and residential care, and is closely related with acute, primary and mental health care; accommodation; transport; pharmaceuticals; and legal and advocacy services. Currently, linkages between residential and community aged care are not strong; this is even more so in the case of linkages between these other services. What has become increasingly clear to the Committee is that changes to one element of this complex and interrelated system will have significant implications for other elements.

There is no national aged care policy which allows for planning for services across the continuum of care and which provides linkages with other related accommodation, care and support services. The Committee has heard that this is a key reason why the Commonwealth has been able to implement significant changes to the residential aged care system without due consultation or consideration of the impacts on other elements of the aged care and related systems. The main mechanism for collaborative planning is through the Health and Community Services Ministerial Council (HCSMC). However, the Committee understands that a decision has been taken at the July 1997 meeting that the meetings will no longer be convened on a regular basis. The Committee is concerned that the absence of any regular forum in which aged care issues can be discussed nationally will lead to further fragmentation of aged care services and national inconsistencies in service provision.

RECOMMENDATION 2:

The Committee recommends the Minister for Aged Services negotiate with the Commonwealth Minister for Family Services to develop a National Aged Care Strategy, including the establishment of a sub-group of the Health and Community Services Ministerial Council.

RECOMMENDATION 3:

The Committee recommends the Minister for Aged Services take up with relevant State and Commonwealth Ministers the need for regular meetings of Ministers on matters in relation to aged care planning and provision.

RECOMMENDATION 4:

The Committee recommends the Minister for Aged Services charge the Ageing and Disability Department to develop a NSW Aged Care Strategy which is consistent with the principles and directions established at the national level (as per Recommendation 2).

1.2 AGEING POLICY IN NEW SOUTH WALES: THE OFFICE ON AGEING AND THE AGEING AND DISABILITY DEPARTMENT

In April 1995 the NSW Office on Ageing (which had been operating within the Premier's Department) was closed and the Ageing and Disability Department was established, with staff and programs transferred from the one body to the other.

According to a briefing provided to the Committee by the Director-General of the Ageing and Disability Department (ADD), the Government's rationale for the change was that the creation of the new department upgraded both disability and ageing issues, so that a department was responsible for ageing and disability policy, planning and funding. The Government believes that this removes the conflict of interest that arises when one body is responsible for funding, implementing programs, providing services, and monitoring the success of programs.

The Department told the Committee that there has been no negative impact on the lives of older people or their services (Woodruff, Briefing - 12 December 1996). The staff from the Office on Ageing were transferred to the ADD, so there was no loss in staff or expertise. The corporate objectives of the Office on Ageing and the Ageing and Disability Department are very similar. The agenda of the Office on Ageing ranged across a number of portfolios and Departments and included issues of employment, discrimination, transport, finance, health and aged care, health and wellbeing, urban design and safety, housing, age issues consultation and 'life long learning' (NSW Government, 1993). Similarly, the Ageing and Disability Department seeks a "whole of government" approach to aged issues such as healthy ageing, accommodation and care, community education, transport, dementia care and elder abuse (Ageing and Disability Department, 1996).

The Committee heard some support for the establishment of the Ageing and Disability Department. The Council for Intellectual Disabilities submitted that:

> *the establishment of the ADD is a major step forward in the development of disability issues in New South Wales ... [and] was extremely important in establishing a necessary and critical funder/provider split with the Department of Community Services* (Submission 67).

And the Consultative Committee on Ageing believes that:

> *there may be some advantages to considering the needs of older people and people with disabilities jointly, provided that equivalent resources are directed to each sector* (Submission 79).

The fear that greater weight is given to disabilities than ageing policies and programs is reiterated by other individuals and organisations. Comments to the Committee included:

> *Ageing within ADD seems to have little influence and to have lost the focus that the Office on Ageing developed* (Submission 59);
>
> *We are not criticising the endeavours of Ageing and Disability Department staff, but their attention is more than fully taken up with disability services and to a lesser extent with aged care service delivery issues. Community perception is that aged services have been disadvantaged by this change* (Submission 36); and
>
> *... the Ageing and Disability Department has a much higher focus on disability and less so on the aged...* (Submission 65).

The Committee was told that the Government acknowledges concern by both the aged community and the disabled community that one of the sections will gain dominance over the other in terms of government focus. However, the Government believes these fears to be unfounded (Woodruff, Briefing - 12 December 1996).

Others oppose the Ageing and Disability Department because they believe it fails to recognise that the requirements of ageing people differ from those of disabled people. Submissions noted, for example:

> *Ageing is not a disability, the care required is quite different* (Submission 50); and
>
> *Despite certain similarities in the needs of older people and disabled people, the differences are sufficiently significant to warrant two separate portfolios* (Submission 66).

The Council for Intellectual Disabilities explained that linking ageing and disability together in one department created difficulties because the services required for each were different:

> *Services for aged people are generally based on a maintenance model, that is, maintaining the current status of people. In comparison, services for people with an intellectual disability are based on a developmental model and make the assumption that people will develop new skills and increase independence* (Submission 67).

The symbolic implication of a Department which links Ageing and Disability together was a key concern of many aged people and their advocates.

One aged care worker noted:

> *Unfortunately the new Ageing and Disability Department, by name alone, may infer that the NSW Government believes that ageing and disability are always related. The fact is only a small number of our elderly have any disability ...* (Submission 17).

A number of submissions were unhappy with the linking of ageing and disability. Statements by aged advocacy groups, aged persons, and those working in the aged care sector include:

> *Given that only some aged people are disabled, we believe it is more appropriate for the Department of Ageing and Disability to be separated into two distinct agencies. Disabled people are not necessarily aged and aged people are not necessarily disabled* (Submission 64);

> *The creation of the Ageing and Disability Department was seen by many older people as reinforcing the negative stereotype of aged or ageing* (Submission 65);
>
> *The symbolic association of the ageing process with disability has understandably been criticised by the community - this is as much an issue as concern about the distribution of resources* (Submission 79); and
>
> *There is no doubt that older people and organisations which represent them remain extremely concerned about the decision, both because they consider it inappropriate to link ageing issues with disability issues, and because they are concerned that ageing issues do not receive adequate attention and priority within ADD* (Submission 82).

The Ageing and Disability Department, and the NSW Government as a whole, were criticised by a number of individuals and groups for failing to develop a healthy ageing policy.

Dr John Ward, a geriatrician with the South Eastern Sydney Area Health Services, noted that:

> *The major weakness of the new Ageing and Disability Department is the absence of any programs to promote healthy or successful ageing* (Submission 10).

The Ethnic Communities' Council of NSW added:

> *The focus of the ADD on the needs of the frail aged, and those with a disability, tended to further disadvantage the majority of older people who are independent and well. ... [T]he anticipated increase in the number of people aged 60 years and over ... requires government to look at the needs of the well aged within a framework that raises the status of older people, facilitates the development of opportunities, encourages participation and utilisation of skills* (Submission 65).

The Committee notes that the NSW Government is currently developing a Healthy Ageing Strategy. The Strategy, which is being jointly developed by the Ageing and Disability Department and NSW Health and in conjunction with key stakeholders, will take a whole of government approach to services and programs for older people. The Strategy is expected to include issues around aged care (community and residential) and be driven from the perspective of maximising the independence of older people and giving them a choice to continue to be involved and to be productive members of society. The Committee looks forward to the finalisation and implementation of the Strategy.

Throughout the course of its Inquiry, the Committee has become increasingly aware of the limitations of its Terms of Reference, which focussed predominantly on the high care end of aged care (provided in nursing homes). **The Committee is aware that it is only a minority of older people who end up living in nursing homes (7%).** The Ageing and Disability Department pointed out in its submission that the Interim Report of this Inquiry had an overly biomedical/clinical approach to aged care, and that aged care needs to be considered within the broader policy context of healthy ageing (ADD, Submission - 5 September 1997). These comments support other expressed views which have been detailed previously about the way in which aged care should be viewed, and in particular where responsibility for aged care should be located within the NSW Government.

In the time that has passed since the Department was established, several organisations which initially were wary of the change have observed its operation and now feel that a return to the previous structure is unnecessary. The Combined Pensioners and Superannuants Association of NSW (CPSA) submitted that they had:

> *objected strongly when the Office of Ageing was closed and the new Ageing and Disability Department was created because the Association believed that there would be a diminution of Government policy on ageing issues* (Submission 71).

However, they noted that since:

> *the establishment of the Ageing and Disability Department the CPSA has seen that there have been genuine attempts at ensuring that the needs of older people are recognised within Government* (Submission 71).

The NSW Council of Social Service also submitted:

> *Given the significant amount of time, energy and resources that have gone into the new department and the establishment of its regional structure to date, NCOSS does not support major changes such as the re-establishment of an Office on Ageing* (Submission 81).

The Committee concurs that dismantling the Ageing and Disability Department now would be time consuming and expensive. The grouping together of Ageing and Disability in one Department was insensitive, and creates the public perception that ageing people are disabled, and, with hindsight, it would have been better to create an effective bureaucratic infrastructure that avoided this association.

The perceptions outlined above have also been reinforced by the recent work undertaken by the Ageing and Disability Department in its review of its Strategic Plan. The review process included conducting focus groups with a number of key stakeholders both internal and external to the Department and one of the key findings was that there is a view that ADD has not achieved what was expected for older people

and in ageing. In its submission to the Inquiry the Department noted its concern about these findings, and highlighted the measures which are being put in place to address these matters. These include:

- *a proposal to form a separate Policy Unit on Ageing;*
- *taking a more proactive role in responding to and monitoring the* Commonwealth Aged Care Act, 1997*;*
- *increasing the HACC program budget by $10.676m in 1997/98, taking the total HACC budget in New South Wales to $250.939m;*
- *the development of a NSW Healthy Ageing Strategy, currently being considered by Government;*
- *representing New South Wales on the National Healthy Ageing Task Force, a draft National Healthy Ageing Strategy is about to be released;*
- *ADD is responsible for funding and administering the NSW Aged Care Policy Framework, to which the Government has committed $4m over three years. This includes managing the NSW Dementia Action Plan; and*
- *a proposal for United Nations 1999 International Year for Older People is being prepared for the Government's consideration* (ADD Submission - 5 September 1997).

While the Committee accepts that there are significant aged care related responsibilities of the Department, it is aware that there are a number of structural impediments which limit the role of the Department in respect of older people. The Department's submission notes that:

> *Despite its best intentions to establish an influential portfolio and department with these responsibilities for ageing and disability, it has not been realised for older people because the Minister does not have substantial legislative or funding responsibilities* (ADD Submission - 5 September 1997).

Whereas the Minister for Aged Services has funding responsibilities in excess of $650m for disability services, and responsibility for the *Disability Services Act*, there is nowhere near the commensurate level of responsibility for funding for aged care, nor is there any legislation for aged care for which the Minister for Aged Services has sole responsibility (apart from the HACC agreements) (ADD Submission - 5 September 1997).

As noted earlier, there are a number of pieces of legislation which cover elements of the aged care system:

> *At the moment we have a bit of legislation in Fair Trading, a bit in Ageing or Youth and Community Services and a bit in the Private Nursing Homes Act* (Fisher, Evidence - 8 September 1997).

The Committee heard that the fragmented nature of legislation for aged care posed a risk for consumers (Fisher, Evidence - 8 September 1997) and seriously impacted on service planning and provision; it would appear that in New South Wales the approach to management of the 'bits' of the aged care system is as 'bits', and there is limited or no integration of service planning or provision.

In its submission to the Inquiry the Ageing and Disability Department describes an integrated system as one which includes health, accommodation, care and support covering:

> *(1) Health Services which are State funded and provided through Area Health Services including hospital and community based health services, day hospitals and centres, rehabilitation and extended care services, post acute care, community based palliative care services, mental health and psychogeriatric services, dementia specific residential facilities, carer support and education, health promotion and early intervention, respite and clinical research and education;*
>
> *(2) Aged Care Assessment Teams;*
>
> *(3) Community Care including HACC, Community Aged Care Packages, Commonwealth Respite for Carers; and*
>
> *(4) Residential care including nursing homes - State and Commonwealth, hostels, and long term respite provided in these facilities* (ADD submission - 5 September 1997).

As noted previously in this Chapter, the Committee believes that there is a need for an aged care strategy which articulates these linkages, and provides a clear agenda for aged care activities in New South Wales. The development of such a strategy should be consistent with the Healthy Ageing Strategy which is currently being developed and for which consultations are expected next year. However, the Committee heard that while the consultations are planned, there are fears that 'in some ways the real hard issues about community and aged care will not form part of that debate because it is a big political player' (Moore, Evidence - 8 September 1997). The Committee would be concerned if this was the case, and strongly supports a comprehensive debate which involves government agencies as well as stakeholders.

RECOMMENDATION 5:

The Committee recommends that the Minister for Aged Services and the Minster for Health ensure that the consultations on the NSW Healthy Ageing Strategy include a comprehensive discussion on the provision of aged care services in New South Wales.

The development of a comprehensive aged care framework would also provide the basis for a review of relevant legislation, including consideration of whether there needs to be a single Aged Care Act in New South Wales which encompasses the elements of the other aged care related legislation.

The Committee believes that the lead agency for undertaking this review of aged care in New South Wales should be the Ageing and Disability Department.

RECOMMENDATION 6:

The Committee recommends that the Ageing and Disability Department conduct a review of relevant aged care legislation following the development of a NSW Aged Care Strategy (as per Recommendation 4) and provide advice to government on whether the interests of older people, service providers and government would be better served if there was a single NSW Aged Care Act developed.

1.3 CONCLUSION

The complexity of needs which face older people poses many challenges to service planners and providers. Without clear direction at the policy and administrative levels, the Committee believes that the delivery of care to older people will remain fragmented, and older people will be at risk of missing out on receiving the accommodation, care and support services they need, when they need it, and in ways which meet their particular needs.

The closure of the Office on Ageing and establishment of the Ageing and Disability Department initially appeared to have resulted in a reduced focus on aged care in New South Wales. However, the Committee received evidence that the Department has now emerged with a strong vision for aged care in New South Wales, and has the capacity to take on a lead role in co-ordinating and planning for aged care in this State. The impediments to doing this lie in the lack of a clear legislative basis and consequent Ministerial responsibility, and also the lack of a coherent framework which sets the direction for aged care services nationally as well as in New South Wales - Recommdentations 1 - 4 in this Chapter address these issues. The Committee believes these issues must be addressed if older people in New South Wales are to receive the accommodation, care and support services they need both now and in the future.

CHAPTER TWO:

ENSURING QUALITY SERVICES: CURRENT ARRANGEMENTS (PRE 1 OCTOBER 1997)

CONTENTS:

Residents of aged care facilities are people who generally have physical or cognitive impairments which result in their need for access to 24 hour nursing and/or personal care. A significant proportion are affected by varying degrees of dementia. As is common with people who are institutionalised, residents are unlikely to be assertive or to complain when their rights are infringed or their care is inadequate. In order to protect the rights of individual residents it is vitally important that adequate mechanisms are in place to maintain and regulate the care and service provided on their behalf, and to ensure that community and residents' expectations are fulfilled.

In the 1970s and 1980s, the condition and treatment of nursing home residents became a public issue. Media stories publicising dramatic cases of neglect and sub-standard care of residents were common. A number of Government inquiries and reports were undertaken on the financing and standards of nursing homes. One of these was the Senate Select Committee on Private Hospitals and Nursing Homes in 1985 (Giles Report, 1985).

The Giles Report found that the regulation of nursing homes was inadequate to ensure uniformly high standards of care and that the regulations failed to monitor issues relating to the quality of life of residents. It further noted that complaints mechanisms were unsatisfactory and difficult to access, that there should be more frequent and more thorough inspections of facilities, and that there were insufficient sanctions available for enforcement of standards (Giles Report, 1985).

A Commonwealth-State Working Party on Nursing Homes was subsequently established, and this resulted in 1987 in the gazettal of the Nursing Home Outcome Standards under Section 45D of the *National Health Act, 1953.* The 31 Outcome Standards form the basis of the quite complex current regulatory framework for nursing home standards (Braithwaite, 1993: 3).

2.1 THE PROTECTION OF RESIDENTS' RIGHTS

This section discusses the current system of safeguards. However, the current system will change as of 1 October 1997. A new accreditation system will commence on 1 January 1998, and is discussed in Chapter Three.

The regulatory regime for nursing homes is made up of several components. At the Commonwealth level, nursing home proprietors are guided in their dealings with and care of residents by the Outcome Standards, Charters of Rights and Responsibilities, and Residential Agreements. Under New South Wales legislation, the *Nursing Homes Act, 1988* and the *Nursing Homes Regulation, 1996* provide additional requirements. Local Government building codes are also applicable.

2.1.1 COMMONWEALTH OUTCOME STANDARDS

The focus of Commonwealth standards monitoring is on the desired outcomes rather than the processes (ie: the practices) or the structures (resources, physical and organisational settings) of nursing homes. That is, the standards monitoring examines how well the nursing home is attaining prescribed goals rather than the way it seeks to achieve them (Braithwaite, 1993: 9).

There are 31 Nursing Homes Outcome Standards and these seek to regulate both the quality of life of residents and the quality of care (Commonwealth Department of Human Services and Health, 1993). The Outcome Standards are grouped into seven categories:

- health care - which includes the right to choice of doctor, individualised care, informed choice of treatment, clean and healthy skin, adequate oral health care, and adequate nourishment and hydration;

- social independence - which includes freedom to come and go, to maintain friendships and receive visitors, manage own financial affairs, religious and cultural freedom;

- freedom of choice - including choosing bedtime and rising time, bathing time, clothing and freedom to complain to staff, proprietors, consumer organisations or government bodies;

- homelike environment - including having personal possessions, homelike decor, and security;

- privacy and dignity - which includes staff attitudes, modes of address, the right to private space, privacy in bathing and toileting, and confidentiality of records and information;

- variety of experience - including organised activities, freedom not to participate; and

- safety - including the right to take risks, design of the building, minimal use of restraints, fire standards and emergency procedures.

It is important to note that these Standards are **minimum** standards, and do not reflect high quality care.

The Commonwealth Standards Monitoring Teams initially aimed to make visits to nursing homes on a two-yearly cycle. In reality, however, most homes are visited much more infrequently, and the Monitoring Teams instead focus on making frequent visits to homes which are known to be in breach of standards (McFee, Briefing - 12 December 1996). The homes are given 24 hours' notice of the initial visit. The two-member teams talk to residents, Residents' and Relatives' Committees, relatives and

staff, and use their own observations to determine the extent to which the minimum standards are met. Each of the 31 Outcome Standards is assessed as being met, requiring action, or requiring urgent action (Law Reform Commission, 1994: 43).

Where the Standards Monitoring Teams find breaches that require action or urgent action, they hold discussions with the Director of Nursing and the Proprietor. The nursing home is provided with an extensive written evaluation, and given 30 days to create an action plan to meet all standards. This action plan may be published with the Standards Monitoring Report if the proprietor desires it (Braithwaite, 1993: 117).

Unannounced follow-up visits are made to determine if the standards have been subsequently met. The follow-up visits do not re-check all Standards, merely those previously determined to be requiring action or urgent action.

The Standards Monitoring Reports are sent to service providers, staff representatives, the Residents' and Relatives' Committee and government agencies. They are also made available to the public, upon request.

The Commonwealth does not have a separate body to enforce sanctions against nursing homes which have failed to meet standards. It is up to Standards Monitoring Teams to "actively recruit support from staff with management and enforcement responsibilities to do something about a recalcitrant nursing home" (Braithwaite, 1993: 50). This contrasts with the standards monitoring in the United States which involves a separate enforcement system. In that system, an automatic suspension of government benefits for new admissions to a nursing home occurs if the same deficiency is found on three consecutive visits, or if the deficiency is not corrected within three months (Braithwaite, 1993: 88).

Under the current Australian system, a home which has a low standards compliance score is labelled a home of concern (Gregory, 1993: 27). The list of homes deemed to be a home of concern is not made public, as they are subject to confidentiality provisions in the *National Health Act, 1953* (Horin, 13 May 1996).

Continued breaches of standards may result in the Minister declaring non-compliance with Outcome Standards. Sanctions for non-compliance include suspension or withdrawal of funding. The most common sanction is that the Commonwealth benefit is not paid for new residents admitted into the nursing home after the facility has been deemed not to comply. The final sanction, revocation of approval, effectively closes the facility (King, Evidence - 5 May 1997). The Minister's decision to declare a nursing home as non-compliant can be appealed by the proprietor to a Standards Review Panel (Law Reform Commission, 1994: 80).

In practice, however, sanctions are infrequently used. The Braithwaite Report noted that, though enforcement is better than it was, "there is still a need for further strengthening of the enforcement effort to make it credible" (1993: 88), and that the authorities "continue to tolerate nursing homes persisting in chronic non-compliance for months and years" (Braithwaite, 1993: xv).

Currently, no sanctions are applied unless there is a very low score, or if the nursing home is "so demonstrably bad that action would be incontestable" (Gregory, 1994: 26). This has created an industry perception that action will not necessarily be taken against sub-standard homes (Braithwaite, 1993: xx). The Committee was told that, in New South Wales at any one time, there are usually 20 or 30 "homes of concern". Of these, an average of ten homes have been formally declared as failing to comply with standards each six months. Perhaps two or three of the declared homes would have financial sanctions imposed, while others may have nursing advisers appointed (McMahon, Evidence - 5 May 1997). However, some homes have been under declaration for two to three years without any financial sanctions (Chadwick, Evidence - 6 February 1997).

Only one nursing home in New South Wales has been closed by the Commonwealth in recent years. Closing a nursing home is a serious step, and one which may be against the interests of the residents, who would have to find another bed in an environment of chronic under supply. Rather than closing down a home, the Department has preferred to negotiate with the proprietors and managers to remove themselves or sell up under threat of closure or financial sanctions. This allows for the facility to continue operation under new owners and managers (McFee, Briefing - 12 December 1996).

The problem of non-compliance may be exacerbated by the lack of effective competition in the nursing home industry. The number of nursing home beds is restricted by the Commonwealth government. With occupancy rates close to 100%, and most areas having waiting lists for beds, nursing home proprietors can expect to fill their beds regardless of the standards of care (Gregory, 1994: 35-6). Because this is a closed supply market, there is no incentive to encourage the provision of quality care. As Gregory notes, if market forces worked in the case of nursing homes, occupancy levels would be low in nursing homes that have low standards monitoring scores, but this is manifestly not the case (Gregory, 1994: 25).

Limits on the number of nursing home beds were originally put in place by the Commonwealth to reduce the number of nursing home residents and to shift the balance away from residential care to community care, a less expensive option for government and the preferred option for consumers. The Committee recognises that the regulation of numbers of residents is appropriate to avoid a return to the high rates of institutionalisation of aged people.

In its Interim Report the Committee surmised that this objective could be met equally well if the restrictions on bed numbers were to be removed, so long as numbers of residents approved for residential aged care remain restricted. If the numbers of approved beds were to increase, providers would be required to compete for approved (subsidised) residents. To that end, the Interim Report recommended that the Commonwealth Government remove restrictions on bed numbers while retaining limits on numbers of approved residents for residential aged care facilities.

The Committee has since received evidence that this approach would not necessarily work. In the first instance, there is no way to restrict the number of approvals for entry into a residential facility; approvals are based on the needs of the client rather than any quota. This is why some areas have lengthy waiting lists for aged care facilities. The Committee was also told that removing the restrictions on bed numbers, or places, could have some negative consequences, and may in fact not assist in ensuring quality care is provided or reducing waiting lists for nursing home care. The Rev Harry Herbert told the Committee that:

> *The theory is that it would drive all the bad operators out of business and leave only the good ones. However, such a system could have other impacts. You could imperil the financial stability of the good operators* (Evidence - 8 September 1997).

Rev Herbert continued:

> *It might lead to an over-investment in the nursing home industry. If a large number of beds are available and some of them are unfilled, that does not mean that those operators would simply fall by the wayside, They might mount high-intensity and perhaps successful campaigns to fill their beds. .... We need to think carefully about increasing the possibilities of that on the grounds that competition will somehow help weed out the bad operators* (Evidence - 8 September 1997).

The Committee also heard evidence that there is the potential for growth in the number of unfunded hostels as a result of closure of facilities which do not meet the certification standards, and that there are already a number of these operating which are not licensed and in which the rights of residents are being compromised (Fisher - Evidence 8 September). The Committee is concerned whether unused capacity of an over-invested industry might lead to an increase in alternative uses of these facilities (ie. unlicensed/unfunded hostels or boarding houses). However, the Committee believes that further examination of the likely consequences of increased bed numbers should be included in the planning for the National Aged Care Strategy, as proposed in Recommendation 2 of this Report.

2.1.2 COMPLAINTS MECHANISMS

Complaints about nursing home standards can be made to the Commonwealth Department of Health and Family Services, and it has a phone hotline. Unannounced inspections may be made as a result of phone complaints. Complaints can also be made to Commonwealth standards monitors (McFee, Briefing - 12 December 1996). The Complaints Officers and the Standards Monitoring Teams operate independently of each other. The Department received 277 complaints about nursing homes in 1995 (Minister for Family Services, Answer to Question on Notice No 74, Australian Senate Hansard for 20 June 1996).

Some have argued that there is an inherent conflict of interest in having the same body responsible for supervising standards and receiving complaints. Suggestions for overcoming that conflict include establishing a new body, independent of the Department, for the purpose of receiving complaints; or allowing the Commonwealth Ombudsman to deal with user complaints (Law Reform Commission, 1994: 60).

2.1.3 CHARTER OF RIGHTS AND RESPONSIBILITIES OF NURSING HOME RESIDENTS

In addition to the minimum standards, the *National Health Act, 1953* and the *Aged or Disabled Persons Care Act, 1954* contain schedules which set out Charters of Rights and Responsibilities of Nursing Home Residents. Charters have a role in educating about rights and responsibilities, and have a symbolic value.

The Charter of Residents' Rights and Responsibilities contains a broad statement of consumer rights. This includes:

> *the right to quality care, information, dignity and respect, personal privacy, freedom of speech, consultation, complaint mechanisms, and personal independence* (Law Reform Commission,1994: 35).

They also set out the responsibilities of nursing home residents. These responsibilities require the resident to respect the rights of other residents and staff, and to look after their own health as far as possible.

A copy of the Charter is in Appendix 7 of this Report.

2.1.4 RESIDENTIAL AGREEMENTS

Residential agreements are written contracts between the nursing home and the resident. Nursing homes must offer residents a Commonwealth-approved model agreement. If they do not, a notice is issued from the Department to notify the proprietor that they are still required to operate in accordance with the terms of the agreement.

The contents of the agreement include rules of service, charges, and the circumstances which permit ceasing of service. The resident's right to privacy, freedom from abuse and discrimination and the right to participate in decision making are also included in the model residential agreement (Law Reform Commission, 1994: 36).

Residential agreements are different from charters because they are legally enforceable, and the focus is on an agreement between an individual and the nursing home. Residential agreements can be useful in the event of a dispute, as they can form the basis of negotiations. However, enforcement through the legal system is an expense beyond the reach of many, if not most, nursing home residents. A further problem is that confused elderly residents may not understand the contract, although relatives may be informally involved in assisting and advising the resident.

2.1.5 CONSUMER GROUPS

The Commonwealth funds an independent advocacy service in each state. Nursing home proprietors are obliged to allow entry of advocates, and to assist them in meeting residents. This is a condition of funding for nursing homes. The role of the advocacy service is to provide residents with information, advise them of their rights, assist them with making complaints, and to provide referrals to other bodies. The Commonwealth-funded advocacy service in New South Wales is The Aged-Care Rights Service (formerly known as The Accommodation Rights Service).

2.1.6 STATE REGULATION OF STANDARDS

The State government regulates nursing home standards through its nursing home licensing provisions under the *Nursing Homes Act, 1988*, and the *Nursing Homes Regulation, 1996*.

All nursing homes in New South Wales must obtain a licence from NSW Health. It should be noted, however, that the Commonwealth regulates the distribution and numbers of nursing home beds. Nursing home licences are processed by the Private Health Care Branch of NSW Health. Licence conditions are spelt out in the 1996 Nursing Homes Regulation. These standards are more input focussed than the Commonwealth standards, and stipulate administrative processes (such as the keeping of records and registers), structural aspects (such as furnishing and equipping of wards, kitchens, common rooms, maintenance of buildings, fire safety) and staffing requirements. The New South Wales licensing standards also incorporate the Commonwealth Outcome Standards verbatim *(NSW Nursing Homes Regulation, 1996*, No 420, under the *Nursing Homes Act, 1988)*.

Following the issuing of a licence, the facility is subject to inspections by state health workers, under sections 44 (1) and 45 (1) of the *Nursing Homes Act, 1988.* The inspectors are now called "nursing supervisors" and their inspections initially were to

occur on a biennial basis (Woodruff, Briefing -12 December 1996). In recent times, however, the approach has been to take a risk management approach, with inspections concentrating on nursing homes which are considered to be a higher risk. The NSW Health inspection reports are not publicly available.

The Ageing and Disability Department, through the *Community Services Act,* has responsibility for licencing hostels, although these are currently exempted.

The final component of State regulation relates to investigation of complaints. The NSW Health Care Complaints Commission (HCCC) receives complaints concerning breaches of nursing home licencing conditions and the professional conduct of staff in all nursing homes in New South Wales. A phone hotline is advertised in the White Pages. Between January 1992 - June 1996, the HCCC received 111 complaints about nursing homes. HCCC informed the Committee that the majority of complaints concerned clinical standards and quality of care (Submission 70). The sources of these complaints are residents and relatives, staff of nursing homes as well as the Health Care Complaints Commissioner and residency rights groups (Wilson, Evidence - 12 May 1997).

There are several sanctions available for use by the State against nursing homes in New South Wales which breach regulations. NSW Health issues section notices for breaches of licensing conditions. Proprietors are given a time period for compliance to be achieved, after which the licence holder can be prosecuted.

Breaches of several sections carry penalties of fines of up to 20 penalty units ($500) including: failure to make repairs or alterations to buildings; overcrowded facilities; and failure to have a registered nurse on duty at all times (McFee, Briefing - 12 December 1996).

Cancellation of a licence is possible under the Act if the licence conditions are violated or there is a breach in "reasonable standards of resident care". The licensee must be given 14 days notice, be given a chance to respond in a submission, and may appeal to the District Court. However, like its Commonwealth counterparts, NSW Health is reluctant to withdraw licences because it creates a further problem of finding alternative beds for existing residents.

Dr Andrew Wilson, Director, Clinical Policy and Practice, NSW Health explained to the Committee:

> ... *We try to avoid the situation of actually forcing a withdrawal of licences because it actually results in a sudden loss of service* (Wilson, Evidence - 12 May 1997).

Dr Wilson also noted that the majority of nursing homes respond favourably when problems are identified, and work with the Department to overcome them. Cancellation of a nursing home licence has not occurred within the last two years (Wilson, Evidence - 12 May, 1997).

2.2 PROTECTION OF RESIDENTS' RIGHTS AND DIGNITY

2.2.1 IS THE CURRENT SYSTEM EFFECTIVE IN PROTECTING THE RIGHTS AND DIGNITY OF RESIDENTS?

In 1996 the *Sydney Morning Herald* ran a series of articles exposing allegedly substandard care and facilities in the nursing home industry in New South Wales. Allegations included residents being left in pain for hours, overuse of chemical restraints and lack of safe environments. The *Herald* reported that, of the 149 homes targeted for full inspections by the Standards Monitoring Teams, more than half failed to provide a safe environment for residents and almost one third of the homes failed to meet six or more of the Outcome Standards (*Sydney Morning Herald*, 13 May, 1996). The Commonwealth Minister for Family Services informed the Senate on 20 June 1996 that only one-third of nursing homes in New South Wales meet all the minimum standards (Minister for Family Services, Answer to Question on Notice No 74, Australian Senate Hansard, 20 June, 1996).

The Committee sought further details about the incidence of New South Wales nursing homes' non-compliance with each of the individual Outcome Standards. This information was not immediately available because the Commonwealth Department of Health and Family Services apparently does not collate such information as a matter of course. The information which was subsequently provided to the Committee by the Department listed 207 nursing homes in New South Wales (around 43%) which have failed to meet all 31 Outcome Standards at full inspections prior to 30 January 1997. There was no indication as to whether the homes had subsequently met standards or whether they had been the subject of sanctions.

The Committee is concerned with the lack of data collected by the Department of Health and Family Services about compliance with Outcome Standards. It is at a loss to discern how the Department can assess the efficacy of the Outcome Standards and the enforcement of the standards if it does not maintain current data indicating levels of compliance. Further, the Committee notes that it would be useful for data to be collected on the progressive implementation of the accreditation system and reported breaches once the accreditation system is established, so that its strengths and weaknesses can be reviewed, allowing modifications where appropriate.

RECOMMENDATION 7:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ensure that the Commonwealth Department of Health and Family Services collects data concerning breaches of accreditation standards and publishes them annually.

The Committee is concerned that up to one-half of nursing homes in this state do not meet the minimum standards, and this suggests that enforcement is inadequate. It is the Committee's understanding the Outcome Standards represent not the ideal, but the minimum standards expected to be met by facilities in order to obtain Commonwealth funding.

While the Committee commends the negotiation-based approach, it is apparent that too many homes continue to operate in breach of the Commonwealth Standards. As changes have been proposed in the regulatory system of Australian nursing homes, it would be futile for the Committee to make recommendations for changes to the current regime. However, the Committee urges the Commonwealth Minister for Family Services to ensure that the new accreditation based system of standards incorporates a workable set of sanctions, and that these sanctions are applied when breaches occur.

The Committee acknowledges criticisms that the Outcome Standards reports make conditions appear worse than they are. Because even minor infringements of a standard can result in an "action required", failure to meet all standards is not necessarily indicative of bad care. Some proprietors also complain that the monitoring of individual standards is subjective (such as the standard requiring a "homelike" environment), and that the decisions on particular standards are not consistent between inspectors. This latter criticism was refuted by the Braithwaite Report, which examined the consistency of decisions and found that "the process accomplishes a high degree of consistency and validity of ratings" (Braithwaite, 1993: 76). There were some exceptions, with consistency problems identified for the continence management standard, the sensory losses standard and the undue noise standard (Braithwaite, 1993: 76).

Evidence received by the Committee from relatives of residents suggest that there are residents whose rights to privacy, dignity and confidentiality are violated in some nursing homes in New South Wales, in spite of the structures set up to prevent this. Most of the submissions from relatives of residents emphasised that they wished their submission to be confidential, as they were reluctant to openly criticise a facility.

The Committee notes, however, that standards of care in most nursing homes are high, and that nursing and personal care staff are generally caring, committed professionals. It is also true that it is the nature of Inquiries such as this one that individuals are usually only driven to make a submission in order to raise a complaint, rather than to give praise, and that this can give a distorted picture of the standards of care.

2.2.2 RESIDENT CARE AND DIGNITY

The Committee recognises that it is difficult to balance the rights of the individual and the realities of communal living. As the Council for Intellectual Disability noted in its submission:

> *The loss or reduction of personal privacy is the most immediate and obvious effect of moving into a facility. This particularly raises issues in nursing homes, as there is considerably more chance that the person will have to share a room with at least one or possibly several other people* (Submission 67).

Many of the problems of loss of privacy and confidentiality are related to the design of nursing home buildings, particularly the older buildings which commonly have four residents in one room.

The Centre for Education and Research on Ageing submitted that:

> *Despite the best of intentions, many nursing homes remain antiquated in their design and decor. One is often left to question how true privacy and dignity can be maintained in environments where elderly people's worlds have so dramatically decreased to a small bed area in a room shared by six other people* (Submission 78).

A former aged care worker noted:

> *You eat, sleep and perform the most intimate chores with strangers. Your possessions are now what you are able to fit in a small wardrobe and a bedside table* (Submission 83).

For couples, there is the additional problem that:

> *rooms which cater for married couples are also rarely available in nursing homes which also causes distress for residents and their families. There is little privacy available to maintain a marital relationship. It is generally assumed older people are asexual* (Submission 54).

In other instances, it was actions of staff and management which breached residents' rights to privacy and dignity. An ex-staff member of an aged care facility noted that the following practices occurred:

> *The withholding of private mail ... [and the denial of] the basic rights of residents being able to make telephone calls from the public phone without such calls being reported to management and residents chastised* (Submission 76).

A relative reported that:

> *when he visits his 57 year old demented wife she is more often than not dressed in clothes other than her own and it makes him very sad to see her in dresses and cardigans that are far too big* (Submission 77).

A relative of another nursing home resident submitted her observations of nursing home care in that particular facility:

> *My mother was in a four bed ward with an ensuite, but I never once saw anyone in that room helped to the toilet. They were put on a commode next to their bed because it was easier for the nurses. The residents were encouraged to buzz if they needed assistance, but the buzzers were either out of reach or unplugged or turned off...* (Submission 37).

She further noted:

> *On more than one occasion I found [my mother] still waiting for her morning shower at 12 o'clock. When I questioned this, I was told that the reason was due to the fact that they were short staffed on that particular day, or she wasn't on the shower list for any particular nurse. On one occasion I was asked to assist with her shower, because there weren't enough nurses. How embarrassing this must have been for my mother* (Submission 37).

The daughter of another resident was distraught when the following incident occurred at her mother's nursing home:

> *I walked into her room to find her sitting in a chair with her skirt slightly up, so I could see that she had no underwear on. A nursing assistant came in and I said, "mum has no underwear on". She stood mum up and lifted her dress to inspect for herself. Mum was in a four bed ward. One of the ladies in that ward also had visitors, so besides mum's dignity it wasn't a very pleasant experience for the people in that room* (Ilbery, Evidence - 21 April 1997).

Professor Brodaty, a psychogeriatrician who makes frequent visits to nursing homes, told the Committee:

> *I often see people in their room, sitting on a commode, in a state of undress, or people actually using a commode as I walk in to see one patient* (Evidence - 21 April 1997).

One confidential submission to the Committee detailed the treatment of a resident in a nursing home-type bed of a small country hospital, as observed by the resident's daughter:

> *Our father was soaked to the arm pit, lying on a urine soaked sheet ... The top sheet and blanket were wet too. There was no [continence] pad to keep him dry* (Submission 18).

Upon complaining of this treatment to a registered nurse, the daughter was told by the nurse that they had been instructed to just use the sheets.

Another relative of a nursing home resident documented her complaints to the home concerning care of several residents, including:

> *Mr B - after having a fall and breaking his hip was admitted to Port Kembla hospital. When admitted he was found to be malnourished, he had an appalling skin condition, his hair was encrusted to his head and he also had an ulcerated mouth ... On occasions when Mr B would not go into the dining room for meals, he was not given meals at all* (Submission 72).

This submission noted that there were several occasions where "residents who have been admitted to hospitals [from this facility] have been found to be malnourished".

The submission further documented:

> *Denial of Care to Mr F - Mr F has diabetes ... and was told [by staff] that he did not need to have his sugar levels tested as he could get AIDS or Hepatitis, therefore no monitoring of his diabetes was conducted* (Submission 72).

The author of this submission, who wishes to remain anonymous, followed the usual complaints process, including complaining to staff, management, the Commonwealth Complaints Unit and the Accommodation Rights Service. The author felt that only the latter organisation made any attempt to investigate fully and improve the situation in that facility, and that complaints to management of the facility resulted in intimidation and ill-treatment of the resident.

The daughter of another resident submitted that her father, after admission to a nursing home, suffered from ulcers and an abscess of the mouth. She felt that this was a result of failure of the nursing home staff to brush her father's teeth, and noted that:

> *my father had been in the nursing home for quite a period of time and I was most surprised to find that some staff thought he had false teeth [when he did not]* (Submission 73).

2.3 WORKFORCE ISSUES

A number of witnesses and submissions made the point that quality of care is very much dependent on attitudes and training of staff. One service providers' organisation submitted "staff attitudes make a fundamental difference to the atmosphere of a nursing home" (Submission 15).

A submission from Berriquin Nursing Home commented that:

> *We can provide a homelike environment but without staff who accept the philosophy of residents' wishes and needs being paramount, success will never be achieved* (Submission 26).

Clearly the attitudes of staff is an area of service that is very difficult to regulate. The Committee believes that qualifications and training are crucial in ensuring that staff have an understanding of the needs and rights of elderly residents.

The Ageing and Disability Department noted that:

> *(I)t is also important that management has a clear philosophy and understanding of carer needs, to support staff in their work* (Submission, 11 September 1997).

The Committee believes it is important that facilities are staffed by adequate numbers of qualified nurses: either registered or enrolled nurses. This is imperative if quality care is to be provided for those residents of aged care facilities who have high nursing care needs, including palliative care needs.

However, the Committee also recognises that for the majority of older people their care needs do not need to be delivered in a clinical setting, and therefore advocates the adoption of a social model of care: just because people are old does not mean they are sick.

Neither Commonwealth nor New South Wales legislation currently regulates specific staff-resident ratios or qualified-unqualified staff ratios. Other states have, or in the past did have, such regulations. The *NSW Nursing Homes Regulation, 1996* states in Section 15 that:

> *(1) The nursing and personal care staff of a nursing home must at all times be sufficient in number, and have appropriate experience, to perform the nursing duties necessary for the proper care of residents*

(2) *The sufficiency of nursing and personal care staff is to be determined in accordance with the Principles for the Classification of Nursing Home Patients and Repatriation Nursing Home Patients.*

The Principles classify residents according to the amount of care needed, though they do not codify a specific staff-resident ratio, or set requirements relating to a qualified staff - unqualified staff ratio. The last survey by NSW Health on staffing ratios in private sector nursing homes was done in 1992, and its findings are incorporated in Table 1.

TABLE ONE

STAFFING MIX IN NEW SOUTH WALES NURSING HOMES

YEAR	REGISTERED NURSES	ENROLLED NURSES	ASSISTANTS-IN-NURSING
1980	34.8%	9.2%	56.0%
1992	31.7%	10.5%	57.8%

Source: NSW Health, Private Sector Nursing Workforce, unpublished.

As can be seen in Table One, in 1992, less than half of the nursing and personal care staff in nursing homes were qualified, and this has slightly decreased since 1980.

The Committee is concerned at the lack of uniform criteria for staff working in residential aged care sectors. For example, there are no qualifications required for Personal Care Assistants or Assistants-in-Nursing, and, under current award conditions, Assistants-in-Nursing must undergo only 12.5 hours of on-the-job training each year (Fredericks, NSW Nurses' Association, Personal Interview, 21 May 1997).

Of particular concern to the Committee is the fact that there are no requirements for Registered Nurses to have specific gerontological training. Registered Nurses are often in leadership positions in aged care organisations, including being charge of other less qualified or unqualified staff. The Committee is aware that there are a number of aged care organisations in New South Wales which have a strong training culture, and other personnel practices which support the provision of high quality care. However, from the Committee's perspective, it is a concern that this is not more widespread.

The Committee believes that the aged care industry should work toward developing a holistic training framework, which is driven from the perspective of a social model of care and which also includes relevant clinical care elements. The Committee notes that the Commonwealth has established a Residential Aged Care Workforce Review Committee to report on how to meet the workforce requirements of the aged care

industry (Aged Care Structural Reform - Fact Sheet 20, June 1997). The Committee is not aware of any formal mechanism by which the NSW Government is involved in this process. The Committee believes it is important to include the State and Territory Governments in this process, as well as community care providers, particularly given the erosion of boundaries between residential and community care which has occurred over the last decade, and which needs to continue to ensure a more cost effective aged care system which is driven from a community care perspective.

RECOMMENDATION 8:

The Committee recommends the Minister for Aged Services request of the Commonwealth Minister for Family Services to include State and Territory representatives on the Residential Aged Care Workforce Review Committee, and extend the Terms of Reference to include community aged care services.

The Committee recognises the inherent difficulties in education and training of staff working in residential aged care facilities, in particular Assistants in Nursing and Personal Care Staff, due to the large proportion of part-time and casual workers, the low levels of education and the low levels of English language skills. In addition, the Committee understands that there is often a high turnover of staff, which could be a result of staff feeling unsupported in their work. To that end, it is important for all levels of staff working in aged care services, including management, to understand the issues of caring for frail older people. The Committee is of the strong belief that it is unacceptable for frail and ill elderly people to be cared for largely by untrained staff. The Committee is encouraged to see that the Accreditation Standards which are being developed by the Commonwealth address a number of these concerns. The Standards include staff training on medication management, palliative care, complex nursing care needs, issues relating to sensory loss.

The criteria for the Human and Resource Management Standard include policies and practices which provide:

- *for recruitment, orientation, training and education to be conducted and documented;*
- *that all staff have their performance formally reviewed on a regular basis, giving consideration to performance, training, education and other developmental issues; and*
- *that staff training and education needs are identified and acted upon. Staff are encouraged to pursue relevant ongoing education and training and progress is monitored* (Criteria d, f and g HFS Draft Standards for Aged Care Facilities, 3 June 1997).

However, given the length of time within which facilities have to be accredited (three years), the Committee believes it is important that the NSW Government monitors the implementation of standards. The Committee believes there are a number of strategies which could be undertaken to improve the training and education of staff in aged care facilities, including the development of an industry training framework for staff, which guides the industry in staffing and training priorities and best practice in training for the needs of the workers and management in the industry. The Committee believes that development of an industry training framework should be in the context of the Aged Care Strategy (as per Recommendations 2 and 4 of this Report) and in conjunction with key stakeholders such as the NSW Nurses' Association, NSW College of Nursing and consumer groups. In particular, the Committee is concerned to see that issues of privacy and dignity, and residents' rights, are incorporated into any industry training framework.

RECOMMENDATION 9:

The Committee recommends that the Ageing and Disability Department include in the NSW Aged Care Strategy (see Recommendation 4) the development of a New South Wales aged care industry training framework, which builds on the work of the Commonwealth's Residential Aged Care Workforce Review Committee, and includes community care workforce issues.

The Committee notes that there are a number of training programs currently available to Assistants-in-Nursing in New South Wales. The NSW Nurses' Association is confident that all Assistants-in-Nursing in this state have access to a training program, including those in rural areas (Illisse, Personal interview, 16 June 1997).

Prospective Assistants-in-Nursing can access a 12 month traineeship or a three month pre-service training program, the latter of which involves 10 weeks course work and two weeks work experience. A pilot program for existing staff to undertake a certificate of accreditation has recently been successful, and will be available to all Assistants-in-Nursing by October 1997. Rural areas have access to the program through distance learning, on-the-job training and Area Health Nurse Educators. Each of these programs are known as level three certificates, equivalent to 320 hours of study.

A level two certificate, known as Care of the Ageing is available through TAFE. Care of the Ageing is an 8-10 week course. A two week, level one certificate is also available in various facilities in New South Wales, but it is not accredited.

In its response to the Interim Report of this Inquiry, NSW Health noted that:

> *(I)t is recognised that Assistants-in-Nursing have an established role in health care delivery, particularly in the provision of aged care* (Submission, 11 September 1997).

The Committee is concerned, however, that existing aged care programs, such as the Care of the Ageing course noted above, may have an overly medical or clinical approach which would be inconsistent with the social model which this Committee believes should drive the provision of care for older people: that is, a model of care directed to supporting people in the community for as long as possible, and when that is no longer possible, providing care in a way which maintains the dignity and autonomy of older people. In its response to the Interim Report of this Inquiry, NSW Health advised the Committee that a review of training programs for Assistants-in-Nursing has recently been undertaken (Submission, 11 September 1997). Any review of course materials should take into consideration the findings of this Review.

RECOMMENDATION 10:

The Committee recommends that, as part of the development of a New South Wales aged care training framework (see Recommendation 9), the Ageing and Disability Department work with relevant stakeholders and the NSW Vocational Education and Training Accreditation Board (VETAB) to review existing accredited or approved aged care programs to ensure that they are driven from a social model of care perspective, as well as including the relevant clinical components.

RECOMMENDATION 11:

The Committee recommends that all nursing and personal care staff in New South Wales residential care facilities be trained to an Assistant- in-Nursing Course Certificate III level by the year 2000 and that a range of programs be made available to ensure equitable access to training.

The Committee notes that under the current system there are mechanisms in place to ensure appropriate staff mixes. Under the CAM/SAM funding arrangement the Commonwealth provides funding to nursing homes for nursing and personal care using the Care Aggregated Module (CAM). Each resident is classified based on their care needs, and facilities are funded accordingly. The funds are validated by the Department of Health and Family Services, so any CAM funds which were not spent on nursing or personal care are required to be repaid to the Department and must not be kept as profit. This reduces the incentive to cut costs by using cheaper staff.

Under the changes proposed by the Commonwealth, CAM and SAM funding will no longer be separate, and care related funding will not be validated. Several witnesses and submissions have expressed apprehension about the likely effects of the proposed changes. They are concerned that these changes will result in providers seeking to

reduce staffing costs and increase profits by employing more Assistants-in-Nursing rather than Registered or Enrolled Nurses, resulting in diminished quality of care (for example, Moait, Evidence - 5 May 1997).

The Commonwealth expects that appropriate staffing mixes in aged care facilities will be ensured through the standards for accreditation which require that services employ appropriately qualified and skilled staff to meet the needs of their residents. In order to meet the quality accreditation standards services will need to show:

- *a staffing mix which meets the care needs of their residents;*
- *the recruitment of appropriately skilled staff;*
- *the continued development of staff skills; and*
- *the provision of adequate opportunities and resources for supervision and on-the-job training* (Aged Care Structural Reform - Fact Sheet 20, June 1997).

The Committee is concerned that the accreditation process will not guarantee appropriate staffing mixes for residents, which witnesses feel will be compromised as a result of the abolition of a validated system of CAM funding for personal and nursing care. In its Interim Report on this Inquiry the Committee noted that the erosion of qualified staff can be averted in New South Wales through an amendment to the *NSW Nursing Homes Regulation, 1996* in respect of the licensing conditions contained therein. Licensing conditions should be altered to include a staff-resident ratio and a staff mix ratio.

The response to the relevant recommendation in the Interim Report has indicated that reform of legislation for these purposes should not proceed. NSW Health noted:

> *It is inappropriate to prescribe staffing ratios for health care settings in legislation as it excludes flexibility in planning and responsiveness of planning to changing service needs, demands, resident acuity and changes which are currently underway across the health and community services sectors* (Submission - 11 September 1997).

The NSW Nurses' Association also noted that:

> *Directors of Nursing at a local level must have flexibility and the resources to adjust their staffing needs to the current acuity of the residents* (Submission - 28 August 1997).

The Ageing and Disability Department cautioned against legislating for staff ratios and mixes:

> *The question of reform of NSW legislation must be considered in the context of the system as a whole* (ADD - 11 September 1997);

and

> *(t)he inclusion of nursing staff on staff may not always be necessary and should be determined according to the level of care required* (ADD - 11 September 1997).

The Committee believes, however, there are still significant concerns that the abolition of the validation of the CAM/SAM components will lead to compromised staffing profiles in aged care services, and is concerned that the accreditation process will not adequately pick up on these issues. To that end, the Committee believes staffing profiles and resident care should be monitored.

RECOMMENDATION 12:

The Committee recommends that the Ageing and Disability Department include in its monitoring of the impact of the *Commonwealth Aged Care Act, 1997* information which will reflect the quality of care for residents and appropriate staffing profiles.

2.4 MEDICATION USE AND RESTRAINT PRACTICES

The Psychotropic Committee is very concerned that there appears to be a high incidence of the use of medication in aged care facilities in NSW. A report in the Medical Journal of Australia (Vol 163, July 1995) concluded that:

> *The percentage of residents in Central Sydney nursing homes who were taking neuroleptics, hypnotics or anxiolytics is among the highest reported from geriatric institutions around the world. Prescribing practices in Australian nursing homes need to be reviewed* (cited in Submission 57).

The Committee understands that one of the chief reasons for prescribing such medication is to control behaviour of people, in particular people with cognitive impairments. There is also a concomitant high incidence of physical restraint used for such residents.

The impact of the over-use of medication for purposes of restraint on residents and their families is significant, as one relative noted:

> *My father [who had Alzheimer's Disease] was sedated without any consultation with me. He had never been prescribed sedation in his life, and it was totally uncalled for. My father was beginning to be "out of it" most of the time ... and it took some stern words from me and a change of doctor before I could get this stopped* (Submission 80).

The extent of the problem was acknowledged in a briefing provided to the Committee by the Ageing and Disability Department. Ms McFee told the Committee:

> *Public attention has been focused recently on the use of psychotropic medication in nursing homes. Aspects of Commonwealth and State legislation, regulatory apparatus and accountability mechanisms have been thought to be inadequate to protect the rights of residents to ensure best clinical practice in this area. Medical attention has highlighted the ease of reliance by nursing home operators on the use of psychotropic medication as a simple and inexpensive way of managing difficult behaviour, rather than developing other appropriate behaviour management strategies* (McFee, Briefing - 12 December 1996).

The Committee notes that some actions have been taken recently to reduce over-medication. A NSW Ministerial Taskforce on the Use of Psychotropic Medication in Nursing Homes was established to examine the problem and to form recommendations. This Taskforce has recently reported to the Minister for Health, who has called for public comment. The recommendations of the Taskforce are included in this Report as Appendix Five. The Committee endorses the recommendations of the Taskforce Report and urges their implementation as a matter of urgency.

The Australian Pharmaceutical Advisory Council (APAC) has recently published a report entitled Integrated Best Practice Model for Medication Management in Residential Aged Care Facilities (1997). This document is the result of the work of the APAC Working Party on quality use of medicines in nursing homes and hostels, and, it is hoped, will assist residential aged care facilities in achieving more appropriate levels of use of prescribed medication (Australian Pharmaceutical Advisory Council, 1997). The Advisory Council's recommendations can be found in this Report as Appendix Six. The Committee endorses the guidelines and recommendations contained in the APAC Report.

2.5 CONCLUSION: ARE RIGHTS PROTECTED?

With a combination of Commonwealth Outcome Standards, Charters of Rights and Responsibilities, Residential Agreements and state licencing standards, nursing home residents are currently protected by a very comprehensive system of safeguards. The current system has successfully raised the standards of care and quality of life of most nursing home residents, and has been assessed as being inexpensive and fair.

However, despite this, there remains some aspects of care which are not provided satisfactorily.

The Commonwealth has addressed the protection of rights of residents through a number of mechanisms outlined in the *Commonwealth Aged Care Act, 1997* including the accreditation standards, revised complaints mechanisms and increased capacity of services to raise funds to improve service provision (through the Accommodation Bond scheme). The effectiveness of these will not be clear for several years.

It is therefore important that the NSW Government continue to monitor the impact of the reforms on the rights and care needs of residents. Whether this is done in the context of continued legislative involvement, such as the *NSW Nursing Homes Act*, or through the review process of the *Commonwealth Aged Care Act, 1997* which the Commonwealth must undertake (and States participate in) is a decision the Government needs to make.

CHAPTER THREE:

ENSURING QUALITY SERVICES:

NEW ARRANGEMENTS

(POST 1 OCTOBER 1997)

CONTENTS:

The Commonwealth is currently in the process of reforming the quality assurance system for residential aged care facilities. Like the current system, the new system will include a Charter of Residents' Rights and Responsibilities, and residential agreements. The major change to the system is the abolition of the standards monitoring regime, and its replacement with an accreditation-based system of standards monitoring. There are also changes to the funding of nursing homes - or residential aged care facilities, as they will be known - which may impact on standards of care. The following sections describe and comment upon these changes.

3.1 ACCREDITATION

The accreditation system of quality assurance, which the Commonwealth will introduce from 1 January 1998, has not been completely developed at this stage. What is known is that all residential aged care facilities will be assessed against the accreditation standards, which are currently in draft form only. The accreditation standards are being developed by a working group consisting of consumers, industry and Commonwealth Government representatives (no State or Territory Government representatives have been involved in the development of the Standards).

An Aged Care Standards Agency, administered by a Board selected by the Minister, will oversee the accreditation process (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 1, 1997). Only facilities which are accredited may charge accommodation bonds and receive Commonwealth funding (*Commonwealth Aged Care Act, 1997*, Division 37-1, p 129).

The Accreditation Standards and sanctions are outlined in Part 18.8 of the third exposure draft of the *Aged Care Act, 1997 Principles*. The Standards appear comprehensive and constructive. They are grouped into four categories:

Category 1	Health and Personal Care (including medical care, pain management, nutrition and hydration, skin care, continence management, behavioural management);
Category 2	Resident Lifestyle (including privacy, dignity, independence, leisure activities, cultural and spiritual life, decision-making);
Category 3	Safe Practice and Physical Environment (including infection control, fire safety, OHS); and
Category 4	Management Systems and Organisational Development (including human resource management, regulatory compliance and information systems).

The draft accreditation standards incorporate standards regulating both inputs and outcomes in most of the aspects of care which are regulated by the current Outcome Standards. The draft accreditation standards differ from the existing standards in several areas.

Some additional measures have been included. The most significant gain for the resident in Category 1 (Health and Personal Care) is draft standard (1.11), "evidence of involvement of specialist assessment and treatment where appropriate" for issues of behavioural management.

In Draft Category 2 (Resident Lifestyle), the significant gains are: expanded emotional support; regular reviews of leisure activities; greater support for cultural and spiritual observances; and the right to be free of harassment, retaliation and victimisation.

Draft Category 3 (Safe Practice and Physical Environment), expands and updates the present standards significantly in the areas of Occupational Health and Safety, and includes environmental services such as catering, cleaning and maintaining facility grounds.

Draft Category 4 is an entirely new category - Management Systems and Organisational Development. The purpose of this new category is:

> *to enhance the quality of performance under all standards in all categories, and should not be regarded as an end in themselves. They provide opportunities for improvement in all aspects of service delivery and are pivotal to the achievement of overall quality* (Draft Accreditation Standards, 1997).

The principle enunciated is that the

> *organisations' management systems are responsive to residents, staff and stakeholder needs and the changing environment in which they operate* (Draft Accreditation Standards, 1997).

This category includes the requirement that there be sufficient numbers of appropriately skilled staff, and that staff be encouraged to undertake ongoing education and training.

The draft accreditation standards also exclude some of the current Outcome Standards. In particular:

- the provision under Standard 1.1 that "residents are aware that they can choose and change their medical practitioner" is removed;
- current Standards 1.5 and 1.3, Pain Management, which require staff awareness of "verbal and non-verbal cues for pain or discomfort" and of "effective pain management practices" have been omitted;

- the new Palliative Care Standard 1.6 no longer includes specific reference to the carrying out of residents' wishes at their death, as elaborated in the current standard 5.6;

- Draft Accreditation Standard 1.7 (Nutrition and Hydration) does not mention that "snacks and drinks are available throughout the day" and "food is presented in a manner that is appetising to residents", as required by current Standards;

- current Standard 5.2 whose principle is that "private property is not taken, lent or given to other people without the owner's permission" has been deleted;

- Draft Standard 2.4, (Independence) has changes in emphasis which reverses the control over independence. The facility proprietors/care givers are now the ultimate arbiters of residents' independence, not the residents (who hold that right in the current standards). For example, assessment of each residents "needs and preferences" are replaced by assessment of "capabilities and restrictions". Although "needs" are mentioned in Draft Standard 2.4c, it is in terms of evaluating and documenting needs, rather than the current requirement under Standard 1.2 to "respect" and "consult" on residents' needs; and

- significant criteria deletions in the area of privacy and dignity are: "residents' wishes are carried out at their death" (5.6); and that "residents' private space is respected by (staff and) other residents" (5.3); Changes in these criteria include the previous "right to privacy" (5.3) being replaced by "needs for privacy". Likewise, "residents are enabled to undertake personal activities, including bathing, toileting and dressing in private" (2.5b), but privacy is no longer "maintained at all times", as in current standard, (5.3).

Accreditation of all residential aged care facilities is aimed to be completed by the year 2001. In the meantime, facilities must obtain interim certification if they wish to charge an accommodation bond. In order to obtain certification, facilities must also meet the requirements of any state laws and Commonwealth authorities in relation to building, equipment and care standards (Certification Principles, 1997: 73).

Facilities with unrenovated buildings exceeding 20 years of age, which are more than one storey, which do not meet any relevant state fire and safety laws, or which were not purpose built, may be required to undergo an assessment for certification. This assessment must be undertaken by a qualified person independent of the Department. The assessment determines whether the building and equipment meets State laws, is safe and secure, ensures privacy for residents, and allows access to public transport and medical care (Certification Principles 1997, Part 4, ss 12 - 14). Facilities which have not achieved accreditation after the transition period of two or three years will lose Commonwealth subsidies (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 1, 1997).

The Aged Care Standards Agency will have the task of inspections of facilities for the purpose of accreditation. It will make recommendations to the Department concerning substandard services (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 18, 1997b). As the Commonwealth Department of Health and Family Services remains the funder of services, it will be responsible, under the Aged Care Bill, 1997 for imposing sanctions.

The Committee is concerned that the accreditation system on its own may be insufficient to ensure a high standard of care in nursing homes. An accreditation and peer review approach usually emphasises the importance of market forces to control standards, believing that facilities with poorer standards, or which lack accreditation, will not be able to attract consumers.

Market forces are restricted in the nursing home industry by several factors. Perhaps most notable is that competition is restricted because of the fixed supply of beds. With waiting lists in most areas, even substandard homes are able to assume that they will be able to fill most, if not all, of their beds. It is the Committee's view that market forces cannot operate in a situation where supply is highly controlled and regulated and demand is inelastic.

The Committee also heard that, as most nursing home residents are admitted straight from hospital, there is often no time for them to assess the different homes before admission. In addition, the quality of care is not the only reason for selection of a nursing home. Other aspects which factor into choice include proximity to relatives and friends, retaining links to ethnic or religious groups, and availability of beds. In country areas in particular, the choice of nursing home is very limited, or even non-existent.

The Committee has reservations about the appropriateness of relying on the Aged Care Standards Agency to investigate and report on the aged care services funded with public monies. Although the structure and make-up of the Agency has not been finalised, at this stage it appears that there will be no Government or Departmental representative on the Board of the Agency. The Committee notes that the care of nursing home residents is a significant budget item, and believes that the Commonwealth should accept the responsibility to ensure that facilities receiving its funds are providing an adequate standard of care.

3.2 SANCTIONS

The *Commonwealth Aged Care Act, 1997* details the principles and processes for application of sanctions for non-compliance under the new regulatory framework. The Secretary of the Commonwealth Department of Health and Family Services can impose sanctions on an approved provider if that provider fails to meet its obligations and responsibilities in relation to the aged care they provide. These responsibilities relate to quality of care, user rights and accountability. Examples of such responsibilities include:

Section 54-1 (1) (a) - to provide such care and services as are specified in the Quality of Care Principles;

Section 54-1 (1) (b) - to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;

Section 54-1 (1) (d) - to comply with the Accreditation Standards made under section 54-2;

Section 56-1 (a) - to offer to enter into a resident agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement;

Section 56-1 (l) - to comply with the requirements of section 56-4 in relation to resolution of complaints (*Commonwealth Aged Care Act, 1997*).

Under the Act, there are a number of sanctions available, including revoking or suspending the provider's approval to provide aged care services, altering the conditions of the provider's approval, prohibiting the further allocation of places to the provider, revoking or suspending the extra service status of a residential care provider, prohibiting the charging of an accommodation bond, and revoking certification (Section 66-1, *Commonwealth Aged Care Act, 1997*).

A provider can avoid losing approval as a provider if she/he agrees to conditions specified by the Secretary, including:

i) providing, at its expense, such training as is specified in the notice for its officers, employees and agents;

ii) providing such security as is specified in the notice for any debts owed by the approved provider to the Commonwealth;

iii) appointment by the approved provider, in accordance with the Sanctions Principles, of an adviser approved by the Commonwealth to assist the approved provider to comply with its responsibilities;

iv) appointment by the approved provider, in accordance with the Sanctions Principles, of an administrator approved by the Commonwealth to administer an aged care service in respect of which the approved provider has not complied with its responsibilities;

v) transferring some or all of the places allocated to the approved provider under Part 2.2 to another approved provider; and

vi) such other matters as are specified in the Sanctions Principle (Part 4.4, Section 66-1).

There are steps which must be taken by the Secretary before sanctions can be imposed, starting with giving a notice of non-compliance, followed by a notice of intention to impose sanctions or a notice to remedy the non-compliance. If there is an immediate and severe risk to the residents, these steps can be omitted. Decisions to impose sanctions are reviewable under Part 6.1 of the *Commonwealth Aged Care Act, 1997.* This is an internal review mechanism: the review is performed by the Secretary - who also made the original decision. External review is available through the Administrative Appeals Tribunal (ss 85-4 and 85-5, *Commonwealth Aged Care Act, 1997).*

The Committee notes that the *Commonwealth Aged Care Act, 1997* provides a range of sanctions designed to encourage providers to meet their obligations and to force out providers consistently breaching standards and responsibilities. In allowing for providers to avoid revocation of approval by adhering to conditions imposed by the Department, the Act also provides a mechanism to ensure that a provider providing sub-standard care can be removed from an administrative and/or management position without a loss of services and the forced removal of residents. This avoids the traditional problem faced by regulators seeking to close down providers of sub-standard care.

However, the Committee is concerned that the standards and sanctions regime proposed under the Act does not overcome the deficiency of the current standards monitoring process: there is no guarantee that the monitoring body will be less tolerant of low standards than is currently the case. The Committee believes that the Department of Health and Family Services should maintain its responsibility for monitoring of standards, and a separate unit within the Department should be made responsible for imposing sanctions for breaches of standards. Such sanctions should automatically be imposed on repeat offenders.

3.3 COMPLAINTS MECHANISMS

The *Commonwealth Aged Care Act, 1997* does not detail the complaints mechanisms to be put in place under the new system; details will be contained in the subordinate legislation (the Principles). The Committee notes that under Section 56-4 of the *Commonwealth Aged Care Act, 1997,* providers are required to institute complaints mechanisms within their aged care facilities, and commends this.

The third exposure draft of the *Commonwealth Aged Care Act, 1997 Principles* provide for the creation of Complaints Resolution Committees. The Committee is independent of government, and is empowered to resolve complaints and to refer systematic or serious issues to the appropriate agency. The Secretary of the Department of Health and Family Services is empowered to negotiate complaints and arrange for mediation prior to referring a complaint to the Complaints Resolution Committee for resolution.

There is now general support for the establishment of this independent committee, overcoming earlier hesitancy arising from earlier exposure drafts which did not specify the mechanism which would be available for residents. The Ageing and Disability Department submitted:

> *ADD supports the creation of an independent monitoring agency which reports to the Minister and has the power to refer cases to the Minister to enforce sanctions* (Submission, 11 September 1997).

The Aged-Care Rights Service also submitted:

> *Overall, the system is an improvement on the existing framework for complaints handling and resolution* (Submission, 11 September 1997).

A number of witnesses and submissions have emphasised that any external complaints body must be independent of both the industry and the Department. The NSW Council of Social Service, for example, noted in its submission to the Committee that for the new system to be successful, it must have "a body separate to both funder and provider which is responsible for monitoring and individual complaints" (Submission 81).

While the Complaints Resolution Committee will be independent of government, the Committee was concerned that complaints must first be lodged with the Secretary of the Department. ADD submitted that it would prefer to see an independent body as the point of first contact (Submission, 11 September 1997).

RECOMMENDATION 13:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services change the complaints resolution process outlined in the third exposure draft of the *Commonwealth Aged Care Act, 1997* Principles, Chapter 3, Part 1: Committee Principles to provide for residents to have direct access to the independent Complaints Resolution Committee without first having to lodge their complaint with the Secretary of the Department of Health and Family Services.

RECOMMENDATION 14:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure the proposed accreditation-based system for quality control in residential aged care facilities embodies the following principles:

- an independent complaints body similar in structure to the Ombudsman's Office;
- the maintenance of the Commonwealth Department of Health and Family Services' role in monitoring the accreditation standards which are currently being developed;
- a separate unit within the Department of Health and Family Services to be responsible for imposing sanctions on facilities which fail to meet the accreditation standards;
- automatic application of the hierarchy of sanctions available under the *Commonwealth Aged Care Act, 1997* for facilities failing to meet the same standard on three consecutive visits; and
- public access to accreditation standards reports, including posting the accreditation inspection reports in the foyer of each facility.

The Committee believes that the accreditation standards themselves should contain, in addition to the existing standards, a strong statement concerning the rights of consumers to privacy, confidentiality, dignity, and independence; and individual standards that incorporate these principles.

3.4 PRUDENTIAL ARRANGEMENTS

The prudential arrangements which have been developed by the Commonwealth aim to protect the funds which residents have deposited as accommodation bonds, and ensure that residents can be certain that any outstanding bond amounts owing to them when they leave a facility will be repaid.

The *Commonwealth Aged Care Act, 1997* requires all facilities charging bonds to comply with the prudential arrangements. The arrangements include the establishment of an industry trust fund, into which all bonds will be deposited, and remain for the

duration of the resident's stay in care. Residents who pay a bond will have a separately identified account within the fund, from which retention amounts (up to $2,600 per year for a total of five years) will be deducted progressively each month. Compliance with prudential arrangements will be monitored by a government appointed, independent Scheme manager and will be part of the assessment of whether a facility should be accredited (Prudential Arrangements Information Kit - Fact Sheet No. 1, 29 August 1997).

Not all providers will need to subscribe to the Scheme; some State Governments, large churches or industry groups may operate their own arrangements as long as they meet legislative requirements and are as stringent as the general industry scheme. Accommodation bonds lodged with such agencies will also be guaranteed, but by the sponsoring organisation of that scheme rather than the industry guarantee fund.

It is expected that services will be able to borrow against the amounts which they have received as accommodation bonds and which are held in the trust fund. Their capacity to borrow will clearly be related to the overall size of the trust fund (such borrowings could be used to invest in any maintenance and upgrading of their facilities which might be necessary to achieve certification and accreditation).

The prudential arrangements have been generally welcomed by consumer groups as a means of ensuring that residents' monies are safe. The Aged-Care Rights Service submitted that:

> *(It) is relieved that the prudential arrangements are stringent and will require all monies from accommodation bonds to be held in trust* (Submission - 8 September 1997).

The Committee heard, however, that there are still some concerns about the signing of accommodation bond and fee agreements, in particular when people are not able to sign on their own behalf.

The Aged-Care Rights Service submitted that:

> *The definition of 'representative' under S.96-5 Commonwealth Aged Care Act, 1997 remains a concern....Our contention is that the definition (or lack) of 'representative' is too broad and may result in parties entering agreements on behalf of others without informed consent or legal standing* (Submission - 8 September 1997).

3.5 RIGHTS AND FUNDING

The Commonwealth's proposal to remove the distinction between CAM (Care Aggregated Module) and SAM (Standard Aggregated Module), and to remove the requirement to validate CAM funding may impact on the quality of care that residents receive in residential aged care facilities.

Under the current system, one of the components of Commonwealth funding is provided for the nursing and personal care of each resident, according to their care needs. This is CAM funding, and it can only be used for nursing and personal care. As previously noted, each service provider has their CAM funds validated by the Department: that is, their records are checked to ensure that funding provided for care was used for care. Any money that was not used for residents' care must be returned to the Department, so a provider cannot increase profits by spending less money on residents' care.

A number of witnesses expressed the belief that subjecting nursing care to the profit motive by removing CAM validation will result in an erosion in the quality of care in nursing homes. They argue that providers will be motivated to cut care related costs to increase their profits, and will do so by hiring less qualified staff, or fewer staff altogether (Moait, Evidence - 5 May 1997; Herbert, Evidence - 21 April 1997; and Johnson, Evidence - 21 April 1997). These concerns are also raised in Stage II of the Gregory Report, which notes that the success of standards monitoring to date has occurred in an environment where there is no financial incentive to reduce care costs (Gregory, 1994: 26). Professor Gregory concluded that a non-acquitted funding system would require more frequent and more stringent standards monitoring to ensure that it did not result in a diminution of the quality of care (Gregory, 1993: 32, 79). Recommendation 12 in Chapter 2 of this Report seeks to address the potential problem of a possible reduction in numbers of qualified staff.

Further details and comments about CAM funding can be found in Chapter Five.

3.6 CONCLUSION

While a number of details of the new care standards monitoring regime are still unknown, the Committee has concerns about some aspects of the proposals. The Committee notes with regret that a number of significant details of the care standards monitoring regime are still not available for comment. In particular, there is a potential for deterioration in care standards resulting from insufficient Government monitoring, and the proposed changes may exacerbate the trend of inadequate training of staff and a declining proportion of qualified staff. The Committee emphasises the importance of strong enforcement and independent complaints mechanisms in ensuring that standards of care in residential facilities are maintained.

CHAPTER FOUR:

RESIDENTS WITH SPECIAL NEEDS

CONTENTS:

The rights of discrete sub-groups of residents are at times overlooked in some aged care services and their specific needs are subsumed in the interests of uniform cost effective services. Younger residents are particularly disadvantaged, and many residents from small rural communities suffer from isolation from their families and lifelong community networks. Residents who have dementia and those with mental illnesses are also at a disadvantage. Residents from non-English speaking backgrounds can experience serious difficulties in obtaining sensitive and culturally appropriate care, as can indigenous Australian communities. In addition, the rights of people to sexual expression and relationships are limited within aged care services.

4.1 RESIDENTS WITH DEMENTIA

The Committee received much evidence about the needs of people with dementia living in residential aged care facilities and the extent to which their needs are not well met. Approximately 60% of nursing home residents and 28% of hostel residents have moderate to severe dementia (Rosewarne *et al*, 1997: 31).

The majority of people with dementia are cared for in mainstream areas, that is, where there is a mix of frail older people who are not cognitively impaired as well as those who are. A major research project which was undertaken by Dr Richard Rosewarne and a team from Monash University, and funded by the Commonwealth Government has found that around 10% of mainstream aged care facilities have a dementia specific area, most usually in a wing of the facility:

> *That is, the main facility has a wing alongside, an attached area, where staff can move in and out but the residents do not* (Rosewarne, Evidence - 8 September 1997).

The research focussed on the care needs of people with dementia who had challenging behaviours, and found that dementia-specific areas cater for those people staff find the most difficult to provide care for. However, in his evidence to the Committee, Dr Rosewarne noted:

> *The interesting thing about challenging behaviour and dementia is that most of the care is provided in the mainstream aged care system* (Rosewarne, Evidence - 8 September 1997).

It is therefore imperative that staff who work in residential aged care services are trained in dementia care and behaviour management (Submission 10). In the absence of trained staff, residents with dementia are often restrained, either physically, or chemically through the use of sedatives. It is often the case, according the Alzheimer's Association, that the:

> *use of psychotropic drugs as a form of restraint in the management of dementia [occurs] without the consent of the person affected or their guardian* (Submission 77).

The behaviour of residents with dementia can also be upsetting for other residents, particularly those who share rooms with people with dementia. One study of 2000 residents in nursing homes in Sydney found behaviour associated with dementing illnesses to include the daily manifestation of:

> *restlessness, pacing, constant calls for help, cursing and verbal aggression, and oft-repeated sentences [for 10% of residents]. Hitting, kicking, and biting were less common ... Few (0.5% each) were reported as making verbal or physical sexual advances daily or more often. Some 4% were said to scream or make loud noises at least once daily; about 2% screamed several times daily, and ... 0.45% screamed several times an hour* (cited in Submission 58).

Most of the residential aged care services are not constructed or furbished in a way which mitigates against some of these behaviours, and are not staffed by qualified staff with expertise in managing the behaviour of the dementia affected. This is regrettable because, as the Committee was told by one specialist:

> *... with good management programmes, with training of staff and judicious use of medication, for most of these people, we can make their lives, and the lives of those around them, much better* (Brodaty, Evidence - 21 April 1997).

Dr Rosewarne's research further demonstrated the need for appropriately trained staff, particularly when assisting the person with dementia with personal care or activities of daily living:

> *...the biggest issues was the challenging behaviour as a product of the resident and staff member and the activity they are trying to do. That interaction is important* (Rosewarne, Evidence - 8 September 1997).

Dr Rosewarne continued

> *... Not everyone with a high level of cognitive impairment and dementia has a challenging behaviour ... It is not as if residents have some characteristic which, no matter where we put them, means that they are challenging at the point eight level out of ten.... It depends on the way they are approached, their current disposition and what sort of activity you are trying to do. It is important for staff training to think carefully about all those issues* (Rosewarne, Evidence - 8 September 1997).

The Committee believes that there is an urgent need for dementia-specific training of all staff caring for residents with dementia. However, this training should not only include nursing staff but also includes the whole of the organisation. In its response to the Interim Report of this Inquiry, the Ageing and Disability Department noted:

> *Training in dementia should not be limited to nursing and personal care staff: management also need to be educated in the care needs associated with dementia, so staff can be supported. This is particularly important for the implementation of flexible work practices, which are fundamental to good care of people with dementia* (Submission - 11 September 1997).

Unfortunately, there are few organisations which provide this level of training for staff and management.

The Committee further understands that there are few dementia-specific training programs available, although most nursing, gerontological and aged care training programs include a dementia module. The Committee is aware that there are a number of training programs being developed as part of the $4m NSW Action Plan on Dementia, including for General Practitioners and hospital staff, but these will not specifically address the needs of people working in residential aged care services.

The Commonwealth currently provides a National Residential Dementia Training Initiative as part of the former National Action Plan for Dementia Care. Under this Initiative, all levels of staff in nursing homes, including management and ancillary staff, are able to access training programs which are provided by dementia educators contracted by the Commonwealth. In New South Wales the training providers are Alzheimer Education (West and Northern New South Wales) and the Hammond Care Group (East and Southern New South Wales and the Australian Capital Territory). Attendance in the program is voluntary and free of charge. There is a small amount of funding available to assist those services which cannot afford to send staff to the training, for example due to the cost of backfilling specialist staff in small facilities or due to the distances involved for rural and remote services. The training includes a train-the-trainer component to assist the continuation of dementia training at the local level into the future. The Initiative concludes in December 1997. An evaluation of the training is being undertaken by the South Eastern Institute of TAFE in Victoria, and the final report will be provided to the Commonwealth in March 1998.

The Committee understands that, as part of the monitoring process, an advisory group has been established by the NSW Office of the Department for Health and Family Services which includes industry representatives. One of the aims of the advisory group is to assist the development of a dementia training infrastructure within New South Wales which will continue dementia training beyond the life of the Initiative.

The Committee believes that a national program of dementia training should continue to be offered to all staff and management of residential aged care facilities. It is unclear at this stage what responsibility the Commonwealth will take in relation to the provision of ongoing dementia training. The Committee believes that dementia training will continue to be required in New South Wales in the future, and that this should be included in the aged care training framework discussed in Chapter Two of this Report.

RECOMMENDATION 15:

The Committee recommends that the Ageing and Disability Department take into account the findings of the evaluation of the National Residential Dementia Training Initiative, and any recommendations of the NSW Advisory Group for the Initiative in its consideration of an aged care training framework (as per Recommendation 9).

RECOMMENDATION 16:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ensure that Dementia Training is included in the training curriculum for aged care services, or any other training program being considered by the Residential Aged Care Workforce Review Committee.

RECOMMENDATION 17:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to determine what dementia training will be made available by the Commonwealth in the future.

RECOMMENDATION 18:

The Committee recommends that, should the Commonwealth not provide dementia training in the future, the Minister for Aged Services develop and implement a training program similar to that offered under the National Residential Dementia Training Initiative, or contract out for the development of such a program, and that the Commonwealth be approached to provide funding for such a program.

The Committee is aware that there are a range of dementia training materials which have been produced in recent years, in part stimulated by the funds provided under the National Action Plan for Dementia Care. In New South Wales a number of organisations received funding for Demonstration Projects for Best Practice in Dementia Care under the National Action Plan. However, the Committee is concerned that while there are many organisations which hold a variety of resources, often for specific target groups (eg. Alzheimer's Association holds information for carers, the Centre for Education and Research on Ageing has resources for care professionals), there is no one identifiable organisation to hold a broad selection of resources and which could ensure that materials on best practice in dementia care are widely disseminated. The Committee understands that a national Clearing House and Resource Centre was funded under the National Action Plan, based at Monash University, however funding for the project is now finished and the resources are no longer available. The Committee believes it is important that there be a similar central dementia resource centre which could market itself to residential aged care services and which could assist in the ongoing development of staff working in these services. This could be considered within the context of the NSW Action Plan for Dementia Care.

RECOMMENDATION 19:

The Committee recommends that the Ageing and Disability Department consider allocating funds from within the NSW Action Plan for Dementia Care to support the establishment and/or ongoing viability of a central dementia resource centre for staff and management of aged care services.

RECOMMENDATION 20:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ascertain the whereabouts of resources produced under the National Action Plan for Dementia, previously housed at the Clearing House and Resource Centre at Monash University, and the possibility of including these resources in the collection to be established under Recommendation 19 above.

While staff training is fundamental to good dementia care, Professor Henry Brodaty told the Committee that while most residents with dementia could be managed in mainstream facilities which have trained staff and good programs,

> *there is a residue, and the numbers are hard to say, who are not amenable to such good management and for them we need special dementia care units. This is a problem* (Brodaty, Evidence - 21 April 1997).

As noted above, there are very few nursing homes with dementia-specific care units. A dementia care unit is usually separate from the mainstream facility, usually in a wing, or secured-off area, and includes a number of design features which appear to enhance the lives of people with dementia, and assist staff in the provision of their care. The Committee heard that while:

> *A lot of research has been done in the area of design ... there is very little empirical evidence proving what is best* (Rosewarne, Evidence - 8 September 1997).

In the course of his research, Dr Rosewarne identified four key issues which were thought to be important in dementia design:

> *(1) Secure areas where people can wander and move from a main kitchen and living area and which are accessible (ie. not locked off);*
>
> *(2) Inclusion of a kitchen area which is incorporated into the model of care;*
>
> *(3) Dining and living rooms which are divided into smaller areas to accommodate small groups of people; and*
>
> *(4) A more open design, where there are no barriers to people trying to get through, over and around* (Rosewarne, Evidence - 8 September 1997).

The Committee believes that the thrust of these principles, which appear to be aiming at smaller, domestic style units, is also of benefit for people who are not cognitively impaired.

Many of the design features which Dr Rosewarne identified are included in dementia specific services which have developed in recent years in New South Wales. The Committee was informed that

> *New South Wales has some very fine examples of design which aim at enhancing the outcomes for people with dementia, including the work which has been undertaken by the Hostel and Care Program* (ADD Submission - 11 September 1997).

The Hostel and Care Program (HCP), which is part of the Home Care Service of NSW, assists organisations in developing aged care facilities, including dementia specific facilities. Under the NSW Action Plan on Dementia the HCP will receive funds to explore design issues for people with dementia, including in residential and community care settings, and disseminate the findings in a user-friendly format (ADD Submission - 11 September 1997).

The Committee was also made aware of a major consultancy on environmental design which was undertaken as part of the National Action Plan for Dementia Care, the findings of which have not yet been published. The Committee considers that, as design of facilities can work towards enhancing the lives of people with dementia, and as organisations consider renovations or rebuilding in order for their facilities to be certified, it is important that this information be made available as soon as possible.

RECOMMENDATION 21:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services make available the findings of the environmental design consultancy undertaken as part of the National Action Plan on Dementia Care.

In New South Wales there is another level of residential care which has been developed for people who have severe dementia who have extremely challenging behaviours, called CADE (Confused and Disturbed Elderly) Units. These units were established as a result of the deinstitutionalisation process which the mental health system underwent during the 1980's. Nine units were established in New South Wales, and the Units incorporate dementia-specific designs and have higher staffing levels and specialised programs to better manage residents' behaviours. CADE Units are funded at a higher rate than nursing homes: the comparative costs are $100 per bed day for nursing homes, and $200 per bed day for CADE units. The lack of suitable services to support or accommodate people with severe dementia who have challenging behaviours and live in aged care facilities often results in those residents being forced to be admitted to acute psychiatric or general hospitals inappropriately, at a cost of $300 - $400 per day (Brodaty, Evidence -21 April 1997).

The Committee understands that a review of CADE units was undertaken which has not yet been publicly released by NSW Health. Any consideration of future directions in dementia care for aged care services should take into consideration the recommendations of this review.

There are a range of developments in recent years in relation to the care and support of people with dementia in residential aged care services. These include the groundbreaking Rosewarne research (noted above), the Commonwealth's Psychogeriatric Care and Support Initiative, the Victorian Aged Care Assessment Review, the Victorian Taskforce on Dementia, and the Future Directions on Dementia Care which was prepared by the Reference Group for the National Action Plan for Dementia Care.

An overwhelming theme of these developments is the right of people to be supported where they are for as long as possible, and the need for appropriate service and system responses to be available to support them. It is clear that the majority of people with

dementia can be supported within mainstream services; some will require specialist care and support within a mainstream setting; a small percentage of people with severe dementia who have challenging behaviours will need specialist accommodation, care and support.

The Committee heard evidence that the Rosewarne research identified twelve elements of service development that need to be addressed if the above outcomes are to be achieved, including nine for the mainstream services and three which were more of a specialist and separate nature:

> *The findings suggested that there was a need to upgrade the general system but also to have some specialist parts* (Rosewarne, Evidence - 8 September 1997).

The mainstream elements include those issues raised above such as improved staff training and environmental design which results in a more homelike setting, as well as the inclusion of relatives/family in care planning and delivery, support to rural ACATs and General Practitioners through teleconferencing and telemedicine, and appropriate levels of funding for dementia care in the Resident Classification Scale (Rosewarne, Evidence - 8 September 1997).

In regard to specialist care, the Committee heard that the findings of Dr Rosewarne's research supported the need for specialist dementia/psychogeriatric services which were based in a community, rather than health system (Rosewarne, Evidence - 8 September 1997). The models of the Victorian Psychogeriatric Assessment Teams (PGATs) and the Commonwealth's Psychogeriatric Care and Support Units were considered useful models.

Both models provide specialist advice to mainstream and dementia specific services, particularly in regard to management of difficult behaviours. The Victorian model

> *operates like a psychogeriatric model but is more of a psychosocial model as it is not so medically focussed* (Rosewarne, Evidence - 8 September 1997).

Both the Psychogeriatric Assessment Team and the Psychogeriatric Care Unit models also have brokerage funds attached, which are used to provide short-term funding to meet specific needs of the client/s who have the challenging behaviours. The important thing to note about this model is that it supports the care of people in the mainstream services for as long as possible, and limits the need for specialist or high cost service provision:

> *It is not just about placement; it is about giving staff advice on management and then pulling out as needed ... and acts as the local resource team for facilities having difficulty with people* (Rosewarne, Evidence - 8 September 1997).

Dr Rosewarne noted that difficult people are not difficult forever, and concluded:

> *We believe that it is important for the service system to have resources that are available; flexible resources where you can pull them in and pull them out. It is another way of saying that you do not always have to build separate things for people who are difficult at a particular time* (Rosewarne, Evidence - 8 September 1997).

There has also been exploration of alternative models of accommodation and care for people with dementia in Europe, including cluster projects and group homes, which the Committee believes may provide important lessons for New South Wales. The Committee believes there are clear lessons to be learned from both national and international developments, and these should be incorporated into any national or State aged care strategy as recommended previously.

RECOMMENDATION 22:

The Committee recommends that when developing the NSW Aged Care Strategy, and contributing to the National Aged Care Strategy, the Ageing and Disability Department take into consideration developments in dementia and psychogeriatric care which have occurred internationally as well as within Australia, such as the cluster and group home models which have been developed in Europe.

The Committee understands that, as part of the recent Federal Budget, additional funding was provided for Aged Care Assessment Teams in New South Wales to continue to employ staff with psychogeriatric expertise, which was initially funded under the National Action Plan for Dementia Care. In addition, the NSW Action Plan has provided funds for Area Health Services to develop local area dementia plans. However, the number of psychogeriatric staff employed in area health services and on ACATs remains limited, and there is significant variability in the provision of comprehensive community psychogeriatric teams across the State. The Committee believes that it is important that New South Wales develop a comprehensive psychogeriatric network, and that this should form part of the NSW Aged Care Strategy recommended above.

RECOMMENDATION 23:

The Committee recommends that the development of the NSW Aged Care Strategy (see Recommendation 4) include the provision for a comprehensive network of community psychogeriatric teams.

RECOMMENDATION 24:

The Committee recommends that the Ageing and Disability Department and the NSW Health Department fund the establishment of a comprehensive network of community psychogeriatric teams, including funding for a budget-holding role which can be used for short-term interventions in community care settings and residential care services for people with challenging behaviours.

The provision of quality care for people with dementia is also dependent upon the amount of funding available to provide that care. The Committee is aware that there are a number of residential aged care facilities which already offer innovative management programs and environmental design to assist in the management and care of residents with dementia within existing funding levels, and a number which do so only by providing additional funding. The Resident Classification Scale which has been developed places greater weightings for dementia related care needs, including appropriate programs and environments. Dr Rosewarne participated in the group which oversighted the development of the scale, and told the Committee that services:

> *will not get separate infrastructure funding for a special dementia unit but will be able to use the funding they have to provide these options if they wish* (Rosewarne, Evidence - 8 September 1997).

The Committee has heard that, while the scale targets care for people with dementia more clearly, there are no additional funds to the aged care budget:

> *It should be remembered that all that has been done is to spread the same pot of money over nursing homes and hostels. Whether in the long run that is a big help we wait to see* (Herbert, Evidence - 8 September 1997).

The Committee is concerned that additional funding for dementia which the Commonwealth Government has promised may not result in improved care for people with dementia.

RECOMMENDATION 25:

The Committee recommends that the Ageing and Disability Department include in its monitoring of the impact of the *Commonwealth Aged Care Act, 1997* on the appropriateness of funding for people with dementia.

The Committee heard that it is difficult for carers of people with dementia to access appropriate respite care. Moving a person with dementia from familiar surroundings and placing them into residential care for respite can be quite unsettling for the person, and their inability to understand the changes or communicate their concerns to staff can result in behaviours which can make care difficult to provide. As a result, the Committee is aware that some residential facilities refuse to take people with dementia for respite on account of the disruption this causes for the resident and staff.

This is of particular concern to the Committee, as the stress of caring for a person with dementia is often a key reason why carers need to relinquish care and place the person with dementia into residential care on a permanent basis. The Committee believes that it is important for services to better understand the care needs associated with providing respite for people with dementia, and that this should improve if all staff receive adequate training in dementia care and management adopts responsive and flexible care practices (see Recommendation 18).

The Committee understands that the Alzheimer's Association Australia received funds under the National Action Plan for Dementia Care to conduct research on the particular respite needs for people with dementia and their carers. The report has not yet been released, and the Committee believes that this would be a resource to service planners who aim to provide appropriate and responsive services for people with dementia and their carers.

RECOMMENDATION 26:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services release the report prepared by Alzheimer's Association Australia on respite needs for people with dementia and their carers as soon as possible.

RECOMMENDATION 27:

The Committee recommends that the Minister for Aged Services negotiate with the Commonwealth Minister for Family Services to improve access to residential and day respite care in dementia-specific facilities and facilitate the development of more responsive and flexible models of respite care.

4.2 RESIDENTS FROM NON-ENGLISH SPEAKING BACKGROUNDS

Older people from non-English speaking backgrounds (NESB) are another group which can be disadvantaged in nursing homes. A right to maintain cultural identity, including practising religion, is encoded in the current Outcome Standards. However, not every home meets the Outcome Standards relating to cultural identity. Some homes, for example, have failed to provide ethnic food; others do not seek to support religious practices.

Specific problems for residents of non-English speaking backgrounds include difficulties in communicating with staff and other residents, and considerable trouble in voicing their complaints. Access to information in their native tongue may also be problematic, reducing their ability to make informed choices.

A particular difficulty for NESB residents is that many facilities fail to use professional interpreters. Instead, providers often rely on family members of residents, or bilingual staff, to undertake informal interpreting for medical assessments and other legal, medical and private matters. The Committee is concerned that this may infringe on the right to confidentiality for NESB residents.

The use of amateur interpreters also could cause mistakes to be made based on inaccurate translations. There is a potential for serious negative consequences when untrained interpreters are asked to translate technical legal and medical terminology. When negotiations for accommodation bonds occur, this need for professional interpreters to be used will be paramount.

RECOMMENDATION 28:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure that all residential aged care facilities with residents of non-English speaking backgrounds be required to provide the services of a professional interpreter or phone interpreter for all medical assessments, consultations and any negotiations concerning accommodation bonds or residents' fees where a resident needs such services to communicate effectively.

Adequate funding is needed to ensure that providers are able to meet the needs of NESB residents who have difficulties in expressing themselves or understanding English. The new Resident Classification Scale, which assesses the level of care needs of residents, should allow for higher funding levels for residents who have higher individual needs, including language-related needs.

RECOMMENDATION 29:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure that the Resident Classification Scale recognises the additional resources needed to meet the needs of non-English speaking background residents with low levels of fluency in English, and that higher funding be allocated accordingly.

The NSW Clustering Service, which is funded by the Commonwealth Department of Health and Family Services, seeks to assist with meeting the needs of NESB residents. A key function of the Clustering Service is to create "clusters" of residents from particular cultural and linguistic backgrounds, so that they can be concentrated into specific nursing homes. This provides residents with opportunities for communication in their native language, and allows facilities to specialise in culturally aware care. The Clustering Service also offers cross-cultural training, encourages community - nursing home networking, and collects data about the numbers and placement of NESB residents and staff (Submission 9).

The Committee commends the NSW Clustering Service for its valuable services. The Clustering Service currently operates on an annual budget which, according to its manager, impedes the Service's ability to project its services over the medium term with any certainty (G Lee, Manager NSW Clustering Services, Personal Interview, 12 May 1997). The Committee is very concerned over the recent changes by the Commonwealth of funding to the Clustering Service. The Committee understands that the Service will need to tender against other organisations for future funding to support people of culturally and linguistically diverse backgrounds in residential aged care services. While the Committee is not opposed to competitive processes in the allocation of public funds, it considers that it is not appropriate in this case: there is limited expertise available in New South Wales to provide such a service and the introduction of competition for funds for this service may lead to reduced co-operation between services and fragmentation of the network which currently exists. The Committee believes that the Clustering Service should be funded on a five-year basis to allow medium term planning.

RECOMMENDATION 30:

The Committee recommends that the Minister for Aged Services support the NSW Clustering Service being funded on a five-year basis, and approach the Commonwealth Minister for Family Services to request this.

RECOMMENDATION 31:

The Committee recommends that the specific needs of people of diverse cultural and linguistic backgrounds who use aged care services be addressed within the NSW Aged Care Strategy to be developed under Recommendation 4.

4.3 SERVICES FOR INDIGENOUS AUSTRALIANS

The care needs of older indigenous Australians are quite distinct. Indigenous Australians have a shorter life expectancy and a higher incidence of illness and disability than other Australians, and make use of aged care services at earlier ages (Australian Institute of Health and Welfare, 1997: 4). Therefore, arbitrary age limits, such as those used by the Commonwealth in establishing planning ratios for aged care, are often inappropriate.

In addition, indigenous Australians tend to prefer community-based to residential services, consistent with their expressed desire to remain on the land and with their families in old age. The Committee has heard that in some country towns aged care facilities have been built for Aboriginal communities yet find that the facility is not used by the people of that community. It appears that the planning for and delivery of services for such communities was often undertaken without due consultation or consideration of the cultural appropriateness. However, the Committee understands that in recent years the Commonwealth has become increasingly more sensitive to the particular needs of Aboriginal peoples, and has been more flexible in its provision of aged care services to this population group.

In its response to the Interim Report of this Inquiry, the Ageing and Disability Department noted that:

> *there is only one successful example of (an Aboriginal Specific facility) in New South Wales, which suggests that people from Aboriginal and Torres Strait Islander communities require greater support from appropriate community services* (Submission, 11 September 1997).

The Committee received no submissions or evidence from Aboriginal communities on the specific needs of older Aboriginal and Torres Strait Islander peoples. It therefore believes it is inappropriate to report on this matter, without adequate information on which to proceed.

The Committee believes that the particular aged care or aged related needs of Aboriginal and Torres Strait Islanders should be considered more fully by policy planners and providers of aged care programs, in consultation with indigenous communities.

RECOMMENDATION 32:

The Committee recommends that the specific needs of indigenous Australians should be considered within the context of the NSW Aged Care Strategy to be developed under Recommendation 4, and developed in close consultation with indigenous Australian representatives.

The Committee understands that Aboriginal communities were consulted in the development of the NSW Action Plan on Dementia, and representatives continue to participate on the Reference Group oversighting the implementation of the Plan. A number of specific projects will be funded under the Plan which target Aboriginal communities, including community awareness and education for health workers about dementia. The major cause of dementia in the Aboriginal community is alcohol-related, rather than Alzheimer's disease as is the case with the general population.

4.4 RESIDENTS FROM RURAL AREAS

The most common problem for rural and remote areas is lack of local residential care services. As a result, it is not unusual for residents requiring nursing home care to be admitted into nursing homes hundreds of kilometres away, where it is very difficult for family and friends to visit, particularly those without cars.

The *Sydney Morning Herald* reported the case of Mr Don Cameron, who had lived together with his wife in a hostel in Bourke. As Mr Cameron's Alzheimer's disease progressed, he was temporarily moved into the local hospital, and finally was transferred to a nursing home at Forbes, five hours' drive away. Mrs Cameron is unable to visit her husband regularly, and their contact is usually confined to a phone call each Sunday (*Sydney Morning Herald*, 4 April 1997).

This situation is not an isolated incident. Due to small populations, people in rural and remote areas may have access to a hospital, a hostel, or a nursing home, but rarely more than one of these services. Some small country hospitals have set aside long term beds for nursing home type care, but they seldom are able to achieve the homelike environment required of nursing homes, and some lack diversional therapy or organised activities.

The Commonwealth has retained a $10 million capital program for the building and upgrading of facilities, a priority of which will be rural and remote communities.

Multi Purpose Services have sought to meet the needs of rural and remote areas. Multi Purpose Services (MPSs) are a joint Commonwealth-State initiative which provides different types of care under one administrative body and one funding structure.

The Committee has examined the delivery of services in MPSs in South Australia and in rural areas of New South Wales because of the potential of the model to expand the range of services offered in rural communities. A Multi-Purpose Service is a centre which integrates several different health and aged care services in one facility under one administrative and funding structure. A single MPS could offer acute care hospital services, nursing home and hostel care, as well as home and community care and ambulance services. Typically, an MPS builds on an existing service such as a hospital or hostel which is not financially viable on its own.

The MPS program seeks to overcome the problems inherent in the provision of health and aged care services to communities in rural and remote areas. Such problems include the small populations and low demand which make the provision of services costly on a per-person basis; fluctuations in demand which can threaten viability; difficulties in obtaining staff in remote areas; and distance from mainstream services.

The MPS program was piloted in New South Wales in 1992 with four MPSs, under a Commonwealth-State agreement. The four MPSs currently operating are at Braidwood, Baradine, Urana and Urbenville. Other states also have piloted MPSs. Funding is a mixture of Commonwealth and State capital funding, with recurrent funding being made up of State HACC and acute care funding, and Commonwealth Community Services funding (Lagaida, Evidence - 12 May 1997).

The potential benefits of the MPS model include:

- improved access to a range and mix of services;
- flexible use of funding to direct resources as required;
- reduced administrative costs as overheads are shared by the different services; and
- reduced capital costs as buildings are used for a number of services.

Multi-Purpose Services can also overcome the problem faced in many small communities with frail elderly people being forced to move to aged care facilities hundreds of kilometres away, or being accommodated inappropriately in long term beds of local acute care hospitals.

Submissions and evidence received by the Committee have revealed support for the concepts of MPSs. For example, the Uniting Church's Uniting Ministry with the Ageing told the Committee:

> *MPSs are an excellent way of trying to maximise the use of the resources in [a] town, because you actually get, as much as you can in small towns, economies of scale because everybody is working together and you can*

> *actually share administrative resources that otherwise you might have to duplicated in the different facilities, so I see enormous potential for MPSs* (MacDonald, Evidence - 21 April 1997).

Submissions received by the Committee reveal that there has been some resistance to the model of MPSs implemented in New South Wales.

The Aged Services Association (ASA) has been outspoken in its criticism of the MPS model in New South Wales. ASA does agree that for some communities, "an MPS is a sensible option" and supports the concept of MPSs. ASA's concerns with the NSW Government's approach to MPSs include:

> *... the absence of consulting with our industry, and secondly in the absence of being able to provide an explanation for the model that was chosen ... we have taken issue with the flexibility of the NSW Department of Health in implementing that particular model* (Frean, Evidence - 28 April 1997).

In particular, the New South Wales model of MPS involves Area Health Services taking control of what had previously been a community-managed facility. An official from NSW Health explained the organisational structure for MPSs in New South Wales:

> *In terms of the actual operation, for the individual MPS site [the auspicing body] is the area health service. But, in terms of the program for the establishing of an MPS site, it is the NSW Health Department* (Lagaida, Evidence - 12 May 1997).

Mr Lagaida gave evidence that there is community involvement in the setting up of the MPS, with community members forming an MPS development committee. However:

> *Once the MPS is established and up and running, the MPS then becomes part of the area health service's operation. ... The ultimate responsibility resides with the area health services. The reason for doing it that way is to ensure that there is an integration and proper planning of acute, aged care and community services* (Lagaida, Evidence - 12 May 1997).

Some communities are clearly unhappy about the prospect of losing management and control of aged care facilities, particularly where community fund raising has financed a large proportion of the existing facility's operation. The Committee received evidence that:

> *where a facility already exists in a local town ... if a community has done a lot of work and put together a local facility, they have raised money, they have bought and built this local facility, the Department of Health has been largely saying to them, in effect: Well, that's fine, if you want to have continued funding, we will continue to provide operational funding to you,*

> *but we will take this MPS over and in fact we'll take ownership of all the assets and they will now belong to the Health Department* (MacDonald, Evidence - 21 April 1997).

Mr MacDonald commented further:

> *... I see enormous potential for MPSs, but you have to go back to square one and start selling the whole thing again because it has been an absolute disaster the way the Department of Health has handled it* (Evidence, 21 April 1997).

Community run facilities are apprehensive of Area Health or Regional Health control. Teloca House at Narrandera submitted:

> *Under the current MPS Agreements, all management control of existing activities - such as participating Hostels and Nursing Homes - comes under the jurisdiction of the Regional Health Authority. From the experience of Urana [MPS], the former Hostel Management Board has no input to "day-to-day" operations of the Hostel, as such is now administered through the Greater Murray Health Board ... Consequently, we object to the current model for a MPS, which removes local management control to regional health authorities, and seek amendment to provide for local management committees to be elected by the local community rather than the need for "Ministerial" appointment of members* (Submission 12).

Teloca House also noted that the considerable contribution of volunteers who freely give their services for a community facility would be less willing to give time to assist a more distant regional health body.

The loss of community control of facilities is avoided in other States. The three MPSs in South Australia are incorporated bodies run by local communities. The Committee visited the Central Eyre Peninsula MPS in South Australia. The Board of Directors of Mid-West Health and Aged Care Inc, the body which runs the MPS, is entirely made up of nominees from the participating facilities and local communities. The Board is divided into sub-committees which examine such aspects of management as continuous improvement, women's health and community services. A full-time Chief Executive Officer is employed for day-to-day management.

Some communities and providers in New South Wales are also concerned about the services and care offered by MPSs. They are critical of the health focus of aged care in MPSs, and their lack of provision of other services needed by the aged population, such as housing, public transport and recreation facilities. One criticism of NSW Health's management of MPSs is that it treats aged care as a health issue.

The predominance of the health focus, including NSW Health's involvement in the MPS Program, may threaten the viability of the facilities, according to the Aged Services Association, because people will be unwilling to pay an accommodation bond to enter accommodation that has the atmosphere of a health facility (Frean, Evidence - 28 April 1997). It is also important to note that MPSs are not required to meet Outcome Standards, and thus there is no independent monitoring of the quality of care. The Commonwealth proposes that MPSs will be required to be certified and accredited under the new system.

With plans for up to 50 additional MPSs to be established in New South Wales over the next few years, some local communities and service providers are complaining that they have been pressured into accepting MPSs, have been threatened with closure of existing health facilities and have received misleading information. They would like to see a more flexible approach which would allow for the maintenance of community participation.

The Committee believes that while there are obvious advantages to the MPS model as a means of provision of aged care services in rural New South Wales, there are also significant barriers to their successful operation. These barriers are predominantly from the management structures dictated by NSW Health. The appointment of managers by the Area Health Service, and locating that management position within the Area Health Service, has removed the connection between the MPS and the local community. While the Committee heard that local MPS committees have been established to provide that link to the Area Health Service, the overwhelming feeling of some of these local communities is that their services have been taken out of their hands. This is of great concern to the Committee. Local communities in rural and remote areas have a history of pulling together to meet the needs of their communities. The Committee heard from a number of people about their community's effort and goodwill over many years, including fundraising activities and private donations, to ensure that the community had the aged care services it requires. The imposition of a manager appointed by the Area Health Service, and external to that community, meant that they no longer had control over the funds which they had raised, and created uncertainty about the use of those funds, and of any future funds which might be raised by the community. To remove the management of the MPS from the hands of local communities has been, for many, a rejection of their contribution to the aged care needs of their community.

The Committee considers that further consideration of the model should be done in the context of the NSW Aged Care Strategy as per Recommendation 4.

RECOMMENDATION 33:

The Committee recommends that the Ageing and Disability Department include in the NSW Aged Care Strategy to be developed as per Recommendation 4 of this Report a review of the Multi-Purpose Service model, including discussion of the most appropriate management structures for this type of service.

4.5 RESIDENTS WITH MENTAL HEALTH NEEDS

According to the Senior Staff Psychiatrist in Psychogeriatrics at the Royal North Shore Hospital, residents of nursing homes are not able to access the same degree of expert clinical attention and services as the wider community when they are suffering from a mental health problem (Submission 20).

Mental health problems are prevalent in the nursing home population, particularly clinical depression and anxiety syndromes. It is estimated that some 30% of nursing home residents suffer from depression (Submission 58). This depression can respond to treatment, but is often undiagnosed, or assumed to be a normal part of ageing, and left untreated (Submission 58). The Ageing and Disability Department noted that

> *Improved diagnosis of depression is also important because it can cause dementia-like symptoms and without proper diagnosis people can be labelled (as is often the case with people with dementia) and treated with less respect* (Submission - 11 September 1997).

Research undertaken by Dr Brian Draper of Prince Henry Hospital also indicates the link between depression and the high incidence of suicide rates among nursing home residents (ADD Submission - 11 September 1997).

As noted above in the discussion on the rights of people with dementia, residents who have a diagnosis of dementia can also have behavioural problems which could be assisted by specialist mental health or psychogeriatric services.

Despite the high level of psychiatric illnesses in nursing homes, there are few specialist mental health care workers to treat them. According to a survey published in the *Australian Journal of Public Health* in 1995, less than one half of the nursing homes in Sydney received visits from a mental health professional for an hour or more each month. Only 7% of facilities in the study received more than four hours a month of specialist care (cited in Submission 57).

It was further submitted to the Committee that:

> *Although a majority of area health services in New South Wales include comprehensive psychogeriatric services, some (especially in rural areas) do not, and most are not staffed adequately; most cannot provide an adequate service to nursing homes ...* (Submission 20).

The submission went on to suggest that the addition of one extra staff member per psychogeriatric team would suffice to meet the needs of most nursing home residents.

The Australian Health Ministers Advisory Council's Mental Health Working Group has commissioned a Scoping Study on Older People and Mental Health which focuses on the linkages between accommodation, treatment, care and support service systems.

However, the Committee understands that the Scoping Study Working Group has not met for over six months, despite work being underway on the Work Program which was identified in the first stage of the Scoping Study.

RECOMMENDATION 34:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ascertain the progress of the Scoping Study on Older People and Mental Health, and to request a meeting of State and Territory representatives to advance the work program and promote improved linkages between accommodation, treatment, care and support service systems for older people with mental health needs.

A common problem for residents who are able to obtain the services of mental health specialists is access to a private space for consultations. A psychogeriatrician told the Committee:

> *If I want to interview a patient - I am asked to see people if they are depressed or something was bothering them or when they have psychosis - it is very hard, usually impossible, to find somewhere private to interview the person. If there is an interview room, it is a long way away. There are three other people in the room; it is not fair to ask them to leave. The person I am seeing often isn't mobile. So it makes life tough* (Brodaty, Evidence - 21 April 1997).

This situation makes it very difficult for residents with mental illnesses to obtain professional help in a confidential manner. No one wants to discuss their problems while there are three other people in the room; this includes mental health as well as other health related problems. It is essential that a private interview room be made available at all residential aged care facilities, and that this room be centrally located.

RECOMMENDATION 35:

The Committee recommends that Minister for Health ensure that all residential aged care facilities in New South Wales be required to set aside a private interview room for residents to consult with health personnel, including mental health specialists. The private room should be located as centrally as possible to ensure that the less mobile residents are able to access it.

While most residents with mental illnesses or challenging behaviour can be treated in-situ, there are always a small number of residents who require care in specialised facilities. In previous times, elderly people with mental illnesses would have been admitted to psychiatric hospitals. However, with the policy of deinstitutionalisation, and the closure of many beds, other alternatives must be sought. Unfortunately, as previously noted, New South Wales lacks alternative facilities suited to caring for older people with challenging or disturbed behaviours. This not only means that older people who have a mental illness are denied appropriate care, but it creates disturbances in nursing homes and can be distressing for other residents (Submission 20). As was proposed in Recommendation 23, the development of an appropriately resourced comprehensive network of psychogeriatric community teams would also benefit older people with a mental illnesses.

The Committee was informed that the Report of the NSW Health Task Force on the Mental Health of Older People is due for release in October 1997:

> *The report's recommendations address a range of issues specific (to) dementia and recognise the current shortfall in long term care places in New South Wales for (people with) severe behavioural disturbances associated with dementia* (NSW Health, Submission - 11 September 1997).

The Committee looks forward to the publication of the Report of the Task Force.

4.6 RESIDENTS WITH PARTNERS

Residential services do not, in the main, include consideration of the rights of residents to sexual expression and relationships. While the Charter of Residents' Rights and Responsibilities stipulates that residents have a right to maintain personal relationships, it does not mention sexual relations. The Committee is concerned that it is frequently assumed that residents of nursing homes are asexual. Couples are often unable to share a room privately together. It was also submitted to the Committee that elderly gay or lesbian couples face discrimination because of their sexuality (Submission 44).

It is not uncommon for married couples in the same facility to be accommodated in separate rooms. It was reported to the Committee, for example, that a husband and wife in a facility in a town in rural New South Wales were placed in separate rooms against their wishes. In other cases, husbands and wives have been separated by many hours' driving time, as discussed earlier.

The Committee was informed that the third exposure draft of the *Aged Care Act Principles* does not include a right to sexual relations.

RECOMMENDATION 36:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to include in the *Aged Care Rights Principles* a specific reference to a right to sexual relations.

4.7 YOUNGER NURSING HOME RESIDENTS

The Committee heard disturbing evidence concerning the situation of younger residents of nursing homes. There are 929 residents of nursing homes in New South Wales who are under the age of 60 years. The most common disabilities of younger residents are acquired brain injuries (28.4%), intellectual disabilities (23.4%), neurological impairments (21.4%) and physical disabilities (21.2%) (Jacobsen, Evidence - 12 May 1997).

It was submitted to the Committee that nursing homes are an inappropriate place for younger residents. Nursing homes catering for older people focus on preventing the degeneration of the health and abilities of their residents. By contrast, the needs of most people with an intellectual disability are developmental or educational. Residents with disabilities require intensive developmental programs implemented by staff who have an understanding of the needs of intellectually disabled people and the skills to meet those needs (Submission 67). For residents with acquired brain injuries, there is a pressing need for rehabilitative services to allow them to develop their potential. These services are unavailable in many nursing homes.

The care and developmental needs of the intellectually or physically disabled and those with acquired brain injuries are very intensive and are more costly than caring for an aged or frail resident. The Committee was told that:

> *The per capita funding that is available under the disability program is far in excess of the upper level of per capita funding available as a subsidy in a nursing home ...*
>
> *... disabled residents of nursing homes, at something of the order of $77,000 per person, per year ... [while] the upper limit for funding in an aged care nursing home is more of the order of $45,000. ... It would be impossible to meet the disability standards of people at the high needs end of the spectrum without extending that level of dollar per capita ...*
>
> *... you could argue that the nursing homes that do accept [younger] people with very high support needs, in the absence of appropriate funding, will be forced into the position of [providing] ... something that is in fact substandard for those particular individuals* (Clark, Evidence - 12 May 1997).

A particular problem for younger people in nursing homes is that they can feel isolated, with few people of their own age group to communicate with, or who share their experiences.

One younger resident described her experiences in a nursing home to the Committee:

> *Because I have cerebral palsy I sometimes get spasms in my arms and legs. At meal times I am not allowed to sit with the other residents because they complain to the staff that I might kick or bump them ...*
>
> *... Most of the people I live with are old enough to be my grandparents, and I don't have anything to talk to them about. Most of them wouldn't talk to me anyway...*(McMinn, Evidence - 12 May 1997).

For many younger residents of nursing homes, there are insufficient activities to occupy them. Some nursing homes exclude disabled residents from their organised activities, and "do not support an individual's access to a range of community services and facilities" (Submission 38). Diversional therapy designed for frail, aged or dementing residents may not be appropriate for younger residents. As Ms McMinn commented:

> *We do have a diversional therapist who comes to the hostel, but the majority of her activities I cannot access because I am blind and I have a profound hearing loss, and you need to be able to walk, or maybe my hands are not good enough, or something....*
>
> *... Someone told me that I could stare at the walls, but I can't; I'm blind, and I can't see them ... If I had the opportunity to go to a day centre it would certainly make my life a lot better. ... then I would be with people like myself and of my age and I would have people to talk to or maybe someone to read my mail for me* (Evidence, 12 May 1997).

Residents of nursing homes are unable to access HACC and other State services such as day centres if they are resident in a facility with a diversional therapist because this would be considered "double dipping". The Committee recognises that cost constraints operate in the area of aged and disabled care, but it appears that younger nursing home residents are missing out altogether as a result of bureaucratic inflexibility.

RECOMMENDATION 37:

The Committee recommends that the Minister for Aged Services ensure that any impediments preventing residents of aged care facilities under the age of 60 years accessing Home and Community Care services and other State services be removed as a matter of urgency.

RECOMMENDATION 38:

The Committee recommends that the Minister for Aged Services approach the Commonwealth to make the financial arrangements necessary to ensure access of residents of aged care facilities under the age of 60 years to Home and Community Care services.

RECOMMENDATION 39:

The Committee recommends that the Minister for Aged Services and the Commonwealth Minister for Family Services resolve the issue of transporting residents of aged care facilities under the age of 60 years to day centres and other Home and Community Care services.

Younger nursing home residents are usually admitted into a nursing home because of the lack of other alternatives. According to the Council for Intellectual Disabilities:

> *At present people with an intellectual disability are entering nursing homes because of a lack of suitable alternative accommodation rather than because of any assessed need for nursing care* (Submission 67).

People with intellectual disabilities and neurological damage are better placed in supported accommodation in group homes, or living in their own flats with support services.

The Committee heard that a high level Accommodation Task Force has been established to consider the accommodation needs of people with disabilities and older people. The Task Force has established estimates of the costs of moving younger people out of nursing homes into the community. The Ageing and Disability Department submitted:

> *the Taskforce has estimated that approximately $55 million in capital funding and $30 million in recurrent funding would be required to address this problem at the lowest level estimate* (Submission - 11 September 1997).

The submission continued:

> *the NSW Government is unlikely to have the resources to address this problem in the near future* (Submission - 11 September 1997).

The Committee believes that the Commonwealth Government as well as the NSW Government should take responsibility for addressing the particular needs of younger people living in aged care services.

RECOMMENDATION 40:

The Committee recommends the Minister for Aged Services approach the Commonwealth Minister for Family Services to (1) develop a joint strategy to facilitate the transfer of the 929 younger people currently residing in aged care facilities out of these facilities into more appropriate accommodation options in the community, where possible, and (2) where this is not possible, ensure that younger persons receive the appropriate therapy and services they need.

The Committee understands the final report of the Accommodation Task Force is expected to be provided to the Ministers for Aged Services, Housing and Health in the near future. While it is inappropriate for the Committee to comment on the recommendations in that report, the Committee commends the Task Force for undertaking such an ambitious task, and it looks forward to more positive accommodation outcomes for older people and people with a disability as a result.

4.8 OLDER PEOPLE WHO HAVE ACCOMMODATION, SUPPORT AND SOCIAL NEEDS

The majority of this Report has focussed on people who require high levels of care and that part of the residential system which supports them. This section considers those people who do not have significant care needs, but require some accommodation and social support, and comments on how the service system best meets their needs, or doesn't, as appears most often the case.

People who require admission to a residential facility need to be first assessed by an Aged Care Assessment Team. One of the main reasons why people have historically entered hostels, or low care level aged care facilities, is because they have been assessed as requiring assistance with personal care needs and/or having accommodation, support and social needs which cannot be met in a community setting. Under the current (pre-1 October 1997) system, residents who mainly required social and accommodation needs, but not personal care, are classified as 'hostel level' residents and a Commonwealth subsidy is provided for those residents in this category who are Financially Disadvantaged Persons (FDPs).

The Commonwealth funding for hostel residents reflects the residents' assessed care needs. The lowest level of funding is for people who are assessed as requiring only hostel care, with no personal care (Submission 53). Hostel Care subsidies are currently

$2.95 per day for residents who entered the hostel before 27 April 1993, and $3.55 per day for those who entered thereafter (Department of Health and Family Services, November, 1996). The Personal Care subsidies range from $26.90 - $35.30 for FDPs and $23.40 - $31.90 for non-FDPs.

The practice in recent years has been to reduce the number of people approved for hostel entry. In the past three years, the proportion of Hostel Care classified residents has dropped from 45% to 30%. Approximately one half of these residents were Financially Disadvantaged Persons (Submission 46); in New South Wales there are approximately 5,000 such residents currently in hostel accommodation. At the same time, some hostel residents whose care needs have increased have remained in hostels rather than move on to nursing homes. Consequently, there is somewhat of an overlap between the most frail residents of hostels and the less dependent nursing home residents (Halton, Briefing - 12 December 1996).

The Committee received a number of submissions about the inadequacy of the current hostel system to meet the needs of this group of older people who require accommodation and social support, rather than personal care needs. The Manning Valley Senior Citizens' Homes commented:

> *the adequacy of supported hostel-type accommodation to meet the needs of independent ageing persons is poor and the situation is becoming worse and will continue to do so until the need for the "social" model hostels for independent ageing persons is recognised and purpose-built buildings are once again provided for that purpose* (Submission 41).

The Director of Nursing of Fairview Hostel in Moree submitted that, as hostel residents have been admitted with increasingly higher care needs, hostel accommodation "meets the needs for the dependent aged person but the independent person is now inappropriately placed" (Submission 50).

The Australian Catholic Health Care Association noted:

> *Hostels are increasingly accommodating more dependent residents and therefore access for Hostel Care consumers has been declining at a significant rate. ... Their need is for safe and secure accommodation, socialisation support and some supervision in their activities of daily living. ... Current Government policy is that people with essentially a housing need have this met through the public housing program. Whilst some hostel care residents may fall into this category, the majority are people who can no longer function while living alone and require some form of congregate housing for social support and security reasons* (Submission 46).

An aged care worker submitted that:

> *The resolution to keep consumers out of institutional care for as long as possible has also changed the social environment of hostel accommodation. Residents are more likely to have advanced dementia and/or high dependency needs. For the more independent residents this may compromise their living environment* (Submission 83).

Under the changes to the residential aged care system which the *Commonwealth Aged Care Act, 1997* will bring, older people who would previously have entered hostels for accommodation and social, rather than personal care, needs will no longer be eligible for a Commonwealth subsidy. These changes apply both to existing residents and prospective residents. The Commonwealth has assured existing Hostel Care residents that their security of tenure is guaranteed under the Outcome Standards, and that most hostels will be able to continue operation (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 16, 1997). However, new residents who need supported accommodation, but who do not have a care need, will have to seek other options in the aged care and housing sectors.

Submissions and evidence reveal a great deal of concern about the abolition of the Hostel Care subsidy. The Aged Services Association, for example, submitted that:

> *The effects of the Commonwealth removing Hostel Care funding without the provision of compensatory housing and care funding will be wide ranging. Those financially disadvantaged hostel residents currently receiving Hostel Care may, in some cases, become homeless. Increased pressure will inevitably be brought to bear upon State-funded services in the housing and community sector, and upon the goodwill of the church and charitable sector. It is critical that funding be made available to enable this group of people to access other forms of supported accommodation* (Submission 66).

Ms Betty Johnson from the Older Women's Network told the Committee:

> *there will be a group of people who thought that they had an opportunity for accommodation in a hostel who will no longer have that opportunity. Many of them no longer have it now. We think it is part of the reason for a rise in homelessness* (Briefing - 12 December 1996).

The Uniting Church submitted that:

> *this means that those people who have retained some level of independence, and who have previously been able to access some minor hostel care services, will no longer be able to take up places in hostels. The sector has expressed considerable concern to the*

> *government about this and has sought the advice of the government as to how it proposes that these people will be dealt with in the future* (Submission 53).

The impact on providers may also be significant: hostel service providers have accepted "Hostel Care" category residents approved by Aged Care Assessment Teams on the assumption that such care for residents who are financially disadvantaged will be assisted by Commonwealth subsidies. These residents will no longer be subsidised, and the proprietors will be expected to absorb the costs. One service provider noted that this will create financial difficulties for providers:

> *The Hostel Providers cannot provide care without the subsidy and the people concerned on basic pensions cannot afford to pay the increased fee ...* (Submission 16).

The Commonwealth believes that increased subsidies for other categories of residents - especially people with dementia - will make up this cost and the overall impact on hostel providers will be "minimal" (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 14, 1997b).

Some hostels may require existing Hostel Care residents to pay an extra amount equivalent to the Hostel Care subsidy. It has also been suggested that, notwithstanding the right to security of tenure guaranteed in the residential agreements, evictions may occur.

A representative of Combined Pensioners and Superannuants told the Committee:

> *I think the withdrawal of the hostel care subsidy will mean that people will have to leave hostels and they will not have anywhere to go ...* (Benson, Evidence - 12 May 1997).

The impact of the abolition of the Hostel Care subsidy was also considered by the Senate Community Affairs References Committee. In its Report on Funding of Aged Care Institutions, the Senate Committee notes that it:

> *believes that although these people are in hostels largely for social reasons the social isolation faced by many people living alone can be debilitating and hostel care of this type will often ensure that these people maintain a better state of health and are provided with a safer lifestyle than when living outside a hostel setting* (June 1997: 38).

The Senate Committee continued:

> *In the long term, providing this type of accommodation may also reduce expensive medical or nursing home costs in the future* (June 1997: 38).

The Committee believes that existing Hostel Care residents who are subsidised should have a level of subsidy maintained to ensure that they are not forced out of hostel accommodation.

RECOMMENDATION 41:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to review the levels of Commonwealth payments for existing and subsidised residents of hostels (or low care residential aged care facilities, as they will be known) who do not have personal care needs.

The loss of access to hostel care will have significant impacts on the need for accommodation and care services such as the Home and Community Care (HACC) program, public housing and boarding houses.

HACC services may be a suitable means to meet the needs of older people who have accommodation but would have entered a hostel purely to overcome isolation or inability to cook and clean.

In the Interim Report of this Inquiry the Committee noted that funding for HACC services is already inadequate to meet demands. The Interim Report noted that the Commonwealth has made significant cuts to the HACC budget, with the difference to be made up by an increase in user-fees, at the discretion of the States. New South Wales currently charges user fees for some HACC services, so that a total of 11% of HACC funding is now raised through service fees. User fees will be required to almost double to 20% if HACC expenditure is to remain at the same level following budget cuts (Ms Moore, Evidence - 6 February 1997). The Interim Report concluded that more independent older person is thus faced with a simultaneous loss of access to hostels and an increase in charges for HACC services, and recommended that both the State and the Commonwealth will need to increase funding for the HACC Program accordingly if needs are to be met.

In its response to the Interim Report the Ageing and Disability Department noted that HACC growth for 1997/98 has been confirmed as $5.871 million following agreement between the NSW Minister for Aged Services and the Commonwealth Minister for Family Services. An additional $4.805 million will go to existing service providers as 2% indexation, which equates to approximately 2.4% growth in funding and is close to the 2.7% that was recommended in the Commonwealth Government's Efficiency and Effectiveness Review of the Home and Community Care Program (1995:14-15). The total budget for the HACC Program in New South Wales is now $250.939 million (ADD Submission - 11 September 1997).

The Committee is pleased that there has been this level of growth in HACC funding, however, it believes it may still be insufficient to meet the increased demand for services which is expected to result from the removal of subsidies for people who

would previously have entered hostels for accommodation and social needs. The Committee understands that the impact of the *Commonwealth Aged Care Act, 1997* on the demand for HACC services will be included in the data collection project which ADD and NSW Health is establishing (this is discussed further in Chapter 6). Should this monitoring confirm the fears of the Committee that the demand will be far greater than supply, then the Committee believes that additional funds should be allocated to the Program.

RECOMMENDATION 42:

The Committee recommends that the Minister for Aged Services closely monitor the demand for Home and Community Care (HACC) services which is expected to rise as a result of the implementation of the *Commonwealth Aged Care Act, 1997* and, if demand is greater than the funds available, the Minister negotiate with the Commonwealth Minister for Family Services to secure additional funding for the Program.

The implications for public housing and boarding houses stems from the fact that those residents who formerly would have been eligible for a Commonwealth subsidy are those who are financially disadvantaged. Many of these people have little or no alternative means of support (Aged-Care Rights Service, Submission - 8 September 1997). The option of the private rental market is not a realistic one. The Committee notes that these changes are being introduced at a time when the State is facing reductions in subsidies from the Commonwealth under the Commonwealth-State Housing Agreement.

As noted previously in this Report (Chapter 2), there are concerns that there will be an increase in unfunded hostels or boarding houses:

> *We anticipate a growth in this type of accommodation, especially in buildings which have failed to gain Commonwealth certification and accreditation. Funded beds can be sold or moved leaving the accommodation for use by unfunded operators* (Aged-Care Rights Service, Submission - 8 September 1997).

The Committee is seriously concerned that some of these operators appear to purposely operate outside any legislation, leaving vulnerable residents without adequate protection.

These changes highlight the need for a comprehensive aged care framework, as recommended by the Committee in Chapter 1, which takes into account the planning and provision of services for older people across the community and residential care spectrum, and for improved debate on sustainable financing options for aged care.

The Committee understands that the impacts of the changes on the demand for public housing and boarding houses will be monitored as part of the data collection project being undertaken by ADD and NSW Health. Should this monitoring confirm the fears of the Committee that the demand for such services will increase, then the Committee believes that additional funds should be allocated to monitor and licence boarding houses and to provide public housing assistance for older people.

RECOMMENDATION 43:

The Committee recommends that if the monitoring of the *Commonwealth Aged Care Act, 1997* shows that there is increased demand for public housing and boarding houses as direct result of the Act, then the NSW Minister for Aged Services and the NSW Minister for Housing commence negotiations to secure additional funding under the Commonwealth/State Housing Agreement, and that additional resources are provided to monitor and licence boarding houses in New South Wales.

The Committee notes that while the removal of the Hostel Care subsidy will have immediate negative consequences, it may also provide an opportunity for serious consideration of alternative accommodation options for older people. This would be consistent with the discussions previously in this Report about the need to consider aged care from a community care perspective, and also about the need for debate on longer term sustainable financing of aged care. While in one sense the changes may provide an impetus to shift the balance of care from residential to community, the Committee notes that this needs to be accompanied by a commensurate shift in funds between the sectors, something which clearly has not occurred.

4.9 PEOPLE WITH HIGH CARE NEEDS

Throughout this Report the Committee has noted the importance of developing aged care from a community care perspective, and the need to shift the balance of care (and funding) to where most people prefer to have that care provided - in the community.

The Committee has received evidence, however, that people with high care needs are currently unable to access services they require, primarily because of the Commonwealth's aged care planning ratios. This is especially a problem in rural areas, where often there are insufficient community based services available to keep people with lower care needs in the community, therefore putting pressure on high care places.

The Committee is concerned that the provision of high care beds is not sufficient to meet the current and future demands for that level of care, and believes that there should be ongoing review of the appropriateness of the planning ratios, in particular the provision of high-care beds/places in rural and remote areas.

RECOMMENDATION 44:

The Committee recommends the Minister for Aged Services include a review of the appropriateness of the allocation of high care places/beds, in particular in rural and remote areas, in the review of the *Commonwealth Aged Care Act, 1997* and development of the National and NSW Aged Care Strategies.

4.10 CONCLUSION

It is clear that the care needs and rights of particular sub-groups of residents in aged care services are not well met.

The Committee believes that this situation arises primarily from the absence of any clear set of principles about the sort of care system we want for people, and how we provide that care. In addition, there is inadequate commitment to using the sanction mechanisms currently available against those organisations which deliver care which is outside of these principles (as discussed in Chapter 2 of this Report).

The Committee also heard that there are a number of structural issues which also need to be addressed, and which will require a commitment of governments to work together more closely to both develop more responsive and appropriate service models, and provide the adequate resources to fund these models. In particular the Committee notes this is needed for the enhancement of community psychogeriatric teams, the transfer of younger people out of aged care services to more appropriate accommodation settings, and development of alternative accommodation options for people who need accommodation and social support, rather than care needs.

The Committee notes that there are a number of mechanisms already underway in New South Wales to address these issues, including the Accommodation Task Force and the NSW Action Plan on Dementia, but it is concerned that the NSW Government must be vigilant and committed if the aged care service system in New South Wales is going to achieve improved quality of life and protection of the rights of people in residential aged care services.

CHAPTER FIVE:

FINANCING AGED CARE

CONTENTS:

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

CONTENTS:

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.

CONCLUSION

The provision of aged care in New South Wales is currently undergoing major change. This Inquiry has been conducted in a highly volatile policy environment, with potential transfer of responsibility for aged care to the States, as part of the COAG negotiations, and the implementation of the *Commonwealth Aged Care Act, 1997* with its reforms to residential aged care services (the details of which are still emerging). It is a concern of the Committee that these significant changes to aged care are occurring in the absence of an over-riding set of principles to provide a holistic approach to the provision of accommodation, care and support for older people.

The Committee believes there is a clear need for a national strategy which ensures older people have equitable access to quality, affordable and appropriate aged care nationally. A similar framework to guide the policy, planning and delivery of services in New South Wales is needed so that the necessary linkages with related services older people use, such as health, transport and accommodation, can be developed.

Without a clearly articulated and agreed set of principles to guide the provision of aged care, the Committee believes that the rights of people who need those services will continue to be at risk of being compromised. In particular, the Committee is concerned about the rights of people to live with dignity and autonomy. To that end, the Committee strongly believes that the delivery of aged care should be focussed on maintaining older people where they most choose to live: in the community. To do this effectively requires governments to shift the balance of funding, as well as care, into the community.

The Committee notes that recent reforms to aged care services require consumers to contribute financially to their care needs. The Committee recognises that there are older people who can afford, and should be required, to pay for their care. However, the Committee is concerned that those who can least afford to pay may be disadvantaged by new arrangements. For these reasons the Committee emphasises yet again the importance of ongoing monitoring and evaluation of the changed arrangements.

The Committee strongly believes that there is a need to explore alternative methods of financing aged care. The debate about sustainable financing options for long term care has commenced in other countries; with the rapidly increasing population of older Australians this is a debate which we also urgently need to have.

The Committee reasserts its belief that older people are valued members of our society, and this needs to be reflected in the services and systems we have in place to support those who need them.

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APPENDIX ONE

SUBMISSIONS RECEIVED

THE COMMITTEE RECEIVED SUBMISSIONS FROM

91 ORGANISATIONS/INDIVIDUALS

NO.	ORGANISATION/AUTHOR OF SUBMISSION:
1	Mr J Turner
2	Ms N Pierce
3	Upper Hunter Village Association Ltd, Mr R Russell
4	Anglican Retirement Villages, Mr J Longley
5	Ms M Prince, Mr B Thompson, Bossley Park
6	Lachlan Lodge Hostel, Mr A Vagg
7	Grey Power NSW, Ms M Jones
8	Ms P Tremlett
9	NSW Clustering Service, Ms G Lee
10	Community Health Services & Programmes, South Eastern Sydney Area Health Service, Dr J Ward, FRACP
11	Yeoval Multi Purpose Health Centre, Mr C Francis
12	Teloca House - Narrandera, Mr A Reichelt
13	Co.As.It., Italian Association of Assistance, Ms C Riccio
14	Georgian Villages, The Uniting Church in Australia, Mr Noel Andrews
15	Australian Nursing Homes and Extended Care Association Limited, Ms Sue Macri, Mr Warren Bennett
16	Sir Leslie Morshead War Veterans' Home, Mr John Lambie
17	Ms T Holland
18	Confidential Submission
19	P & V Boardman
20	Royal North Shore Hospital and Community Health Services, Dr R J Russell, MB, BS, FRANZCP
21	Quirindi Retirement Homes Association Inc., A G Carter
22	Pioneer House Nursing Home, Mrs J Blackman
23	St Joseph's Hospital Auburn, Ms M Smith

No.	Organisation/Author of Submission:
24	National Association of Nursing Homes and Private Hospitals Inc., Mr A Brotherhood
25	Ms E McFarland
26	Berriquin Nursing Home Foundation Limited, Mr P Vamvas
27	S Wai
28	Catholic Care of the Aged, Diocese of Maitland-Newcastle, Mr R Watson
29	Ms F Cornford
30	Horton House, Ms P Collins
31	The New South Wales College of Nursing, Associate Professor D Picone
32	G McGroder, E Fountain, S Radvin, M Seskus, A Redpath, G Selby, R Little
33	North Western Slopes Community Transport, Mrs B Turner
34	Merrylands Nursing Home, Sr M Coulton
35	Lee Hostel Committee Incorporated, Reverend R Patterson
36	Council on the Ageing, Mr A Brown
37	Ms B Gorman
38	The Spastic Centre, North West Sydney Region, Ms L Cloughton
39	A Allan
40	Henry Kendall Village Pty Ltd, Mr P Wilde
41	Manning Valley Senior Citizens' Homes Ltd., D J Hawkins
42	Lutheran Aged Care, Ms S Joss
43	Agecare Group, Mr C Young
44	Matrix Guild NSW Inc., Ms M Hounslow
45	St Michael's Parish Nelson Bay, Ms C Norman, Ms E Maguire
46	Australian Catholic Health Care Association, Mr R Gray
47	Local Government and Shires Associations of NSW, Mr B Hartnett
48	Central Coast Community Care Association Limited, R E Brown
49	Fairview Nursing Home & Hostel, J Brett
50	Miss C Kelly
51	Ms D Lewis

No.	Organisation/Author of Submission:
52	Kenna Investments Pty Ltd, Ms M Hamilton
53	Uniting Church in Australia, NSW Synod, Mr L MacDonald
54	Westmead Hospital and Community Health Services, Geriatric Medicine Domiciliary Care Team, R Zugajev
55	Council of Retired Union Members Association of New South Wales, Mr J Holland
56	Royal College of Nursing Australia, Ms E Percival
57	Department of Psychiatry, The University of Sydney, Central Sydney Psychogeriatric Services, Clinical Associate Professor J Snowdon
58	Mr L Packham
59	Nepean Health, Governor Phillip Special Hospital, Geriatric & Rehabilitation Division, Dr G Bennett
60	Canterbury City Council, Mr J Montague
61	Manilla Shire Council, Mr J Hunt
62	Ms L McNabb-White
63	Home Care Service of N.S.W., Hostel & Care Program, W McDonald
64	Baptist Community Services - NSW & ACT, Ms J Heinrich
65	Ethnic Communities' Council of NSW Inc., Ms A Chan
66	Aged Services Association of NSW & ACT Inc., Ms I Frean
67	The New South Wales Council for Intellectual Disability, Mr J Jacobsen
68	Geriaction, Ms P Pallister
69	Country Women's Association of N.S.W., Mrs P Keill
70	Health Care Complaints Commission, Ms M Walton
71	Combined Pensioners and Superannuants Association of New South Wales Inc., Ms N McGuire
72	Confidential Submission
73	Confidential Submission
74	Confidential Submission
75	Confidential Submission
76	Confidential Submission

No.	Organisation/Author of Submission:
77	Alzheimer's Disease and Related Disorders Association of NSW Inc., Ms J Simms
78	The Australian Association of Gerontologists - NSW Division, Ms S Kratiuk-Wall
79	NSW Committee on Ageing, Mr J Mountford
80	Ms J Turner
81	Council of Social Service of New South Wales (NCOSS), Mr G Moore
82	NSW Aged Care Alliance, Mr G Moore
83	Confidential Submission
84	Confidential Submission
85	The Australian Podiatry Association (NSW), Ms K Robinson
86	Confidential Submission
87	Guardianship Board of NSW, Mr N O'Neill, President
88	New South Wales Nurses' Association, Ms S Moait, General Secretary
89	Ageing and Disability Department, Ms J Woodruff, Director General
90	The Aged-Care Rights Service Inc., Ms W Fisher, Solicitor
91	NSW Health, Health Services Policy Branch, Ms R Dewar

APPENDIX TWO

WITNESSES AT HEARINGS

THURSDAY, 6 FEBRUARY 1997 .

MONDAY, 21 APRIL 1997 .

MONDAY, 28 APRIL 1997 .

MONDAY, 5 MAY 1997 .

MONDAY, 12 MAY 1997 .

MONDAY, 8 SEPTEMBER 1997 .

THURSDAY, 6 FEBRUARY 1997:

MR GARY MOORE	Council of Social Service of New South Wales (NCOSS)
MS CATHY MOORE	Council of Social Service of New South Wales (NCOSS)
MS NATASHA CHADWICK	National Association of Nursing Homes and Private Hospitals.

MONDAY, 21 APRIL 1997:

MS JOAN SIMMS	Alzheimer's Disease and Related Disorders Association of NSW Inc.
PROFESSOR HENRY BRODATY	Alzheimer's Disease and Related Disorders Association of NSW Inc.
MS EVELINE ILBERY	Alzheimer's Disease and Related Disorders Association of NSW Inc.
REVEREND HARRY HERBERT	Uniting Church in Australia - NSW Synod, Board for Social Responsibility
MR LES MACDONALD	Uniting Church in Australia - NSW Synod, Uniting Ministry with the Ageing
MS HEATHER JOHNSON	Council on the Ageing.

MONDAY, 28 APRIL 1997:

PROFESSOR JOHN BRAITHWAITE	Australian National University, Faculty of Law
MS ISOBEL FREAN	Aged Services Association of NSW and ACT
MR JOHN IRELAND	Aged Services Association of NSW and ACT.

MONDAY, 5 MAY 1997:

MR CONOR KING	Commonwealth Department of Health and Family Services, Accountability and Quality Assurance Branch
MR PAUL MCMAHON	Commonwealth Department of Health and Family Services, NSW Office
MS SANDRA MOAIT	NSW Nurses' Association
MS SUE MACRI	Australian Nursing Homes and Extended Care Association
MR WARREN BENNETT	Australian Nursing Homes and Extended Care Association.

MONDAY, 12 MAY 1997:

MS PATRICIA BENSON	Combined Pensioners & Superannuants Association of NSW Inc.
MS CAROL BUNT	Combined Pensioners & Superannuants Association of NSW Inc.
MS LESLEY MAHER	Combined Pensioners & Superannuants Association of NSW Inc.
MS WENDY FISHER	The Accommodation Rights Service
MS ANN CLARK	The Spastic Centre
MS MARIKA KINTELLIS	The Spastic Centre
MS IRENE MCMINN	Yuranna House, Pennant Hills Nursing Home
MR JOHN JACOBSEN	NSW Council for Intellectual Disabilities
DR ANDREW WILSON	NSW Health Department, Public Health Division
MR ROBERT LAGAIDA	NSW Health Department, Performance Management Division.

MONDAY, 8 SEPTEMBER 1997:

DR RICHARD ROSEWARNE	Monash University, Senior Research Fellow
REVEREND HARRY HERBERT	Uniting Church in Australia - NSW Synod, Board for Social Responsibility
MS CATHY MOORE	Council of Social Service of New South Wales (NCOSS)
MS WENDY FISHER	Aged Care Rights Service
MS JANE WOODRUFF	Ageing and Disability Department
MS GILLIAN MCFEE	Ageing and Disability Department.

APPENDIX THREE

COMMITTEE BRIEFINGS

NEW SOUTH WALES

SYDNEY - 12 DECEMBER 1997 .

INTERSTATE

MELBOURNE - 2 MAY 1997 .

PARLIAMENT HOUSE, SYDNEY

THURSDAY, 12 DECEMBER 1996:

Ms Jane Woodruff	Department of Ageing and Disability
Ms Gillian McPhee	Department of Ageing and Disability
Ms Betty Johnson	Older Women's Network Australia
Ms Mary Banfield	Australian Pensioners and Superannuants Federation
Ms Sarah Halton	Commonwealth Department of Health and Family Services, Aged and Community Care Division
Mr Paul McMahon	Commonwealth Department of Health and Family Services, NSW Office.

PARLIAMENT HOUSE, MELBOURNE

FRIDAY, 2 MAY 1997:

Ms Jill Clutterbuck	Australian Nursing Federation (Vic)
Ms Anne-Marie Scully	Australian Nursing Federation (Vic)
Ms Mary Lyttle	Residential Care Rights
Ms Sue Healy	Older Persons' Action Centre
Ms Edith Morgan	Older Person's Action Centre
Mr Alan Hall	Department of Human Services, Aged Care.

APPENDIX FOUR

VISITS OF INSPECTION

INTERSTATE

- WUDINNA, SOUTH AUSTRALIA
- ELLISTON, SOUTH AUSTRALIA

NEW SOUTH WALES

- CESSNOCK
- WAVERLEY
- SUMMER HILL
- BARADINE, WARREN, TRANGIE, WALGETT

VISITS OF INSPECTION

Thursday, 1 May 1997	Wudinna Multi Purpose Service (MPS), South Australia
Thursday, 1 May 1997	Elliston Multi Purpose Service (MPS), South Australia
Friday, 9 May 1997	Allandale Nursing Home, Cessnock
Friday, 23 May 1997	Illowra Hostel, Waverley
Friday, 23 May 1997	Edith Cavell Nursing Home, Summer Hill
Thursday, 24 July 1997	Macquarie Area Health Service including: • Baradine Multi Purpose Service (MPS); • Calara House Hostel, Warren; • Kurrajong Court Hostel, Trangie; and • relevant health professionals, Walgett. Committee Members were accompanied by Mr Ray Fairweather, Area Chief Executive Officer.

APPENDIX FIVE

REPORT OF THE NEW SOUTH WALES MINISTERIAL TASKFORCE ON PSYCHOTROPIC MEDICATION USE IN NURSING HOMES

RECOMMENDATIONS

MAY 1997

EDUCATION AND TRAINING RECOMMENDATIONS:

That the Best Practice Model for the Use of Psychotropic Drugs in Residential Aged Care Facilities developed by the Guidelines Working Party of this Taskforce be accepted by NSW Health and promoted and distributed to all aged care facilities, other relevant services and general practitioners.

That a Resource Package be developed and evaluated for use as an adjunct to the Best Practice Model. The model and the Resource Package would be available for all staff and persons responsible for residents in residential aged care facilities.

That both the Best Practice Model and this Resource Package be distributed to all general practitioners, other relevant services and nursing homes through the Royal College of General Practitioners, NSW College of Nursing and industry organisations. The Package could be prepared for release to the private sector at a recovery cost fee.

That NSW Health should bring to the attention of the current training provider for National Action Plan for Dementia Care the education and training needs of staff. The current providers are the Hammond Care Group (Western and Southern New South Wales) and Mr Bob Price (Northern New South Wales). Given the high turn over of staff in the industry, any education and training must be ongoing. The availability of training should be included in the Best Practice circular.

That NSW Health accept the guidelines in the Report for the Use of Restraint in Nursing Homes provided by the Restraint Working Party which oblige nursing homes to provide restraint free environments to their residents wherever possible.

That NSW Health promotes relevant recommendations of this Taskforce by writing to other Departments who have a monitoring role with regard to residential care, drawing their attention to the Best Practice Model for Use of Psychotropic Medication and the possibility of the application of the model to other residential care situations regardless of occupancy arrangements.

PATIENT REVIEW RECOMMENDATIONS:

This Taskforce supports the recommendations by the Australian Pharmaceutical Advisory Council that each nursing home should institute a Medication Advisory Committee (MAC) to "develop, promote, monitor and evaluate activities which foster the Quality Use of Medicines in Residential Aged Care Facilities" through existing QA programs prescribed by the Regulations. Although one focus of the MACs would be the development in each nursing home of general policies, procedures and practices concerning medication, it also recommended that MACs establish a mechanism for the review of resident medications in the context of overall treatment/care.

It is recommended that NSW Health writes to the Urban and Rural Coordinating Units for the New South Wales Divisions of General Practice suggesting they apply for Commonwealth project funding to facilitate the implementation of a general practice peer review process to review general practitioner prescribing patterns in nursing homes.

- Clinical Indicators could be used in the peer review process.

- NSW Health request RACGP (NSW) to initiate the development of the clinical indicators mentioned in the above point which could be included in the Resource Package.

RESOURCE RECOMMENDATIONS:

That NSW Health recommends to the Commonwealth that the accommodation and resource needs of different resident groups in nursing homes be identified and that the issues relating to staff numbers and skills mix be examined.

That NSW Health Senior Executive Forum considers the need for further development of Area Mental Health Services for Older People through:

- determining appropriate services, such as specialist management on-site and counselling for nursing home residents referred to them;

- identifying the support and education needs of staff;

- reviewing the need for psychogeriatric beds for acute assessment and management of nursing home and community patients requiring such services;

- review the need for appropriate alternative accommodation for those people whose behaviours are unmanageable in mainstream nursing homes.

That NSW Health (Director, Centre for Mental Health and Director, Centre for Clinical Policy and Practice) examine mechanisms for the promotion and implementation of non-pharmacological strategies.

That NSW Health recommends that the Commonwealth review the level of remuneration for general practitioners who have patients in nursing homes. This should reflect the amount of time required for collaborative, multidisciplinary team work for optimal care including involvement in medication review committees and the higher administrative requirement.

LEGISLATION RECOMMENDATIONS:

That NSW Health accepts the recommendation to amend the *Nursing Homes Regulation* to:

- require Directors of Nursing to advise the Director-General of NSW Health within seven days of the failure of a medical practitioner to comply with the requirements of cls 44 and 45 of the *Nursing Home Regulation*;
- require medical practitioners to write reasons for prescribing medications in the nursing home clinical records;
- vary the requirements of cl 45 from requiring that all medications be reviewed every three months to no later than every three months, depending upon the duration of the treatment and the purpose for which the drug is being used;
- cross reference the provisions of the *Poisons and Therapeutic Goods Act* concerning the emergency ordering of medications by medical practitioners and dentists;
- amend cl 17(2) to provide for the adoption of guidelines concerning the use of restraint and of psychotropic medications;
- include a provision that the licensee must ensure compliance with all written policies and guidelines required to be in place by the regulation. Without such a requirement little value is achieved in having written policies or guidelines.

RESEARCH RECOMMENDATIONS:

That New South Wales recommends that the Commonwealth consider the provision of funding for research into the comparative costs and outcomes for caring for people in nursing homes, acute hospitals and acute psychogeriatric services to better understand the resource requirements of caring for older people requiring psychotropic and/or associated non-pharmacological therapy. This would include the impact of increasing complexity of illness and functional dependency of residents in nursing homes on clinical practice, resourcing and resident outcomes.

That a wider trial of the consultant pharmacist and nurse education as an intervention be undertaken to examine its broader applicability.

OTHER RECOMMENDATIONS:

That, as many recommendations impact on the Commonwealth's role in funding of aged care, a copy of this Report should be forwarded to the Commonwealth for their consideration and action.

APPENDIX SIX

INTEGRATED BEST PRACTICE MODEL FOR MEDICATION MANAGEMENT IN RESIDENTIAL AGED CARE FACILITIES

AUSTRALIAN PHARMACEUTICAL ADVISORY COUNCIL

FEBRUARY 1997

MEDICATION ADVISORY COMMITTEES

Each residential aged care facility should establish, or have direct access to and utilise the services of, a Medication Advisory Committee to facilitate the quality use of medicines.

MEDICATION CHARTS

a) All residents in residential aged care facilities, including respite as well as longer-term residents, should have a chart for recording administered drugs. Residents who self-medicate should receive a pharmacy-provided list of their medications, which must be updated whenever there is a change to the medication regimen. This could be in the form of a medication record chart.

b) The medication chart for use in the residential aged care facility should comply with the following requirements:

- the design must be adequate to enable certification of administration of the medication
- provision of a mechanism to indicate that review of medication has occurred by both prescriber and pharmacist
- provision of sections for PRN medications and once only doses
- provision of a section for nurse-initiated medication
- documentation of known adverse drug reactions
- provision of a mechanism to record telephone orders
- be rewritten by the prescriber at least every three months
- any other issues necessary to comply with relevant Commonwealth and State/Territory legislation.

MEDICATION REVIEW

A formal medication review should be undertaken in cooperation between the prescriber and an accredited pharmacist at least every six weeks. Confirmation that the review has occurred should be made on the medication chart.

ADMINISTRATION OF MEDICINE

1. A resident may choose to administer his or her own medication where it has been assessed by the medical practitioner that medication administration can safely be carried out by that individual.

2. For residents who are not self-administering, medication administration should be undertaken by a registered nurse. If a registered nurse is not available, it is recommended that the facility provide medications in dose administration aids. In all cases, medication should only be administered by adequately trained or qualified staff.

3. Standing Orders for the administration of a new medication in response to a resident's changed clinical state should not be used in residential aged care facilities.

4. The administration of nurse-initiated medication in residential aged care facilities should be:

- with the prior agreement of the medical practitioner
- from a defined list of drugs selected by and in accordance with protocols developed by the Medication Advisory Committee
- reviewed at least six monthly
- in line with State and Commonwealth legislation and guidelines.

APPENDIX SEVEN

CHARTER OF RESIDENTS' RIGHTS AND RESPONSIBILITIES

THE RESIDENTIAL CARE MANUAL

DEPARTMENT OF HEALTH AND FAMILY SERVICES

12 SEPTEMBER 1997

CHARTER OF RESIDENTS' RIGHTS AND RESPONSIBILITIES

A. Each Resident of a residential care services has the right:

- to full and effective use of his or her personal, civil, legal and consumer rights
- to quality care which is appropriate to his or her needs
- to full information about his or her own state of health and about available treatments
- to be treated with dignity and respect, and to live without exploitation, abuse or neglect
- to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation
- to personal privacy
- to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction
- to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect
- to continue his or her cultural and religious practices and to retain the language of his or her choice, without discrimination
- to select and maintain social and personal relationships with any other person without fear, criticism or restriction
- to freedom of speech
- to maintain his or her personal independence, which includes a recognition of personal responsibility for his or her own actions and choices, even though some actions may involve an element of risk which the resident has the right to accept, and that should then not be used to prevent or restrict those actions

- to maintain control over, and to continue making decisions about the personal aspects of his or her daily life, his or her financial affairs and possessions
- to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service
- to have access to services and activities which are available generally in the community
- to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service
- to have access to information about his or her rights, care, accommodation, and any other information which relates to him or her personally
- to complain and to take action to resolve disputes
- to have access to advocates and other avenues of redress
- to be free of reprisal, or a well-founded fear of reprisal, in any form for taking action to enforce his or her rights.

B. Each Resident of a residential care service has the responsibility:

- to respect the rights and needs to other people within the residential care service, and to respect the needs of the residential care service community as a whole
- to respect the rights of staff and the proprietor to work in an environment which is free from harassment
- to care for his or her own health and well-being, as far as he or she is capable
- to inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and his or her current state of health.